Canterbury District Health Board

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC01252)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 13 February 2012, Mrs A, aged 86 years, was admitted to a public hospital after a review by her general practitioner suggested a diagnosis of pneumonia. Mrs A had a complex medical history including dementia. At the time of her admission, Mrs A was noted to have had a recent fall, and was confused.

2. In 2006, Mrs A had appointed her daughter (Mrs B) to be her Enduring Power of Attorney (EPOA) for personal care and welfare. However, the EPOA was not activated via medical certification of Mrs A's incompetence.

3. At admission, sections of the hospital admission forms were left incomplete. On 13 February 2012, Dr D, a general physician, saw Mrs A. An X-ray showed no evidence of pneumonia, and Dr D considered that Mrs A might have a urinary tract infection. He performed a neurological examination but did not document it. On 14 February 2012, Mrs B was advised that her mother's behaviour was disrupting the ward. Mrs A was thought to have delirium in addition to cognitive impairment, and the medical team sought a review by Psychiatric Services for the Elderly (PSE). On 18 February, Mrs A was prescribed low dose (0.5mg) haloperidol (an antipsychotic), to be administered two-hourly as required. Mrs A was not assessed to ascertain whether she was competent to consent to the proposed treatment, and there is no evidence of any discussion with Mrs A and/or Mrs B about the options for treatment, or the risks, side effects, and benefits of treatment with haloperidol, or consent having been obtained for the administration of haloperidol to Mrs A.

4. The haloperidol was first administered on 19 February, after Mrs A became agitated and combative.

5. Mrs A was discharged on 23 February 2012, and her GP stopped prescribing haloperidol on 8 March 2012. Prior to the hospital admission, Mrs A had been able to walk well without an aid, but following her discharge she shuffled, taking small steps, and was unable to get in and out of bed by herself. Her facial expression was blank. Mrs B felt that the haloperidol was a major contributor to her mother's deterioration.

6. On 9 March 2012, Mrs A was readmitted to the public hospital, as she had not managed at home and was considered to have a severe risk of suffering falls. A cognitive assessment was not fully completed at admission. Mrs B requested that haloperidol not be administered to her mother. However, again it was administered five times between 15 and 19 March 2012 when Mrs A was agitated and non-compliant with cares. No consent was obtained for the administration of haloperidol.

7. Haloperidol was ceased on 20 March 2012 and, subsequently, Mrs A was administered low dose quetiapine (an alternative antipsychotic).

8. Mrs A was transferred to the dementia ward.

9. On 24 April 2012, Mrs B lodged a formal complaint with the DHB about the care provided to her mother. On 23 July 2012, Mrs B was advised of the final outcome of the DHB's consideration of her complaint. She was not satisfied with the response. Mrs B contacted the DHB again in August 2012, November 2012, and January 2013, seeking a further meeting with key staff. A further meeting was held with DHB staff on 1 February 2013.

Findings summary

10. Clinicians failed to be clear as to the legal basis on which haloperidol was being administered to Mrs A in February and March 2012, either by consent from Mrs A or within the terms of Right 7(4) of the Code.[1] Overall, this failing is concerning, and clearly suboptimal. It was found that Canterbury DHB breached Right 7(1) of the Code.[2]

11. In addition, the use of haloperidol during the second admission was unwise, and the issue of cessation of the haloperidol should have been considered earlier during that admission. Furthermore, the overall standard of communication between DHB staff, Mrs A and Mrs B could have been much improved.

12. There was a pattern of suboptimal documentation by multiple DHB staff. Canterbury DHB failed to comply with legal standards and, accordingly, breached Right 4(2) of the Code.

13. During April–July 2012 the DHB should have updated Mrs B more regularly about its consideration of her complaint.

Complaint and investigation

14. The Commissioner received a complaint from Mrs B about the care provided to her mother, Mrs A, by Canterbury District Health Board (CDHB). The following issue was identified for investigation:

Whether Canterbury District Health Board provided Mrs A with services of an appropriate standard between February and April 2012.

15. An investigation was commenced on 29 April 2014. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

[1] Right 7(4) of the Code states: "Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where —
(a) It is in the best interests of the consumer; and
(b) Reasonable steps have been taken to ascertain the views of the consumer; and
(c) Either, —
(i) If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
(ii) If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider."

[2] Right 7(1) states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

16. The main parties referred to in the report are:

Mrs A (dec)	Consumer
Mrs B	Complainant, Mrs A's daughter
Mr C	Mrs B's lawyer
Canterbury District Health Board	Provider
Dr D	General physician
Dr E	General medicine consultant
Dr F	Geriatrician
Ms G	Specialist nurse

Also mentioned in this report:

Dr H	Registrar

17. Independent expert advice was obtained from geriatrician Dr Maree Todd (**Appendix A**).

Information gathered during investigation

Introduction

18. This is a report about the administration of the antipsychotic drug haloperidol to Mrs A in response to her episodes of agitation and distress during her admission to hospital after a fall and with possible pneumonia. Mrs A's competence was not assessed and, although her daughter had been appointed as her Enduring Power of Attorney (EPOA) for personal care and welfare, the EPOA was never in force.

19. The consequence of the DHB's failure to assess Mrs A's competence was a lack of clarity as to who was able to provide informed consent to her care and treatment. As a result, appropriate consent was not obtained for the administration of haloperidol, either from Mrs A (if she was found to be competent) or from her daughter, Mrs B (if Mrs A was found incompetent and the EPOA activated).

20. Mrs B stated that the medication had an adverse effect on her mother, and that on the second admission it was given against Mrs B's express wishes.

21. This report considers whether it was appropriate, in the circumstances of this case, for Mrs A to have been given haloperidol, and whether appropriate consent was obtained.

First admission — 13 to 23 February 2012

Background to admission

22. On 13 February 2012, Mrs A, aged 86 years, was admitted to a medical ward in the public hospital,[3] after she was assessed by her general practitioner (GP) as possibly

[3] The medical ward had been temporarily relocated from another hospital because of the Canterbury earthquakes.

suffering from pneumonia. Mrs A was noted to have had a recent fall at home, and she had a temperature of 38.9ºC,[4] tachycardia (a pulse of 120+ bpm), respirations of 36 breaths per minute,[5] and oxygen saturations of 94%.[6] Mrs A was also noted to be mildly confused, with significant short-term memory loss (STML), but she was alert and cooperative. It was reported and explained by Mrs A's daughter, Mrs B, that Mrs A had also been non-compliant with her medications for the previous three to four days.

23. Mrs A had a complex medical history, including coronary artery disease and bypass grafting, dementia of two to four years' duration, hypothyroidism, and renal failure. At the time of her admission to the public hospital, Mrs A was living in an independent retirement village unit with her husband.

Enduring Power of Attorney

24. When Mrs A was admitted to the public hospital, the transfer of care documentation provided by the retirement village recorded that Mrs B held Enduring Power of Attorney (EPOA) for Mrs A's property and for personal care and welfare. This was recorded by hospital staff. The transfer documentation from the retirement village did not include a copy of the signed EPOA document. No medical certificate had been completed previously activating the EPOA for personal care and welfare.[7]

25. The DHB stated:

> "[We could] find no obvious evidence of any medical certificate detailing [Mrs A's] diminished capacity or of the EPOA being 'activated'. However, the premise followed by staff throughout the admissions, appears to have been one of consensus, and always involving [Mrs A] within the limitations of her capacity at the time, along with her husband and daughter [Mrs B], in any plans or decisions around her care and treatment (Right 7(3)), any EPOA notwithstanding."

Admission documentation

26. Mrs B told HDC that, on her mother's admission to the public hospital on 13 February 2012, she helped her mother to complete a hospital admission form. Mrs B said that she included information on the form regarding management of her mother's longstanding constipation, and indicated to staff that her mother should not receive calcium or iron supplementation as this worsened her constipation. Mrs B told HDC that she explained at admission that her mother was acting "typically for her" at that time.

[4] Normal body temperature can range from 36.5°C to 37.2°C for a healthy adult.
[5] The normal respiration rate for an adult at rest is 12 to 20 breaths per minute. A respiration rate under 12 or over 25 breaths per minute while resting is considered abnormal.
[6] Oxygen saturation is the concentration of oxygen in the blood. Normal blood oxygen levels are 95–100%.
[7] An Enduring Power of Attorney (EPOA) document for personal care and welfare was signed on 21 June 2006, outlining Mrs A's wishes that, in the event that she became mentally incapable, her daughter, Mrs B, would be her EPOA. HDC requested and received a copy of the EPOA from Mrs B's lawyer. Mrs B is also an executor and trustee of her mother's estate.

27. The patient admission questionnaire indicates in the section headed "support/cultural/lifestyle" that Mrs B was the family/whānau member by whom Mrs A wished to be helped during her hospital stay.

28. In the section headed "Advanced Directives/Resuscitation Status/Living Will", in answer to the question, "Do you have an Enduring Power of Attorney (EPOA)?", a box is ticked "Yes", naming Mrs B as the EPOA. A box is ticked "No" in relation to whether a copy of the EPOA document was with Mrs A.

29. The patient admission questionnaire was completed and signed as being "pp'd" by Mrs B. Mrs A did not sign the form. Mrs B also signed a "Contacts and Disclosure Details" form specifying that Mrs A's health information was to be disclosed to Mrs A's husband or herself. "EPOA" was added after her name.

30. The CDHB Older Persons Health Specialist Service Guidelines (the DHB Guidelines), in relation to obtaining a history and the management of a confused elderly patient, state: "In cases where the patient is unable to give the required information, collateral history from family, friends, carers, GP, neighbours, etc is essential."

31. It is recorded in the care assessment and planning admission documentation that Mrs A had altered cognition due to STML, but many sections on the hospital admission form are ticked as "No risk identified, proceed to next section". The "patient specific section" is blank.

32. However, an entry in the progress notes on 13 February 2012 refers to a discussion with Mrs B regarding her mother being very short of breath that morning, and also notes that Mrs A was noted to be alert but confused with time and date. In addition, nursing notes recorded at 2pm state that Mrs B had advised nurses that her mother was usually independent with mobility cares, but Mrs B was concerned that her mother was not compliant with taking her medication. Mrs A denied having falls. In response to my provisional report, Mrs B told HDC that her mother had had a fall causing a leg wound, and that "she decided in her state of delirium, that it was her medication which was causing the problems, and why she stopped taking it".

33. The DHB considers that staff liaised adequately with Mrs B on admission regarding her mother's needs.

Admission and initial care under the general medical team

34. Mrs A was noted to have reduced mobility and complicated co-morbidities, and she was admitted under the General Medical Team (the Medical Team). Mrs B told HDC that her mother's reduced mobility was a consequence of the leg wound and oedema from not taking her medication.

35. On 13 February 2012, general physician Dr D reviewed Mrs A. He also saw her on the morning ward rounds of 14 and 15 February 2012.

36. Dr D considered that his initial clinical findings (ventricular failure, angina, non-compliance with medication, possible respiratory tract infection, and possible increased confusion) suggested a urinary tract infection (UTI). Mrs A was treated with Augmentin (for infection) and frusemide (for her heart condition). An X-ray performed on 13 February showed no evidence of pneumonia. Mrs A was walking unsteadily at this time, and it was recommended that she be supervised. She was mobilised and seen by physiotherapy staff.

37. Dr D advised HDC: "There is mention of mild confusion and I instigated a delirium screen, but it was not a troublesome feature at that time and the above medical problems seem to more than adequately explain the delirium." He said that he performed a neurological examination but acknowledges that he did not document it. Dr D told HDC that given that Mrs A's symptoms were cardiac and pulmonary in nature (Mrs A had a significant cardiac history and was admitted very short of breath), the neurological examination would have been brief. Mrs B told HDC that she was not present, despite having been advised that she could be present at any neurological examination.

38. CDHB advised HDC that re-starting Mrs A's medications, particularly the frusemide, significantly improved her breathlessness.

39. Mrs B told HDC that she was contacted by staff, after 9pm, on the night of 14 February 2012 and advised that her mother's behaviour was "disrupting" the ward. Mrs B recalled that, during the call, a nurse asked her to consent to the administration of a sedative to Mrs A. Mrs B told HDC that she assumed it was a one-off and agreed, but said that the nurse gave her no information on the proposed sedative. There is no record of this telephone call in Mrs A's clinical records.

40. On 15 February 2012, it was recorded on Dr D's ward round that Mrs A appeared to have mild delirium in addition to her cognitive impairment associated with dementia.

41. Mrs B said that on 15 February 2012 she was telephoned by a nurse, who advised her that her mother was constipated. Mrs B told HDC that she advised the nurse that there was information about this on the admission form. Her recollection is that the nurse said that the forms were "not looked at after three days". There is no record of this telephone call in Mrs A's clinical records. Mrs B also told HDC that she had read a note that she saw in a red nursing folder, which recorded that a nurse had seen her mother perform a "manual faecal extraction".

42. On the evening of 16 February 2012, Mrs A became disorientated, and a sensor clip (an early warning device) was put in place to alert nursing staff of wandering.

43. On 17 February, staff from the DHB Community Rehabilitation Enablement and Support Team (CREST)[8] recorded that they discussed Mrs A with Psychiatric

[8] CREST was launched in April 2011 to ease pressure on capacity-stretched hospitals after the Canterbury earthquakes. It began as a community-based supported discharge team to facilitate earlier discharge from hospital to appropriate home-based rehabilitation services. It has since been extended to

Services for the Elderly (PSE), and that the PSE would review Mrs A on Monday 20 February.

Prescription and administration of haloperidol

44. Mrs A was first prescribed haloperidol on 18 February, to be administered two-hourly as required (prn).

45. Haloperidol is termed a "typical" antipsychotic, used to manage the behavioural and psychological symptoms of dementia (BPSD[9]).[10] The Medsafe data sheet for haloperidol applicable at the time of these events[11] includes in the indications for haloperidol use: "The management of manifestations of psychotic disorders such as schizophrenia, psychosis due to organic brain damage or mental deficiency, senile psychosis, the manic phase of manic depressive illness, Gilles de la Tourette syndrome." Acute management of BPSD is not specifically listed as an indication for use of haloperidol, and the use of haloperidol for this purpose is regarded as an "off-label" use of the medication.[12] However, haloperidol has historically been used for BPSD and does not differ significantly in effectiveness from atypical antipsychotics. Low dose haloperidol can also be used in the short-term management of the acute symptoms of delirium and appropriate symptoms of BPSD.[13]

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accept referrals directly from general practice, providing older people referred this way with care and support to be rehabilitated in their own homes so as to avoid hospital admission.

[9] BPSD refers to the behavioural and psychological symptoms of dementia, which includes the symptoms of disturbed perception, thought, mood or behaviour. Common behaviours associated with BPSD include calling out, aggression, agitation, delusions, wandering, insomnia, resistance towards carers, anxiety, and inappropriate social behaviours. Depression and delirium can also be associated with BPSD-like symptoms.

[10] BPJ. "Managing patients with dementia: What is the role of antipsychotics?" Issue 57, pp 26–36. See http://www.bpac.org.nz/BPJ/2013/December/dementia.aspx. Newer "atypical" antipsychotics (risperidone, olanzapine, quetiapine, and aripiprazole) are now also used for this purpose; however, risperidone is the only "atypical" antipsychotic formally approved for management of BPSD in New Zealand. If risperidone is not tolerated or not appropriate, then other antipsychotics may be considered for the management of BPSD, but they are regarded as being used "off-label" for this indication (see footnote 11).

[11] Dated 20 May 2009. New Zealand Data Sheet. Serenace. Haloperidol tablets, oral liquid and injection solution.

[12] Companies wishing to sell a medicine in New Zealand must make an application to Medsafe for approval. Medsafe then reviews the application, including information about the quality, safety and efficacy of the medicine concerned, and makes a recommendation to the Minister of Health as to whether the medicine should be approved. Medicines are approved for particular indications, dosages and routes of administration, as specified on the approved New Zealand data sheet. Approved medicines may legally be used in ways other than as specified on the data sheet, a practice that is termed "off-label" use. See: Medsafe, "Information for Consumers: Quality and Safety of Medicines: Medsafe's Evaluation & Approval Process" www.medsafe.govt.nz.

[13] BPJ. "Managing patients with dementia: What is the role of antipsychotics?" Issue 57, pp 26–36. See http://www.bpac.org.nz/BPJ/2013/December/dementia.aspx.

46. The Australia and New Zealand Society for Geriatric Medicine Position Statement 13, Delirium in Older People,[14] states:

> "10. Pharmacological measures are not always needed but should be considered to control distressing symptoms or when safety is compromised. Small doses of antipsychotics are effective and appropriate in the short term. When patients with an extrapyramidal[15] syndrome require treatment, atypical antipsychotics should be considered …"

47. With respect to haloperidol, the DHB Guidelines state:

> "To treat significant distress arising from agitation or psychotic symptoms, use haloperidol 0.25–0.5 mg BD [twice daily] PO … Regular dosing is preferred to PRN. Titrate up or down according to the response and withdraw as soon as possible."

48. The name of the person who prescribed haloperidol for Mrs A on 18 February is not printed in the records, and the DHB has not been able to identify which of the three doctors working at the public hospital that weekend was the prescribing medical officer.[16] There is no record that the proposed treatment was discussed with Mrs A or Mrs B, and Mrs B told HDC that there was no discussion with her about haloperidol.

49. A stated indication for the medication (such as dementia/confusion/agitation/prior use in the rest home) is not documented in the clinical records. There is no record that the prescribing doctor had ruled out other causes of Mrs A's confusion (such as infection).

50. The haloperidol was first administered subcutaneously at 5pm on 19 February, after Mrs A had become agitated and combative.

51. Dr D considers that, in Mrs A's circumstances, the very low dose of haloperidol that was prescribed was clinically reasonable. However, there is no documentation to indicate any discussion with Mrs A and/or Mrs B about the options for treatment, or the risks, side effects, and benefits of treatment with haloperidol, or whether consent was obtained for the administration of haloperidol to Mrs A. There is also no documentation to indicate that Mrs A was assessed as competent to consent to the proposed treatment at that time.

52. The CDHB policy document on informed consent[17] contains the statement:

> "Determining Competency
>
> Clinicians are often concerned to determine competence, i.e. to form an opinion as to whether a patient has the capacity to give informed consent.

[14] 2012 version.
[15] Relating to or denoting motor nerves that descend from the cortex to the spine but are not part of the pyramidal system.
[16] Dr D was on leave when the haloperidol was prescribed.
[17] Section 1.9 Diminished Capacity and Competence to Consent. Page 21. Volume 11 — Clinical Informed Consent (Reviewed July 2010). At the time of writing, the DHB was reviewing the policy.

> There are reasonably well established guidelines as to what criteria to use in the assessment, but clinical opinion and practice may vary. The law is vague, using such terms as 'mental capacity' and 'sound mind', but not specifying exactly what is meant by competence or its absence. Courts usually defer to clinical judgement."

53. Nursing notes for the afternoon shift of 19 February record "PRN haloperidol given as a preventative measure" and "A/W effect [awaiting effect] as was very unsettled, agitated last night)". Mrs A had a settled night.

54. Later on 19 February 2012 Mrs A was moved closer to the nurses' station for observation, and a healthcare assistant was assigned to her to assist with her mobility. Mrs B told HDC that she understood that the healthcare assistant was required to keep her mother in her room, as she was being disruptive.

Review by Psychiatric Services for the Elderly (PSE)

55. On 20 February 2012, PSE Specialist nurse Ms G reviewed Mrs A. Ms G said that Mrs A was diagnosed with cognitive impairment with associated functional impairment (suggesting dementia) and a non-adherence to prescribed medications at home because of an expressed paranoia regarding them. Ms G advised HDC that Mrs A had also been identified as having delirium "related to identified medical precipitants" with associated agitation. Ms G recommended regular twice daily lowest dose haloperidol, 0.25mg, for "delirium/paranoia". Ms G stated that her recommendation was a standard protocol for delirium as stated in the DHB Guidelines. Ms G also stated: "It is an off-label use [of haloperidol] but is a recognised international gold standard for managing agitated delirium."

56. On 20 February 2012, Mrs A received 0.25mg of haloperidol subcutaneously at 2pm and at 5pm. An additional dose was given at noon on 21 February 2012.

57. On 21 February, a trainee intern performed a modified mini-mental state examination (3MS).[18] Mrs A scored 67 out of 100, indicating cognitive impairment. Mrs B said that she was not informed that the examination would take place, and she was not present at the examination.

Discharge

58. On 23 February 2012, Ms G reviewed Mrs A, and noted that her delirium was resolving. Ms G recommended that Mrs A's GP wean and discontinue Mrs A's haloperidol after one month.

59. Discharge planning and social worker input occurred, and Mrs A was discharged on 23 February 2012 for follow-up by her GP. Mrs A was mobilising but unsteady, and it was noted that at times she did not lift her feet when walking. Mrs B told HDC that her mother was barely able to walk and she needed a wheelchair to convey her to the

[18] The modified mini mental state examination (3MS) is an expanded version of the MMSE (a questionnaire used to measure cognitive impairment) increasing the content, number and difficulty of items included in the assessment. The score of the 3MS ranges from 0–100. A score of 79/80 or less indicates the presence of cognitive impairment. A score of less than 48 suggests severe impairment.

car. During this admission she had also been noted to be iron deficient, and was started on oral iron. She was also discharged on Vitamin D.[19]

60. Mrs B told HDC that, at discharge, a nurse advised her that her mother had had no constipation during the admission, in contrast to the information in the earlier telephone call she said she had received.

61. The discharge summary indicated that Mrs A's cognition had improved. Mrs B's view was that it had not. Mrs B believes that the haloperidol prescribed during Mrs A's admission added to Mrs A's confusion and caused her further difficulty in walking. Mrs B told HDC that her mother had never previously needed to use a walking stick.

62. Mrs B became increasingly concerned at her mother's health after discharge. She was concerned that her mother was having difficulty walking, and she considered that her mother's face was strangely blank, which she attributed to the haloperidol. Mrs B queried with retirement village staff whether her mother had had a stroke.

Second admission — 9 to 23 March 2012

63. On 7 March 2012, a DHB social worker visited Mrs A at Mrs B's request and noted that, prior to the hospital admission in February 2012, Mrs A had been walking well without an aid, but now shuffled taking small steps, and was unable to get in and out of bed by herself. Mrs A was noted to be saying that she wanted to die and did not know what was wrong with her because she woke up one day unable to "remember how to do anything".

64. On 8 March 2012, following a discussion with Mrs A's GP, the manager of the retirement village and a community gerontology nurse sent a referral form to the DHB, which noted that Mrs A's mobility had deteriorated over the past week, and that she had required several visits by retirement village staff to assist her with toileting and getting out of bed. Mrs A's GP discontinued the haloperidol, and the plan was for her to be reviewed by hospital staff.

65. On 9 March 2012, Mrs A was readmitted to the medical ward of the public hospital owing to safety concerns because of her severe falls risk. Mrs B said that it was her understanding that her mother was to be admitted to the stroke ward for walking rehabilitation, and that the admission to the medical ward was against her wishes. Mrs B said that she was told that the stroke ward was full. Mrs B told HDC that she advised DHB staff that haloperidol had been stopped by her mother's GP prior to admission, and she requested that her mother not be prescribed haloperidol. Mrs B advised HDC in her complaint that she "told every staff member every day, that I talked to, 'that she was NOT to be given haloperidol'" (emphasis in original).

66. The admitting clinical notes for 9 March record that Mrs A's "daughter felt that haloperidol was a major contributor of this decline ([Mrs A] stopped taking it [two

[19] Mrs B complained that despite her having advised staff not to give Mrs A calcium, calcium was prescribed for her mother. There is no record in the clinical records of calcium being prescribed for Mrs A during this admission.

days] ago and improved)". Admitting staff also recorded querying that Mrs A's reduced mobility may have been secondary to haloperidol use and a degree of inactivity and disuse of her limbs. A sensor clip was in use during this admission.

67. Nursing staff documented that Mrs B was present at Mrs A's admission. However, the initial cognitive assessment and screening was again not fully completed at this admission.

68. On 11 March 2012, nursing staff recorded that Mrs B wanted to meet with the medical team to discuss her mother. There is no evidence that a meeting took place with the medical team in response to that request. Mrs B complained that she was increasingly concerned about the lack of communication regarding her mother's care and treatment, and she attempted to raise her concerns with staff on several occasions. She said that on one occasion on 13 or 14 March she was left waiting 40 minutes for the Charge Nurse after asking to speak with the person in charge, but that she had to leave before the Charge Nurse came.

Dr E

69. General medicine consultant Dr E was the consultant responsible for Mrs A during her second admission. He first saw Mrs A on Monday 12 March 2012. He performed a 3MS examination and obtained input from an occupational therapist and physiotherapist. The examination showed a result of 80/100, an improvement from the previous test on 21 February undertaken by a trainee intern. Mrs A was assessed as a high falls risk. Over the next two days, Mrs A remained confused and restless.

70. Mrs A was disorientated but otherwise well. Blood tests were repeated to investigate the cause of her delirium. Mrs A's blood count was normal, although it was noted that she had a slightly low potassium level (3.0mm/L),[20] an impaired but stable creatinine level (131µmol/L),[21] and a slightly raised calcium level (2.7mmol/L).[22] Mrs A had a normal urinalysis. She was given potassium replacement.

71. A meeting was subsequently held on the afternoon of 13 March 2012 with Mrs B and Mrs A's husband. Mrs A did not attend. Mrs B agreed that her mother would benefit from a higher level of care. The next day, Mrs A was referred to the Older Persons Health Service (OPHS) for review.

72. The DHB stated that, at 10pm on 14 March 2012, Mrs A was restless and disturbing other patients. Nurses discussed this with the duty medical officer, who did not favour the use of haloperidol at that time, and felt that Mrs A might settle after toileting. This advice was documented and supportive care was provided.

Dr F

73. On the morning of 15 March 2012, it is recorded that Mrs A's mobility had improved, and the sensor clip had been set off several times because Mrs A was moving around while indicating that she wanted to go home. Later that day Mrs A became agitated

[20] Normal reference range for serum potassium is 3.5 to 5.3mmol/L.
[21] Normal range is 45–90µmol/L.
[22] Normal reference range is 2.25 to 2.5mmol/L.

and threw a cup of soup at a window. Mrs B told HDC that her mother had told her that she threw the cup because she was "sick of being talked to like an idiot". It was noted that Mrs A was a retired health professional and had been attempting to help other patients, and became agitated when she was prevented from doing so. She was moved to an area where one-on-one supervision could occur.

74. In the afternoon of 15 March 2012, Mrs A was assessed by OPHS geriatrician Dr F. Dr F told HDC that Mrs A was stable and mobilising freely. He felt that she had dementia with superimposed delirium secondary to a new environment and the effect of a raised calcium level.[23] Dr F noted that haloperidol had recently been stopped. He considered that a rest home placement should be organised for Mrs A. Mrs B said that she had already made her own enquiries about moving both her parents to the main wing of the retirement village, where they would have more care.

75. In his responses to the complaint, Dr F also commented that:

- Mrs A had significant dementia and was living precariously at home;[24]
- the dementia, together with her other health issues, meant that Mrs A was more prone to in-hospital delirium;
- haloperidol is a recognised and appropriate agent to use for the agitated or paranoid element of a delirium; and
- DHB guidelines recommend low dose haloperidol and are in keeping with standard guidelines (such as the Australian and NZ Society of Geriatric Medicine position statements).

76. Dr F was not involved further with Mrs A's care.

77. On 15 March, registrar Dr H prescribed Mrs A haloperidol 0.5mg prn, four hourly. At 1.30pm, 0.5mg was administered subcutaneously.[25] Mrs B told HDC that Dr H telephoned her to advise that she had reviewed Mrs A's medications but that Dr H made no indication of any change to the medication.

78. There are no medical notes regarding the decision to use haloperidol at that time, and there is no record of Mrs A and/or Mrs B being informed about the treatment options or the benefits and risks of haloperidol, and no record that appropriate consent was obtained for the administration of haloperidol to Mrs A. There is also no documentation that Mrs A's competence to consent to that treatment was assessed at that time.

79. On 15 and 16 March 2012, Mrs A had periods of agitation and uncooperativeness. On 16 March, Dr H documented a lengthy telephone call to Mrs B. The call focused on Mrs B's expressed frustration at hospital staff communication with her during that week regarding whether her mother was to go home, or whether a rest home

[23] Dr E considered that the raised calcium level was due to Mrs A's vitamin D supplement, which he ceased. No other cause for the raised calcium was identified.
[24] Mrs B told HDC that to the best of her knowledge her mother had no significant dementia.
[25] Dr E accepted overall responsibility for his team and for Mrs A being prescribed haloperidol while under his care during this admission.

placement was to be organised. There was no discussion regarding the use of haloperidol. Mrs B told Dr H that her mother had been declining over the week, and would continue to do so if nothing was done. Dr H explained that Dr F's assessment was that a rest home placement was best. Dr E said that he also unsuccessfully attempted to contact Mrs B that day.[26]

Further reviews and haloperidol

80. On 16 March 2012, Dr E reviewed Mrs A. She remained confused, and it was noted that she did not recall why she was in hospital. On 17 March, Mrs A was non-compliant with cares and treatments — refusing medication, food, and fluids. She also threw a jug of water. She exhibited some paranoia, called out to other patients, and pulled a bandage off her leg.

81. Over the period of the weekend 16–19 March, haloperidol was given to Mrs A subcutaneously in doses of 0.5mg on four occasions — three times on 17 March, and once on 19 March. It was given by nursing staff, with good effect noted. Mrs A, although still confused, became more settled and was eating and drinking well and mobilising with a frame. On 18 March 2013, Mrs A was noted again to be well settled.

82. On 20 March 2012, Dr E saw Mrs A again at 10.40am. Dr E assessed Mrs A as having controlled congestive cardiac failure, with ongoing mildly raised calcium and stable kidney impairment. His treatment plan included stopping haloperidol and having Mrs A reviewed by PSE. He stated that he ceased the haloperidol because of the "concern that it may have contributed to her decline previously". Mrs B told HDC that on 20 March her mother was completely unable to function, and could not put on her glasses or wipe her nose.

83. Mrs A was also assessed at 11.30am on 20 March 2012 by Ms G, who noted Mrs A's periods of intrusive behaviour, new hallucinations, and a mild rolling tremor of her left hand, and raised the possibility of a diagnosis of Lewy body dementia.[27] However, it was considered that Mrs A's cognitive decline over a long period went against that diagnosis.

84. Ms G told HDC that Mrs A was referred for assessment for dementia level rest home care. Ms G's notes indicate that Mrs B told staff that her impression was that her mother's mobility was reduced, and that it was related to haloperidol usage.

85. Ms G also recommended stopping the haloperidol, and instead using an alternative medication to manage Mrs A's psychiatric symptoms. Ms G recommended low dose quetiapine be used as required, which she said was in line with the DHB guidelines. This change was instigated.

[26] The records note that Mrs B did not have a cellphone.

[27] Lewy body dementia causes a progressive decline in mental abilities. It may also cause visual hallucinations. Another indicator of Lewy body dementia may be significant fluctuations in alertness and attention, which may include daytime drowsiness or periods of staring into space. Like Parkinson's disease, Lewy body dementia can result in rigid muscles, slowed movement and tremors.

86. On 22 March, it was noted that the haloperidol had been discontinued because it was "? affecting mobility/[extrapyramidal side effects]". Mrs A was disorientated, agitated, had variable mobility, and wanted to leave the hospital.

87. On 22 March, Dr E reviewed Mrs A. At that time, her disorientation was unchanged. She was clinically stable, but had a left leg skin tear.

Family meeting

88. On 22 March 2012, Mrs B requested a meeting with the medical team.

89. A meeting was held that day at 2.45pm with Dr E, Dr H, Ms G and a social worker. There is no record that Mrs A was present. Staff discussed in detail Mrs A's health problems, the treatment of her delirium, and the use of haloperidol. Dr E offered an apology for Mrs A having been given haloperidol despite Mrs B having explained earlier in the admission that it seemed to have made her mother worse.

Transfer to dementia ward

90. During the family meeting on 22 March 2012, Ms G suggested the possibility of Mrs A being transferred to the dementia ward for specialist assessment and medication management. Mrs A was taken there for a look around and to meet some staff. A dementia ward consultant, agreed to accept Mrs A, and she was transferred there on 23 March 2012.

91. On 22 March 2012, Ms G's supervising consultant discussed and signed a completed application for dementia level residential care.

92. An Older Persons Health Service document dated 23 March makes note of Mrs A having had an adverse reaction to haloperidol, causing extrapyramidal side effects.

93. Mrs B's lawyer told HDC that Mrs B understood that Mrs A's EPOA was activated on Mrs A's admission to the dementia ward on 23 March 2012. However, Mrs B's lawyer also advised HDC that, as far as Mrs B was aware, there was no clinician's medical certificate certifying that Mrs A was incompetent.

94. There is no record in Mrs A's DHB clinical file that a medical certificate was completed outlining Mrs A's level of competence.

95. Mrs A was transferred to dementia hospital level care in April 2012. The OPHS discharge summary dated 26 April addressed to a dementia hospital level care facility states: "EPOA has been in place for 5–6 years — welfare held by [Mrs B] and property shared with lawyer."

96. Mrs A passed away a year later.

Additional information

97. Dr E reiterated in his response to HDC that:

- In relation to the use of haloperidol during the second admission, every attempt was made to manage Mrs A's delirium conservatively with good nursing care and supervision. As the delirium escalated and Mrs A posed a risk to herself and others, she required three doses of haloperidol on Saturday 17 March. Overall she had five doses subcutaneously between 15 March and 19 March. This helped to settle her and assisted in her management while in hospital.

- Although a neurological examination was not documented, neurological disease was considered. After she was transferred to the dementia ward, Mrs A had a CT scan, which showed mild small vessel ischaemic change and cerebral atrophy (common for a patient of that age) but no other reversible neurological abnormality. Dr E had considered Lewy body dementia a possibility, but unlikely, because of her slow decline and a left arm tremor having been present for seven to eight years.

- While there was no clear medical documentation for the reasons for prescribing haloperidol, it is commonly used for management of delirium. Mrs A had been assessed for causes of the delirium, and had had blood investigations (showing kidney impairment and mildly raised calcium, both of which could have contributed to the delirium) and urinalysis (showing no growth). Thus, other underlying reversible medical contributors were considered and looked for.

98. Dr E also stated:

> "In summary, [Mrs A] had a delirium which had been difficult to manage on a background of dementia and multiple other health problems. Investigations revealed electrolyte imbalances including the slightly low potassium (corrected with potassium supplement) and a slightly high calcium, which in a frail person, along with the new environment would have contributed to the delirium."

99. The DHB and Dr E also explained other relevant background to Mrs A's admissions, including the following:

- At the time of Mrs A's admissions, another hospital's acute medical wards had been temporarily re-located to wards at the public hospital as a result of the February 2011 earthquake. These temporary wards had limited capacity and facilities/supports. Medical teams often moved between the two hospitals multiple times a day (several kilometres return trip).

- Even though Mrs A's GP had ceased her haloperidol, it was re-charted several days into her admission to help manage her agitation and behaviour. Haloperidol is commonly and routinely given in small doses for this indication in elderly patients. Small doses are given because of elderly patients' altered metabolism. Haloperidol does have side effects including shuffling gait, tremors, and a mask-like facial expression. Mrs A had a left arm tremor, and the haloperidol may have made this worse. It can be given if patients have concurrent infection, if agitated

behaviour poses a risk. The goal is to manage delirium and improve a patient's safety. Haloperidol is used cautiously, continued once delirium resolves, and then is withdrawn gradually.

- Because of her altered behaviour, Mrs A was moved into a single room, where the environment was safer. Mrs B told HDC that this was for one night only.

- Rehabilitation of the elderly is always considered to improve safety and mobility prior to discharge. Dr E said that he had involved a geriatrician and the psychiatric service to assist with this.

Complaint to the DHB

100. Mrs B lodged a formal written complaint with the DHB on 24 April 2012. The letter was acknowledged by the DHB on 30 April 2012.

101. A letter advising on the progress of the DHB's review of her mother's care was sent on 29 May 2012. Despite contacting the CEO's Office, Mrs B received no further correspondence from the DHB until 12 July 2012, when the DHB updated Mrs B advising that resourcing pressure was affecting the response time.

102. On 23 July 2012, Mrs B received notice of the outcome of the DHB's investigation into the complaint. She was not satisfied with the response, and felt that the DHB had not investigated it properly. The DHB advised HDC that due to pressure on Customer Services staff, there was a long delay in replying to Mrs B. The DHB apologised to Mrs B for the delay.

103. Mrs B contacted a DHB Quality Manager in August 2012, November 2012, and January 2013 seeking a further meeting with key staff.

104. A further meeting was held on 1 February 2013 between Mrs B, Dr E, a Nursing Director, and a Quality Manager. The notes from the meeting record that Mrs B felt that if she had been better consulted during Mrs A's admissions then she would have been able to explain to staff what was normal for Mrs A, and the use of haloperidol could have been avoided. The DHB said that full explanations were offered to questions raised, and personal apologies given for the poor level of communication and that the involvement of family had been less than ideal.

Changes made to CDHB services

105. CDHB advised HDC of the following changes to its services as a result of issues highlighted by Mrs A's care and Mrs B's complaint:

- The general medical admission standard document now has a specific section prompting a neurological examination.
- The introduction of electronic prescribing is being rolled out in 2015.
- The learning from this case will be used by the DHB Medical Education and Training Unit.

- The DHB is involved in an international programme to produce an acute interRAI[28] electronic assessment tool to become part of the interRAI international suite of tools. This will provide the basis of assessments in the DHB where acute care patients are admitted.
- To improve communication with patients and families, a quality improvement step being implemented is a "4 Questions Form", which outlines the current working diagnoses and other basic information about management, and which is left with the patient for sharing, if they wish, with their family members.
- Patient Admission Questionnaire, Risk Screening/Assessment and care plans (newly introduced at the time of Mrs A's admission in February 2012) were reviewed and revised in July 2013.
- Procedure governing care of patients with delirium and dementia — the "Blue Book" Management Guidelines for Common Medical Conditions — has sections specific to managing the confused elderly and the patient with delirium. This handbook is now online on the CDHB intranet. Additional information on changed behaviour, memory loss, and dementia is also available on a DHB shared HealthInfo website.
- Information provided by the patient and family at admission has been, and continues to be, an important component of an individual care plan.
- Clinical nurse managers and social work managers have reminded all staff of the importance of recording all interactions with families in the case notes.
- Contact details for next of kin and significant others are part of the standard admission process, including recording EPOA details.

Response to provisional opinion

106. Mrs B's response to the "information gathered" section of the provisional report has been incorporated where relevant. Overall, Mrs B believes the "information gathered" section represents a fair review of the events that gave rise to her complaint.

107. Canterbury DHB accepted that a finding that it breached Right 4(2) of the Code is appropriate because of the pattern of inadequate documentation, which it said did not meet its own expectations and standards. Canterbury DHB said: "However, it is inappropriate to assume that this absence of documentation meant that [Mrs A] was unable to provide consent to the administration of haloperidol."

108. Canterbury DHB noted that delirium is fluctuating and variable in nature, and stated: "It is a changing and transient impairment of cognitive ability that can vary on an hour to hour basis. It is also exceptionally common." A senior DHB clinician said that of all the people aged over 65 years in an acute hospital setting in New Zealand today,

[28] InterRAI is an electronic assessment tool used by many health professionals working with older people throughout New Zealand. The assessments highlight any issues and help assessors to match services more closely to needs.

one-third will have delirium — ie, some impairment of their cognitive ability — but this may alter in a matter of hours.

109. Canterbury DHB submitted that Mrs A's competence was compromised, and as is consistent with delirium, her level of competence fluctuated. However, it stated that this "does not indicate that there was a prolonged period of incompetence throughout both hospital admissions".

110. Canterbury DHB agreed that the second administration of haloperidol was unwise. It also accepted that its processes for recording whether an EPOA exists, and whether it has been appropriately activated, would benefit from being reviewed.

111. Canterbury DHB stated that the facts of Mrs A having stated that she wanted to go home and her not attending the family conference on 22 March 2012 does not mean she had a prolonged period of incompetence during both hospital admissions, as was implied in the provisional opinion.

Opinion: Canterbury DHB

112. A DHB is responsible for ensuring that it has robust systems in place to provide an appropriate standard of care to its patients. It is also responsible for taking reasonably practicable steps to ensure that its staff members understand, and are compliant with, its policies, procedures and guidelines. Several deficiencies in Mrs A's care have been identified in this report (see below). I consider that failures by the DHB at an organisational level contributed to these deficiencies.

Informed consent

113. Mrs A was given haloperidol during her two admissions to the public hospital in February and March 2012. However, no consent to the administration of haloperidol to Mrs A appears to have been obtained. Mrs A did not give informed consent, her EPOA was not activated, and Mrs B was not consulted.

114. Except in limited circumstances, services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent (Right 7 of the Code). For consent to be valid, it needs to be given freely and competently. Right 7(2) of the Code provides that every consumer must be presumed competent unless there are reasonable grounds for believing that he or she is not competent.

115. The level of competence required to make a decision may depend on the nature of that decision. There are not always clear lines between states of competence and incompetence, particularly in cases like Mrs A's, and a consumer's competence may vary from time to time.

116. The issue in this case is whether there were reasonable grounds to believe that Mrs A was not competent to consent to the administration of haloperidol, at the time it was

administered to her. If there were not reasonable grounds to rebut the presumption of competence, then Mrs A should have given consent to her treatment herself. There is no evidence that Mrs A's consent to the administration of haloperidol was sought or obtained from her when the drug was administered to her in February and March 2012.

117. Canterbury DHB accepted that Mrs A had some capacity in relation to decisions about her care and treatment. However, it appears that clinicians may have had reasonable grounds to believe that Mrs A was not competent to consent to the administration of haloperidol, at the time it was administered to her. In particular, before Mrs A was admitted to the public hospital, she was exhibiting some confusion. Mrs A was known to have dementia, which was likely to result in a lessening of her cognitive facilities over time. It is documented that Mrs A was agitated and suffering from STML. Clinicians considered that, at times, she was suffering from delirium.

118. If Mrs A was not competent to consent to the administration of haloperidol at the times it was administered to her (in February and March 2012), then clinicians should not have proceeded to administer the drug to her unless they had a legal basis to do so. In this case, that legal basis could be provided through the application of Right 7(4) of the Code,[29] or through the activation of Mrs A's Enduring Power of Attorney for Personal Care and Welfare (EPOA). Under Right 7(4), haloperidol could be provided to Mrs A without her consent if she was not competent to consent to its administration herself and its administration was considered to be in her best interests and if reasonable steps had been taken to ascertain her views and either, after ascertaining Mrs A's views the treatment of haloperidol was considered to be consistent with the informed choice Mrs A would have made if she were competent or, if it was not possible to ascertain Mrs A's views, clinicians had taken into account the views of other suitable persons interested in Mrs A's welfare. This was particularly important with regard to the administration of haloperidol in March 2012, as Mrs B had expressed clear objections to her mother being given further haloperidol in light of the effect it had on her.

119. Mrs B informed DHB staff of the existence of an EPOA document, signed by Mrs A in 2006, which shows that Mrs A had turned her mind to surrogate decision-making should she be unable to make decisions for herself, and had decided that, in such a case, Mrs B would be the decision-maker on her behalf. The admission records note that a copy of the EPOA document was not with Mrs A at admission. I consider that,

[29] Right 7(4) of the Code states: "Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where —

(a) it is in the best interests of the consumer; and
(b) reasonable steps have been taken to ascertain the views of the consumer; and
(c) either, —
  (i) if the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
  (ii) if the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider."

in this case, Mrs B was clearly a suitable person who was interested in her mother's welfare and was available to advise the clinicians and, accordingly, if treatment of Mrs A with haloperidol was to be provided pursuant to Right 7(4) of the Code, Mrs B should have been consulted first, and her views should have been carefully considered.

120. As noted above, there is no evidence that Mrs A provided her consent to the administration of haloperidol in February and March 2012. Neither is there any evidence that clinicians considered that, at the time the haloperidol was to be administered, Mrs A was not competent and that the clinicians therefore turned their minds to the issue of substitute decision-making, either through the application of Right 7(4) of the Code or the activation of Mrs A's EPOA. The apparent lack of consideration of consent to the administration of haloperidol in this case is concerning.

121. In response to my provisional opinion, Canterbury DHB submitted that delirium is fluctuating and variable in nature, and stated: "It is a changing and transient impairment of cognitive ability that can vary on an hour to hour basis. It is also exceptionally common." It stated that the approach taken by staff "appears to have been one of consensus, and always involving [Mrs A] within the limitations of her capacity at the time, along with her husband and daughter [Mrs B], in any plans or decisions around her care and treatment (Right 7(3)),[30] any EPOA notwithstanding".

122. If it was known that Mrs A's competence to consent to her treatment fluctuated, it would have been prudent for the public hospital clinicians to have discussed the issue of treatment preferences with Mrs A when she was able to understand the information provided and weigh the risks and benefits of the proposed treatment. This would have helped ensure that her clinicians were able to provide treatment consistent with Mrs A's wishes during any periods of incompetence. I am particularly concerned that Mrs A's treatment with haloperidol was not discussed with her after it was first administered in February 2012, and her views sought on treating her with haloperidol in circumstances where she became incompetent in the future.

123. The DHB stated that, at any one time, a third of patients over the age of 65 years will be experiencing delirium that may result in fluctuating competence. However, neither the Canterbury DHB policy document on informed consent nor its Older Persons Health Specialist Service Guidelines provide clinicians with guidance on consent in cases of fluctuating or diminished competence. Given the frequency with which the public hospital treats elderly patients with competence issues and with delirium, I consider the lack of clarity in the DHB's informed consent policy in relation to substitute decision-making in the case of fluctuating competence to be suboptimal.

124. Mrs A should not have been administered haloperidol in February and March 2012 without her consent to that treatment, or there being clarity as to the alternative basis

[30] Right 7(3) of the Code provides that a consumer with diminished competence retains the right to make informed choices and give informed consent to the extent appropriate to his or her level of competence.

on which it was being provided. There was a lack of consideration as to who was able to provide informed consent to the administration of haloperidol to Mrs A. As a result, appropriate steps were not taken regarding that administration, either in terms of consent from Mrs A herself (if there were no reasonable grounds for believing she was not competent), or if there were reasonable grounds for believing that she was incompetent, either within the terms of Right 7(4) after appropriate consultation with Mrs B or with consent from Mrs B (if Mrs A was found incompetent and the EPOA activated).

125. The failure of DHB staff to take appropriate steps (in relation to consent issues) prior to the administration of haloperidol to Mrs A in February and March 2012 is concerning, and clearly suboptimal.

Clinical use of haloperidol

First admission

126. My expert advisor, geriatrician Dr Maree Todd, advised me that, in her view, the use of haloperidol during the first admission and at discharge was appropriate and reasonable in the circumstances. In addition, its use was in line with standard guidelines.[31] There is evidence of DHB staff investigating and treating the underlying causes of Mrs A's delirium and initially using supportive care.

127. Dr Todd also advised that the team caring for Mrs A tried to avoid using medications for her agitation (which is evident in the records for the period from 9 March to 15 March 2012), using it only when appropriately indicated for symptoms of paranoia, agitation, and behaviour that put Mrs A and other patients at risk.

128. Taking into account Dr Todd's expert advice, I am satisfied that the clinical reasoning for low dose use of haloperidol during the first admission was appropriate.

Second admission

129. I am mindful that Dr Todd has advised that the use of haloperidol during the second admission, although not appearing to be clinically contraindicated, was unwise for the following reasons:

a) The medical team thought that haloperidol was at least a contributor to Mrs A's reduced mobility.
b) Mrs B had expressed her concerns about its use to the team.
c) Alternative antipsychotics with fewer extrapyramidal side effects were available (one of which was used on 20 March).

130. I note that after Dr E ceased the use of haloperidol, it was formally recorded and highlighted that Mrs A had an adverse reaction to it. However, the cessation occurred some time after Mrs B had first raised her concerns. I agree with Dr Todd and, given the above three factors, the issue of cessation of haloperidol should have been considered earlier.

[31] Dr Todd referred to: Australia and NZ Society of Geriatric Medicine Position Statement, *Delirium in Older People*, and the Clinical Guidelines Centre UK.

131. Dr Todd also advised that on 17 March 2013, Mrs A's behavioural change should have prompted staff to consider a medical examination for new causes of delirium. I am mindful that later on 17 March and again on 18 March, Mrs A had settled, was eating and drinking, and was mobilising and, on 20 March, she was reviewed again by Dr E. However, I encourage nursing staff to reflect on their judgement in relation to this particular point.

Communication

132. The overall standard of communication between DHB staff, Mrs A, and her primary support, Mrs B, could have been much improved. Mrs B did not feel listened to as a concerned daughter, particularly in relation to issues she had raised about her mother's constipation, the use of supplements, and her observations of how haloperidol had affected her mother after the first admission. There were lost opportunities to communicate effectively with Mrs B to help to establish and identify Mrs A's needs clearly, and to record details on file accurately to assist other staff reviewing her records to provide continuity of care.

Conclusion

133. In my opinion, clinicians failed to be clear as to the legal basis on which haloperidol was being administered to Mrs A in February and March 2012, either by consent from Mrs A or within the terms of Right 7(4). Overall, this failing is concerning, and clearly suboptimal. In my view, Canterbury DHB breached Right 7(1) of the Code.

134. In addition, I consider that the use of haloperidol during the second admission was unwise, and the issue of cessation of haloperidol should have been discussed and considered earlier during that admission. Furthermore, the overall standard of communication between DHB staff, Mrs A and Mrs B could have been much improved.

Documentation — Breach

135. Dr Todd has identified deficiencies in documentation associated with the use of haloperidol, and I am critical of Canterbury DHB for these shortcomings.

136. First, there were no neurological examinations documented before prescribing haloperidol, which Dr Todd considered to be a mild departure from standards. Dr Todd added that a neurological examination is seen as a standard part of any admission documentation and progress examination for people who have a neurological disorder.

137. DHB clinicians have given an assurance that such examinations did occur, despite not being documented. I am pleased to note that the learning and improvements made as a result of this case include DHB admission documentation having been altered specifically to prompt neurological examination and its recording.

138. Secondly, I am concerned that there was no documentation as to whether there were any underlying reversible medical contributors to Mrs A's behaviour, or that explained the rationale for the prescribing of haloperidol in either admission. I am

satisfied that Mrs A had been assessed for underlying causes of the delirium, as is evident from the blood test investigations and urinalysis undertaken prior to its use. However, I would have expected this to be documented.

139. I am also concerned that the identity of the junior doctor responsible for prescribing haloperidol on 18 February 2012 remains unclear because of the poor legibility of the records. Clinical records need to be clear and legible.

140. Thirdly, after later reviewing her mother's records, Mrs B was concerned that some of her interactions with nursing staff were not documented. I have no reason to doubt that nursing staff had some degree of discussion with Mrs B about her mother at admission; however, this is not fully documented, and I am critical that the "Care assessment and planning: Initial Assessment" documentation was not fully completed at either admission.

141. This Office has continually stressed the importance of clear and accurate documentation. As set out in the Health and Disability Services (Core) Standards,[32] consumer information must be uniquely identifiable, accurately recorded, current and accessible when required.

142. In my view, there was a pattern of suboptimal documentation by numerous DHB staff. I find that Canterbury DHB failed to comply with legal standards and, accordingly, breached Right 4(2) of the Code.

DHB actions in response to complaints made — Adverse comment

143. Mrs B first raised her concerns with the DHB on 12 March 2012, requesting a meeting. A meeting was held with Mrs B on 13 March. A further family meeting was held on 22 March 2012, involving Dr E and other staff to discuss Mrs A's care. Dr E offered an apology for Mrs A having been given haloperidol despite Mrs B having explained earlier in the admission that it seemed to have made her mother worse.

144. On 24 April 2012, Mrs B lodged a formal written complaint with the DHB. While Mrs B's complaint was acknowledged and she was initially updated about the progress of her complaint, there was a delay in the DHB responding fully to her concerns, and it was not until 23 July 2012 that Mrs B received notice and details of the outcome of the DHB's further consideration of her complaint, after she had contacted the CEO's Office. The DHB apologised to her for the delay.

145. Mrs B was not satisfied with the DHB response and contacted the DHB again in August 2012, November 2012, and January 2013. A further meeting was held on 1 February 2013, involving Dr E and other senior staff. Explanations were offered and personal apologies given at this meeting.

146. While acknowledging the DHB's initial timely arrangement of a meeting in March 2012, I am of the view that the DHB should have more regularly updated Mrs B in the period April–July 2012 (in line with timeframes outlined in Right 10 of the Code of

[32] NZS 8134.1.2:2008, Standard 2.9.

Health and Disability Services Consumers' Rights) while making its efforts to address and resolve Mrs B's subsequent outstanding concerns. This may have avoided further escalation of the matter.

Recommendations

147. I recommend that within three weeks of this report being issued, Canterbury District Health Board provide Mrs B with a formal apology for its breaches of the Code. This is to be sent to HDC in the first instance, for forwarding.

148. I recommend that within three months of this report being issued, Canterbury District Health Board:

a) Review the medical ward admission procedures.

b) Conduct an audit of a random selection of dementia patient admission notes from the last 12 months for compliance and completion of admission and cognitive assessment documentation. This audit should include the recording of contact details for a liaising family member and any individuals holding EPOA for personal care and welfare, and clearly ascertaining whether the EPOA has been formally activated by medical certification before decisions were made regarding significant matters and the appropriate documents sighted by staff.

c) Update the CDHB Older Persons Health Specialist Service guidelines and the DHB policy on informed consent (under review in 2015) and implement a process that ensures and records that pertinent patient information obtained on admission includes that of cognitive functioning and assessment of competency, and that this is brought to the attention of the senior clinician with primary responsibility for the patient, and is included in the patient care plan.

d) Provide HDC with a copy of the general medical admission document, which now has a specific section prompting a neurological examination for patients with dementia and/or delirium.

e) Update HDC on the introduction of electronic prescribing, and on its involvement in the international programme to produce an acute care interRAI electronic assessment tool.

f) Provide HDC with a copy of the "4 Questions Form" developed, together with a copy of the revised Patient Admission Questionnaire, Risk Screening/Assessment and care plans now in use.

g) Survey OPHS nursing staff regarding knowledge of how to access online and web-based procedures governing care of elderly patients with delirium and dementia.

Follow-up actions

149. A copy of this report with details identifying the parties removed, except the expert who advised on this case, and Canterbury District Health Board, will be sent to the Royal Australasian College of Physicians (RACP).

150. A copy of this report with details identifying the parties removed, except the expert who advised on this case, and Canterbury District Health Board, will be sent to DHB Shared Services, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent geriatrician's expert advice

The following expert advice was obtained from geriatrician Dr Maree Todd:

"I, Maree Ann Todd, am a registered medical practitioner in Internal Medicine (Geriatric Medicine).

1. I have read the guidelines for independent advisors to the Health & Disability Commissioner.
2. I am a consultant specialist in Geriatric Medicine and have worked as a consultant at Auckland City Hospital since 1991. My qualifications are MBChB (University of Auckland), FRACP and Diploma of Professional Ethics (University of Auckland). I am experienced in the care of older people, with a particular interest in the appropriate use of anti-psychotic agents in delirium and dementia.
3. Instructions and advice requested from the Health & Disability Commissioner is as follows:

[Removed for brevity.]

4. In reaching my opinion I have read:
   - The letter from [HDC], requesting my assistance.
   - The complaint about Canterbury District Health Board from [Mr C] [dated] to the Health & Disability Commissioner including [Mrs B's] comments.
   - I have read the complete file of responses from the Canterbury District Health Board regarding the investigation and their response to the complaint.
   - I have read the full Canterbury Health Medical Records on [Mrs A], NHI: [number] (as supplied by HDC) with particular reference to:
     (a) The first admission from 13/02/12 to 23/02/12 including the clinical notes, care plans and drug sheets.
     (b) The full clinical records from the second admission 09/03/12 to 23/03/12 when she was transferred to the [dementia ward] at the public hospital where she stayed until her discharge on 26/04/13.
     (c) I particularly noted the clinical notes, the drug charts and behavioural records from the Health Care Assistants on the days she was administered Haloperidol.

5. Summary:

[Mrs A] was admitted on 13/02/04 a few days after she had had a fall sustaining a haematoma to her leg. She then became more confused at home, thought her pills had caused her fall and then she stopped her medications. She had a background history of coronary artery disease with coronary artery bypass grafting in 1987, severe mitral regurgitation and required medications to control her cardiac failure. She had a known history of dementia that is described as between 2–4 years in

duration. She also had a history of hypothyroidism, a past history of delirium associated with E. coli sepsis and chronic renal failure. On 13/02/13 she was seen by her GP who noted her to be febrile, tachycardic and tachypnoeic and he felt she may have had a right sided pneumonia and admitted her to hospital.

On admission she was noted to have an acute confusional state (delirium) and was afebrile on admission. She had one spike of high temperature on the night of 13/02/13 and was started on antibiotics (augmentin) the next day. Standard investigations to find the causes of her delirium were done and I note a chest X-ray showed signs of early left ventricular failure but no evidence of pneumonia. Her white cell count and CRP (a marker of inflammation) were elevated, supporting the use of antibiotics for a presumed respiratory infection.

Her treatment included reinstating Frusemide for treatment of her heart failure, oral Augmentin for a lower respiratory tract infection, re-orientation and supportive care. I note that she was mobilised early and a comment was that she was walking without a stick or frame although was a little unsteady. It was recommended that she was supervised when walking. There was no documentation of her neurological examination on admission but neither was there comment on any Parkinsonian features. I also reviewed the geriatrician notes from previous community visits and no comments were made of features of Parkinsonism or other features of Lewy Body Disease, although a tremor of her left hand was noted (type not specified).

She was mobilised early and seen by the physiotherapists who gave her a walking frame. They noted that she had poor balance. She tended to grab furniture to walk. The physiotherapist did not document any Parkinsonian features on 15/02/13. Over the 15th and 16th February her short term memory problems were noted and she was described as being intermittently disorientated and specific comments were noted about re-orientation to the ward and environment on the 16/02/13. On the 16/02/13 when the physiotherapist saw her she was walking without an aid to the TV room and back and again no comment was written about her gait.

On the night of 16/02/13 she became more disorientated, nursing staff introduced the sensor clip to alert them to her mobility (an early warning device). On 17/02/13 her daughter told the social worker that her confusion was far from her normal state. Supportive care including re-orientation, reassurance, and ongoing mobility continued, but on 19/02/13 she became very agitated, suspicious and combative. The nursing staff moved her closer to the nurses' station for closer observation. They put in place a Health Care Assistant for 1:1 care to help with her safety. On 19/02/13 in response to her increased agitation and combativeness — haloperidol 0.5 mg prn was prescribed.

There was no medical comment in the notes related to this. Haloperidol 0.5 mg q2h was prescribed. No maximum dose was prescribed. On 19/02/13 she had one dose at 1700 hrs, on 20/02/13 she had one dose of 0.25 mg at 1400 hrs and at 1700 hrs, and regular haloperidol 0.25 bd was prescribed because of ongoing agitation.

On 20/02/13 she was seen by a specialist nurse for Psychiatric Services for the Elderly who felt she had been paranoid on admission and she felt that she was guarded and suspicious at the time of her assessment. She recommended that

haloperidol 0.25 mg bd be started along with a prn use of haloperidol for the specific indications of paranoia and agitation. She only had one extra prn dose of haloperidol on 21/02/13 at midday.

She was reviewed again by [Ms G] on 23/02/13 and she noted there had been some improvement in cognition and orientation, and the suspiciousness had seemed to have resolved. Discharge planning continued with social worker and the multidisciplinary team and she was discharged home with support later on the 23/02/13. At this stage she was mobilising independently although was still unsteady. On the 22/02/13 it was noticed that she had some difficulty initiating steps with a comment that this appeared to be due to her not lifting her feet (physiotherapy aide). She was independently able to get in and out of bed. She was discharged home on haloperidol 0.25 mg bd with a clear plan for GP review and reduction of this. During her stay she was also discovered to be iron deficient and was started on oral iron. She was also discharged on vitamin D but I can see no record of her being prescribed calcium.

She was readmitted on 09/03/13 to the general medicine service after being seen in the community by a community registrar for Older Peoples Health. She had not been managing at home because of reduced mobility, difficulty getting in and out of bed and chairs. It was also felt that haloperidol had been contributing to her decline and her GP stopped this two days prior to admission. Apart from her mobility and transfer issues there didn't appear to be any other new symptoms. Her daughter felt she had been slightly more orientated than the previous day. The admitting doctors thought that her mobility had deteriorated possibly secondary to her haloperidol plus a degree of disuse and unfitness. There is no documentation of the neurological examination and no comment was made about any Parkinsonian features. I note that on 09/03/13 she was able to walk with a stick with minimal assistance to the bathroom.

Over the next few days she [was] described as being disorientated with evidence of short term memory impairment, she was mobilising with minimal assistance with a stick and supervision around the ward. On the evening 14/03/13 she became particularly restless and was disturbing other patients.

The nurses discussed her management with the duty manager and a decision made not to use haloperidol in case it made her worse. They continued with supportive care.

On 15/03/13 she was more restless, agitated and she threw a cup of food against the window. Due to safety issues for her, other patients and staff she was transferred to an area where she could have a healthcare assistant for 1:1 supervision. She was prescribed haloperidol 0.5mg po/sc 4 hourly prn. There were no medical notes relating to the decision. She had one dose at 1330.

On the same day (15/03/13) she was seen by a geriatrician [Dr F] who noted that she walked freely with a stick. He did not comment on any Parkinsonian features but he thought the haloperidol may have contributed to her mobility problems at home. He felt that she needed a higher level of care and recommended that she and her husband go to a rest home. He noted the mild hypercalcaemia which he

felt contributed to her delirium. He suggested that her aspirin be stopped in the context of her iron deficiency.

On 15/03/13 it was noted that she was a retired [health professional] and she had been trying to 'help' other patients and became agitated when the healthcare assistant tried to stop her doing this.

On the 17/03/13 she became non compliant with all cares and medications, needed constant monitoring, became very agitated, was going into other patients' bed spaces, threw a jug of water on the floor and became quite paranoid (thought they were trying to poison her via her drink). She was 'calling out to other patients, being disruptive and aggressive' (hospital aide record). She pulled the bandage off her leg. She had three doses of haloperidol over the day — 0.5mg sc at 1050, 0.5mg at 1700 and 0.5mg at 2100. There seemed to be some response to this with a settled night, compliance with eating and drinking and no behavioural issues documented on the 18th.

A further dose of haloperidol 0.5 mg was given on the 19th March following unpredictable agitation and food throwing early in the day.

Specialist advice was sought from the Psychiatry for the Elderly service and [Ms G] saw [Mrs A] on the 20th. The haloperidol was switched to quetiapine and the possibility of Lewy Body Disease raised for the first time. She was reviewed by [the] psychiatrist on the 22nd and transferred to their care on the 23rd March. She continued to have a fluctuating mental and physical state with overall deterioration in the absence of haloperidol.

6. Opinion

i) In my opinion the use of haloperidol during her first admission, from 13/2/13 to 23/2/13 and on discharge was appropriate and reasonable in the circumstances. The use of haloperidol was in line with standard guidelines, eg the Australian and New Zealand Society of Geriatric Medicine Position Statement, Delirium in Older People[1] and National Clinical Guidelines Centre UK.[2]

There is evidence of investigating and treating the underlying causes of the delirium, and using supportive care first. Appropriately low doses were used, specialist advice sought and a clear plan for review and discontinuation implemented at discharge. Haloperidol is an appropriate first line agent and in low doses (which were used in this case) and short term use have no more side effects than other atypical antipsychotics.[2]

ii) The use of haloperidol during the second admission was unwise rather than strictly contraindicated. The team tried to avoid medications for her agitation, using them only when appropriately indicated for symptoms of paranoia, persistent agitation and behaviour that were putting her and others at risk. On the morning of the 17th March she required subcutaneous medication and haloperidol sc is still a reasonable choice in a person who is refusing oral medications. (Many other agents are only available orally.) Although antipsychotic agents should be avoided if at all possible, this has to be a balance of benefit and harm to the individual patient and to others.

Parkinson's disease or Lewy Body Disease are the major contraindications to the use of haloperidol and these were not present or diagnosed at admission. Her mobility on the 9th and 10th March seemed to be back to a similar level prior to any use of haloperidol. It often takes a lot longer for the extrapyramidal side effects of haloperidol to wear off leaving me uncertain as to whether her readmission was due to the side effects of haloperidol, or an ongoing delirium or progression of her underlying dementia. In reality, the readmission was probably due to a combination of these factors. The diagnosis of Lewy Body dementia is difficult and is often only made with the passage of time. I do not think the medical team could be expected to have made this diagnosis.

The choice was unwise as

a) the team thought haloperidol was at least a contributor to her deterioration
b) her daughter had expressed her concerns to the team about the use
c) alternative antipsychotics with fewer extrapyramidal side effects are available eg quetiapine

iii) However I do have concerns about her care in the following areas

a) In neither admission was there a neurological examination documented. This is a standard part of the admission particularly if symptoms are related to the neurological system as in this case. If extrapyramidal signs had been detected this may have changed the choice of antipsychotic.
b) There was no medical documentation about the prescribing of haloperidol in either admission. In particular there was no documentation of the underlying causes to her behaviour and what her unmet needs might be. There was no documentation of whether there were any underlying reversible medical contributors to her behaviour (eg pain, infection, constipation, retention, etc).
c) On the 17/3/13 her behaviour change was severe enough to prompt a careful medical examination for new causes of delirium. There is no medical record of this happening.
d) There was a lost opportunity on admission on both occasions to identify her needs. If the 'Care Assessment and Planning: Initial Assessment' section on cognitive assessment and the Risk screening (C24009A) form, section communication/cognitive/mental health had been filled in appropriately earlier communication with her daughter about her mother's specific needs, background, likes and dislikes may have helped deliver more person centred care.
e) Factors a,b,d are mild departures from standards and c a moderate departure.

All the above frequently occur in our hospitals. Ongoing systematic improvements in the care of frail older people, and people with delirium and dementia need to be encouraged at all levels of the health system and in part are being addressed with the development of dementia care pathways throughout New Zealand.

I am unable to comment on the environment in which she was nursed, or the training of the nursing staff and hospital aides in respect to delirium, dementia, and the need for person centred care. These are all important aspects of care provision for people with dementia and those with delirium who are frequent users of health services.

1 http://www.anzsgm.org/documents/PS13DeliriumstatementRevision2012.pdf accessed 8/3/14

2 http://www.nice.org.uk/nicemedia/live/13060/49908/49908.pdf accessed 8/3/14"

Dr Todd also provided the following further comments:

"I have reviewed the documents provided to me which included my initial advice to the HDC dated 06/03/14. [Mrs B's] complaint details [date], initial DHB response dated 29/11/13, further DHB responses dated 14/08/14 and further DHB responses dated 20/10/14.

The only change I would like to make to my initial comments are on *page 3, paragraph 2* — I stated that on the 19/02/13 Haloperidol 0.5 mg prn was prescribed. On review of the notes I think this is the 18/02/13 although the first dose was given on the 19/02/13. This error would not change any of my advice.

In response to [Dr E's] comments in his letter to the Deputy Health & Disability Commissioner dated 23/05/14 regarding the lack of documentation as to whether any neurological examination of [Mrs A] took place my comments are:

The neurological examination is seen as a standard part of any admission documentation and progress examination for people who have a neurological disorder. He commented that neurological disease was considered and a CT was performed. A CT scan in this situation might be necessary but it is not sufficient to pick up many neurological abnormalities including acute stroke, Parkinson's disease or Parkinsonism and many other neurological abnormalities.

<u>In regard to remedial actions</u>

1. I doubt whether the InterRai acute tool will be done early enough to make a decision to help patients.
2. Doctors and nurses need to elicit information about cognitive functioning as part of the earliest assessment of patients, otherwise how will they know the information they are gathering is valid, how do they know they are giving informed consent, how do they know they are implementing appropriate treatment.
3. The revised forms (C240076 and C240076) will improve detection and subsequent management."