Gore Health Ltd

Southland District Health Board

A Report by the

Health and Disability Commissioner

(Case 08HDC03994)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr B, aged 82, had a history of heart and kidney problems. He was admitted to Gore Hospital on 23 March 2007 with symptoms of angina. Soon after admission, Mr B developed symptoms of gastrointestinal bleeding. Following a sudden deterioration in condition, he was transferred to Southland Hospital[1] on 2 April 2007 for further investigations.

Investigations were performed at Southland Hospital to check for gastrointestinal bleeding, but no source of bleeding was found. However, Mr B became increasingly confused and agitated over the next few days, and further tests were performed as his renal function deteriorated.

Mr B's family were increasingly concerned about his condition and, on 11 April 2007, they arranged for him to be transferred to Dunedin Public Hospital under the care of renal specialist Dr G, who had previously cared for Mr B. Despite aggressive treatment, Mr B subsequently died.

This report considers the care provided to Mr B by Gore and Southland Hospitals, in particular the specialist and senior medical staff support available to the doctors providing day-to-day care on site.

Parties involved

Mrs A	Complainant/Consumer's daughter
Mr B (dec)	Consumer
Dr C	Physician, Southland Hospital
Dr D	Physician, Southland Hospital
Dr E	Medical officer
Dr F	Medical officer
Dr G	Renal specialist
Gore Health Ltd	Provider
Southland District Health Board	Provider

[1] Southland Hospital is also known as Kew Hospital or Invercargill Hospital. In this report, all references to it have been amended to Southland Hospital.

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Complaint and investigation

On 11 March 2008, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her father, Mr B, by Gore and Southland Hospitals. The following issue was identified for investigation:

An investigation was commenced on 20 November 2008.

Information was received from Mrs A, Otago District Health Board, Southland District Health Board, and Gore Health Ltd. Independent expert advice was obtained from physician Dr Denise Aitken (see **Appendix**).

Information gathered during investigation

Background

Gore Health Ltd, which owns and manages Gore Hospital, describes itself as a "not for profit community owned health provider that has charitable trust status". Gore Health is contracted by Southland DHB (SDHB) to provide health services to the Eastern Southland community. The funding arrangement with SDHB requires Southland Hospital to be consulted as the "first port of call", and Southland DHB's Chief Medical Officer is the liaison person for general inter-hospital relations. Patient transfers are generally arranged by emergency department staff. Gore Health Ltd advised that it "works alongside SDHB with policy review and mortality reviews", and the Gore Health Chief Executive Officer regularly attends SDHB Board meetings.

Gore Hospital is staffed by medical officers, most of whom work part time, and was fully staffed at the time of Mr B's admission in April 2007. Gore Health advised that if a medical officer requires specialist review, he or she telephones the appropriate registrar at Southland Hospital to discuss the case.

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Mr B had a number of chronic medical ailments, including coronary artery disease, chronic renal failure, hypertension, severe aortic stenosis, and diabetes. He had a number of admissions to Gore Hospital from 2003 onwards.[2] In the past he had been treated by specialists at Dunedin Hospital for his cardiac and renal problems, as well as by a rheumatologist. In 2005, Mr B had been admitted to Gore Hospital, and subsequently transferred to Dunedin Hospital as his condition had deteriorated.

Mr B had also been a patient at Gore Hospital from 9 to 26 May 2006 with cardiac symptoms. According to Gore Health, he was given the opportunity of transferring to Dunedin Hospital, but chose to remain at Gore Hospital. Gore Health advised that on that occasion medical staff consulted with cardiac and renal specialists in Dunedin.

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Mr B was admitted to Gore Hospital on 23 March 2007 with increasing symptoms of heart failure. It was noted on admission that his medical history included chronic renal failure, congestive cardiac failure, diabetes, gout, angina, aortic stenosis[3] and atrial fibrillation. It was also noted that Mr B was "poorly compliant" with his medications: "… he tends to stop and start [medicines] as he feels he needs them and depending on side effects". An abnormal ECG was also noted.

The admitting medical officer reduced Mr B's medications and commenced treatment for right ventricular heart failure, which included four-hourly clinical observations and daily weight (to observe for fluid retention). Due to the possibility that Mr B may have suffered a heart attack, the anticoagulant Clexane was commenced.

Mr B's condition appeared to settle over the next few days. He was independent with his cares, and had no complaints of chest pain.

On 26 March, Mr B was reviewed by medical officer Dr E, as it had been noted that his stools were black, which indicated the possibility of gastrointestinal bleeding. His blood pressure was also noted to be low (85/65mmHg). The prescription of Clexane was discontinued and nursing staff were advised to inform the medical officer if there were further black bowel motions, or if his clinical observations altered. During the day, Mr B's bowel motions were reported to be black.

Dr E reviewed Mr B again at 9am on 27 March. She ordered that Mr B be encouraged to get up, and his haemoglobin was to be checked. Later that day it was noted that his blood pressure "remains low" (95/55mmHg). Later still, Dr E noted that Mr B's haemoglobin had fallen — to 102g/L, from 122g/L the day before, and 130g/L on

[2] On 17 November 2003, Mr B was admitted overnight to Gore Hospital with increased breathlessness. Having improved in condition following treatment, he was discharged because he had an appointment the following day with a cardiologist at Dunedin Hospital. Mr B was admitted to Gore Hospital from 25 to 30 August 2005, with increased shortness of breath and angina. He was discharged home. Mr B was admitted to Gore Hospital from 9 to 26 May 2006 with symptoms of heart failure. After treatment, he was discharged home.
[3] Narrowing of the aorta.

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admission.[4] Dr E ordered that his blood be tested again the following morning, and that transfer to Southland Hospital for an endoscopy should be considered.

Mr B was reviewed on the morning of 28 March by a medical officer who concluded that there was no need for a transfer; his haemoglobin was 103g/L, and his blood pressure was 100/60mmHg. Later that day, Mr B went home on leave for an hour.

Dr E reviewed Mr B at midday on 29 March. She noted that Mr B had been experiencing some chest discomfort, and anti-anginal medication was commenced (isosorbide mononitrate). Mr B reported that his bowel motions were still "darker than normal" and Dr E planned for him to be medically reviewed on 31 March. Dr E completed a referral for Mr B to have an endoscopy, which would be performed at Southland Hospital. Over the next few days, Mr B was regularly reported as having angina, and on 31 March his bowel motions were described as "black and 'tarry'". The following day (1 April), the nurses documented:

> "Doesn't appear well. States he gets angina when he gets up to walk."

On 2 April, Mr B's haemoglobin fell to 88g/L. Mr B's family also raised the possibility of transferring him to Dunedin Hospital. Medical officer Dr F contacted consultant physician Dr C at Southland Hospital, and a transfer there was arranged.

Mrs A recalls:

> "Both Dad and I told [Dr F] … that we did not want [my father] to go to Southland Hospital. We asked for him to be transferred to Dunedin Hospital as that was where his specialists were. [Dr F] spoke to [Dr C] in Invercargill to see if he could be sent to Dunedin Hospital, but the reply was that [my father] had to go to Southland Hospital first, because of rules and regulations!! We both said that we did not want Dad to go to Southland Hospital but he was sent [there] on 2 April 2007."

Although both Mr B and his daughter requested that Mr B be transferred to Dunedin Hospital, Gore Hospital decided that he did not require tertiary level care and the endoscopy could be carried out at Invercargill.

Mrs A was actively involved in the decisions about Mr B's care in accordance with his wishes as, at times, he found it difficult to speak to the doctors involved in his care. She had been appointed as his attorney under an enduring power of attorney but, as Mr B remained able to formulate and express his wishes, the power of attorney did not come into effect.

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Following assessment on admission by the medical registrar, Mr B was given a blood transfusion, and the plan was set to perform an endoscopy. It was noted that his

[4] Normal range for haemoglobin for males: 132–170g/L.

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medical history included chronic renal failure, and that his blood results were abnormal (creatinine of 0.22mmol/L).[5]

Soon after Mr B's admission, Mrs A spoke to Dr C, "who commented that he had examined my father and that he was a 'very complicated case and he isn't young'". Mrs A asked Dr C to talk to her father's specialists at Dunedin Hospital.

Mr B was reviewed on 3 April by the medical registrar, and it was decided that he should have an endoscopy the following day.

The endoscopy was performed on 4 April by a surgical registrar, but no source of the bleeding was found. The medical registrar on duty noted that the on-call team had not been informed that this procedure was taking place, and also that "there is no plan in the notes or in fact known to the [house surgeon] as to what the result of this investigation will mean for the management of the patient". The registrar also wrote:

> "This is very poor communication — not fair to the on-call team and not good for the patient."

Overnight the nursing staff recorded that Mr B was confused and "disorientated", and pulled out his intravenous lines.

Mr B was reviewed by Dr C on 5 April.[6] It was decided to perform another endoscopy (this time a colonoscopy to check for a lower gastrointestinal tract bleed), and his medication was altered "in view of renal impairment". It was also suggested that Mr B be transferred back to Gore Hospital once he felt better. However, the nursing staff noted that Mr B became pale and unresponsive at 10.40am. He recovered after 10–20 seconds, but was feeling "exhausted". He was subsequently reviewed by a registrar, who proposed repeat blood tests and intravenous (IV) fluids.

At 11pm, the nursing staff recorded that Mr B had been "tired and sleepy" over the preceding shift, and had not got out of bed. The nurse also noted that Mr B said he had not passed urine in over 12 hours; the house surgeon was notified of this. The subsequent nursing record (at 5am on 6 April) noted that Mr B had passed only 250ml of urine since midnight.

Mr B was reviewed by a house surgeon and a registrar on the morning of 6 April because of abdominal "tightness", and further blood tests and an electrocardiogram (ECG) were performed. The nursing record states that Mr B was "very pale", had "severe pain", and said he was "feeling terrible". Later that day, Mrs A stated that she would like to be kept informed about her father's care. That evening, Mrs A telephoned the ward and spoke to the nursing staff. The nurses requested (and highlighted in the notes) that the staff on duty the following day should ask the medical staff to telephone Mrs A.

[5] Normal creatinine: 0.05–0.12mmol/L.
[6] Mrs A had gained the impression from her telephone call with Dr C that he would be away until 11 April. In fact he was only absent on sick leave on 3 and 4 April.

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On 7 April, following medical review of Mr B's blood results, it was noted that he had "acute on chronic renal failure". A strict fluid chart was commenced and further blood tests ordered. The clinical records note that Mr B was "bright and chatty and enjoying a joke with staff", but Mrs A believes that his renal impairment was "worsening".

Mr B was not reviewed again by a doctor until 9 April. In the intervening period, he was reported as occasionally confused, and this contributed to difficulty maintaining an accurate fluid balance chart. On 9 April, the house surgeon reviewed Mr B, and discussed him with the medical registrar. A chest X-ray was ordered to check for fluid overload and it was noted that Mr B's ankles were very oedematous (swollen).[7]

Mrs A spoke to her father on the telephone. She recalls that "he sounded particularly upset". He told her that he had been at Southland Hospital for six days, and they had done "absolutely nothing" for him. He asked her to get him to Dunedin Hospital.

Mrs A stated that the Southland Hospital staff did not respond to her father's or her wish that he be transferred to Dunedin, or that the staff "at the very least phone the specialists in Dunedin".

Mr B's confusion was reported as having increased. He was reviewed by a house surgeon on 10 April but there was no change in plan. Overnight, Mr B's confusion continued, and it was recorded that he had "pitting oedema to knees". Mrs A was concerned that her father was being given excess fluids.

On 11 April, Mr B was reviewed by a medical registrar who recorded that he was "extremely disorientated and appears to have some expressive dysphasia[8]". The medical registrar noted that Mr B had "worsening renal impairment", increasing confusion, abnormal blood results, atrial fibrillation with "suboptimal" control, "deranged" liver function tests, and unstable diabetes. The medical registrar contacted consultant physician Dr D, and it was decided to arrange an abdominal CT scan because of the abnormal liver function tests, and a brain CT scan because of the increasing confusion.

Meanwhile, at 9am Mrs A telephoned renal specialist Dr G at Dunedin Hospital and told him of her concerns about her father's care in Southland Hospital. Dr G advised Mrs A that he would take over her father's care if he was transferred to Dunedin Hospital, but that the medical staff at Southland Hospital would have to arrange it. Accordingly, Mrs A telephoned Southland Hospital and left a message for Dr D to call her back.

[7] The house surgeon reviewed the chest X-ray and wrote in the notes that there was "no fluid overload … no consolidation". However, the chest X-ray was subsequently reported on 12 April 2007 as "Cardiomegaly and probable left basal pneumonia".
[8] Impairment of the power of verbal expression.

When Dr D returned Mrs A's call, she stated that she wanted her father transferred to Dunedin Hospital by 5pm that day. Dr D advised Mrs A that he had not yet reviewed her father.

In a subsequent letter to Dr C, Dr D wrote:

> "During your absence, [Mr B's] daughter rang me and was quite insistent that we transfer his care to Dunedin Hospital. In fact, I understand that [Mr B] had previously been treated by [Dr G] and [Mr B's] daughter had directly contacted [Dr G] who was agreeable to having him transferred to Dunedin.
>
> [Mr B] was therefore transferred to Dunedin Hospital and I believe his daughter had indicated to nursing staff that she does not want her father treated in this hospital."

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Mr B was subsequently transferred to Dunedin Hospital by ambulance, and arrived at 6.30pm. Unfortunately, despite specialist treatment from the cardiology and renal teams, Mr B's condition deteriorated, and he subsequently died. The discharge summary summarised Mr B's care:

> "[Mr B] was transferred to Dunedin Hospital due to worsening renal failure, increasing confusion and [liver function test] derangement.
>
> He was admitted under the renal team to manage his renal failure, but this was deteriorating as a consequence of his worsening heart failure. He was discussed with the cardiac team with regards to further management of his cardiac failure. Unfortunately, the management was a difficult balance between gentle rehydration and diuresis. [Mr B] deteriorated and passed away from uncontrolled hypertension."

Responses to complaint

SDHB advised that all patients should be reviewed within 24 hours of admission. In the period from 6–10 April 2007, medical staffing was reduced as it was Easter weekend, with a consultant being available on call. However, the consultant was also present every morning in the hospital to do a ward round and see patients as requested by the registrar on site.

SDHB stated:

> "It is evident … that Southland Hospital did not meet its own expectations that all admissions are reviewed by a Senior Medical Officer (SMO) within 24hrs of admission. We offer an unreserved apology to the family for this.
>
> …

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> During the two days of [Dr C's] sick leave, [Mr B] was not reviewed by a SMO (though the registrar did discuss the case directly with a SMO during this time). This breaches Southland Hospital's standard for clinical review and we apologise unreservedly for this."

SDHB advised that the following changes have been made since this incident:

> "Following [Mr B's] admission, the Department of Medicine at Southland Hospital has instituted a weekend and public holiday handover process as follows:
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> Patients are identified during public holidays and/or weekend that will require SMO review. This occurs at a Friday departmental handover meeting involving all of the members of the medical teams. At this meeting all patients are discussed with the weekend team, with specific note made of patients requiring SMO review over the weekend. At 8am … the night registrar and house surgeons handover to the day registrar and house surgeons. At 10.30pm … there is again a formal handover between the medical house surgeon and registrar to the oncoming medical registrar and house surgeon.
>
> Southland Hospital has also commenced a project to investigate how best to identify signs of physiological deterioration in adult patients and ensure rapid clinical assessment and intervention as appropriate. Considerable clinical input has been sought through workshops focusing on all aspects of assessment and recognition of signs of deterioration in adult patients, including explaining and trialling a new observation scoring system and related graded response strategy (Unstable Patient Score — UPS)."

Following Mrs A's complaint to Gore Health, an internal investigation was performed by the Quality Co-ordinator. The Quality Co-ordinator's report concluded:

> "All conversations with [Mrs A] were well documented and family's concerns acknowledged. This did provide a good background to understanding the family /social situation. However better documentation around family consultation (during this admission) from all staff, would have helped clarify the issues raised in this complaint.
>
> It is proposed to review issues around documentation and the importance of family/whanau consultation in the decision making process. This case could be used as an exemplar to raise the awareness of these topics at the next Gore Health compulsory study day."

In July 2007, Dr F performed a mortality review study, and reviewed 50 deaths at Gore Hospital. (Mr B's case was included even though he died at Dunedin Hospital.) One of Dr F's observations was:

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> "In the elderly, sepsis, cardiac events and GI bleeds are very insidious and often have unusual presentations and need to be detected and treated early for best outcome. Clearly we have not performed well in this area based on the records in the mortality study."

Dr F made 19 main recommendations. Relevant to this case are the following recommendations:

- That patients with a changing condition "must be aggressively evaluated and treated as if there has been sepsis, cardiac event or GI bleed until proven otherwise and/or family consult is made to decide on appropriateness of such aggressive treatment";
- "Changes in status and/or vital signs have to be aggressively evaluated and treated to allow for the patient's best chance for survival";
- "Patients who have abnormal vital signs, the staff feel they are deteriorating, new problems, multiple system problems, unclear diagnosis, and/or elderly should be evaluated by at least two physicians and the care nurse in conference to develop a clear plan."

The CEO of Gore Health stated:

> "I'm confident Gore Hospital provided a reasonable standard of care for [Mr B] during his 2007 admission based on our internal investigation. I believe [Mr B] was improving and was directed to where he would normally receive the appropriate further testing and treatment. I do feel we advocated the family's concerns upon transfer. I do think the issue about the concern about speaking with the Dunedin specialists was exacerbated only upon the decision to transfer to Southland Hospital.
>
> From a Gore Hospital perspective, I believe we are stuck in the middle here — we provide health services under contract from the SDHB and they have the policy in place that all transfers go to Southland Hospital unless a consultant there approves transfer to another facility. … In this case, we advocated the family's concerns to the specialist at Southland Hospital who determined they could treat the patient there. There were a number of phone calls about it but in the end it is their (SDHB consultant's) decision which we are obliged to respect. [Mr B's] complete file was transferred with him."

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Opinion: Breach — Southland District Health Board

Mr B was transferred from Gore Hospital to Southland Hospital for investigation of the cause of a suspected gastrointestinal bleed. Mrs A wanted her father transferred to Dunedin Hospital where his specialists were based. However, because the transfer was to carry out an endoscopic examination, which could be done at Invercargill, he was transferred to Southland Hospital in accordance with established policies. At that stage it was felt that his condition did not warrant input from the Dunedin specialists.

I accept that the decision to transfer Mr B from Gore Hospital to Southland Hospital was appropriate since at that stage he did not require tertiary level care. I note that under Right 7(8) of the Code, consumers are able to express a preference as to who will provide their care, and have that preference met where practicable. That is not the same as allowing consumers (and their families) to dictate where care is to be provided, and by whom. I am satisfied that it was not necessary or practicable to meet Mrs A's preference for transferring her father to Dunedin Hospital at the outset.

Mr B was not reviewed in person by a senior medical officer (SMO) until three days after arrival at Southland Hospital on 2 April, nor over the period from 5 to 11 April. During this time, Mr B's condition deteriorated, with cardiac and renal failure.

It is not possible to state definitively whether the lack of SMO review affected the outcome in Mr B's case. However, its absence certainly jeopardised the provision of an appropriate standard of care. SMO review is needed to ensure that there is a coherent management plan that is set, followed, and adjusted as necessary. This did not occur in Mr B's case. Lack of SMO review is also evident in relation to the house officer's incorrect reading of the chest X-ray of 9 April. While I accept that the reading of X-rays is a specialist skill, a senior doctor may have made a different assessment of the X-ray, and different care may have been ordered. Instead, the junior doctor was left to review the X-ray on his own.

In a hospital setting, good handover is essential to ensure high quality care for patients. There needs to be well defined handover procedures that are followed by the clinical staff.[9] The quality of handover in Mr B's case was very poor. As noted by the on-call medical registrar on the evening of 4 April 2007: "There is no plan in the notes or in fact known to the [house surgeon] as to what the result of this investigation will mean for the management of the patient." The registrar added:

> "This is very poor communication — not fair to the on-call team and not good for the patient."

[9] See Jorm C, White S and Kaneen T, "Clinical handover: critical communications" (2009) 190(11) MJA S108-S109.

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Southland DHB has accepted and apologised for these lapses in the management of Mr B's care. More importantly, changes have been made to ensure that patients do not fall between the cracks, particularly at weekends and public holidays.

Mrs A was concerned that her father's complex problems were exacerbated by his being given excessive fluids. Between 2 and 4 April, 7 litres of IV fluid were given and between 5 and 10 April, 9 litres of IV fluid were given. Mr B was progressively overloaded with fluid. The lack of appreciation of the complexity of his fluid balance management in light of his renal impairment contributed to Mr B's deterioration at Southland Hospital.

Prior to 11 April, Southland DHB failed to recognise that Mr B's condition was deteriorating. I have previously noted the importance of DHBs having systems to help staff identify and respond to patients who become physiologically unstable.[10] The key requirements are to recognise when a patient is deteriorating and respond promptly and appropriately.

In 2007, following the case of Mr A, who died in Wellington Hospital,[11] I requested each DHB to report on the safeguards they had in place to prevent a similar case in their DHB. With respect to the identification and management of deteriorating patients, Southland DHB reported that Medical Emergency Teams and scoring tools were under development, scenarios were being developed to encourage nursing and midwifery staff to improve their critical thinking abilities, and medical/surgical review was planned to address increasing after-hours and weekend access to expert clinical nursing and midwifery advice and support.

In her review of the Southland response, Dr Mary Seddon queried the lack of timelines for this work. In her overall review of all DHB responses, Dr Seddon commented that single criteria threshold systems such as Medical Emergency Teams are less sensitive to early patient deterioration than "track and trigger" systems and require staff to know the criteria and be confident in calling on the teams.[12]

The failure to appreciate and respond to Mr B's deteriorating condition highlights the need to develop appropriate systems at Southland Hospital and to train staff in their use.

I conclude that Mr B's care was jeopardised by inadequate SMO review and inadequate handover procedures. When his condition deteriorated he did not receive a prompt and appropriate response from clinical staff at Southland Hospital. In these

[10] Opinion 05HDC11908 at pages 48–50; Opinion 06HDC19538 at page 8; Opinion 07HDC21742 at pages 13–14.
[11] Opinion 05HDC11908.
[12] Seddon M, (2007) at page 7, available at: http://www.hdc.org.nz/files/hdc/publications/seddon-review.pdf.

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circumstances, Southland DHB breached Rights 4(1) and 4(5) of the Code of Health and Disability Services Consumers' Rights.[13]

Opinion: No further action — Gore Health Ltd

Having considered the advice from my independent expert, physician Dr Denise Aitken, I am satisfied that staff at Gore Health provided an appropriate standard of care to Mr B. However, Mr B was, by Gore Health's own admission, a patient with highly complex medical needs, well known to renal and cardiac specialists at Dunedin Public Hospital, and I share Dr Aitken's concern at the lack of specialist support available to the staff at Gore Hospital. Dr Aitken commented that "Gore Hospital failed to provide specialist support for its medical officers in caring for complex medical patients". I endorse Dr Aitken's suggestion that specialist support should be more readily available. I also note that Gore Health instructed Dr F (one of the medical staff involved in Mr B's care) to perform a mortality review. Dr F made a number of sensible recommendations that need to be implemented.

Recommendations

I recommend that Gore Health Ltd:

- advise HDC by **30 September 2009** what actions it has taken as a result of Dr F's mortality review;
- review the availability of specialist medical advice, in light of Dr Aitken's recommendation that ward rounds occur with specialists "on a regular basis to provide helpful clinical oversight", to report the results of the review to HDC by **30 September 2009**.

I recommend that Southland DHB:

- advise HDC by **30 September 2009** on the progress of the project to identify and respond to signs of deterioration in adult patients and processes to audit staff compliance with the procedures;

[13] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill." Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of service."

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- advise HDC by **30 September 2009** on its processes for SMO review at times when there are unforeseen staff absences.

Follow-up actions

- A copy of this report, with details identifying the parties removed, but naming Southland DHB, Southland Hospital, Gore Health Ltd, Gore Hospital and Dunedin Hospital, will be sent to the Director-General of Health, the Royal Australasian College of Physicians, and the Quality Improvement Committee, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix — Expert advice from physician Dr Denise Aitken

"[Mr B] was an 82 year old man with multiple medical problems. These were severe. His cardiac echo of April 2007 at Dunedin Hospital showed very poor left ventricular function with an ejection fraction of 12% and severe aortic stenosis. He had significant renal impairment.

During this admission he had chest pain at rest and on minimal exertion, low blood pressure at times, signs of heart failure and an elevated troponin test which possibly represented cardiac injury. He had a falling haemoglobin from the day of admission which, added to the above problems, significantly increased his statistical risk of mortality from this admission.

During his stay at Gore Hospital, he received good care. He was reviewed daily by nursing and medical staff who documented their careful assessments.

The added medical risk secondary to the gastro-intestinal bleed, in the setting of his known other conditions, does not appear to have been fully appreciated. I do not consider this inappropriate to the level of training of his medical attendants who provided excellent care for their level of training.

[Dr F] identifies in his Gore Hospital mortality review of July 2007 …'in the elderly, sepsis, cardiac events and gastro-intestinal bleeds are very insidious' and comments on the outcomes of patients such as this at Gore Hospital and makes specific recommendations based on his observations around this.

It is very difficult to design an admissions policy for a peripheral hospital. The CEO of Gore Hospital points this out in his response … 'Gore Hospital does not have any policies/procedures pertaining to transfer criteria. The need to transfer a patient has always been a clinical judgment by the attending MO'. I agree that this is appropriate.

However, given the complexity of this patient and presumably other similar patients in the patient population served by Gore Hospital, I believe that consideration should be given to supporting the medical officer staff by regular physician review of inpatients. This is the model of care provided at Tokoroa, Taumaranui and Te Kuiti Hospitals, which provide a similar patient bed volume as Gore Hospital.

I do not believe there are any failings in the care provided by medical or nursing staff at Gore Hospital. However, if they continue to provide inpatient care to patients of this complexity, specialist support in the form of ward rounds of patients on a regular basis to provide helpful clinical oversight is recommended. This would have the additional benefit of assisting visiting consultant staff to better understand the practice environment at Gore Hospital and improve communication and confidence between Gore Hospital and the secondary service provider.

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I agree that the decision to transfer to Southland Hospital was appropriate and that the level of care required should be able to be provided by a secondary hospital. I agree with [the Gore Health Chief Executive Officer's] assertion that [Mr B] did not require tertiary level care.

I do not agree that this admission was similar to that of May 2006. I have commented previously that the gastro-intestinal bleed is a significant additional risk factor for mortality. The estimated mortality for this admission using APACHE III score and SAPS II is approximately 20%.

With regard to the care received at Southland Hospital. In my preliminary report, I described the paucity of consultant level review during [Mr B's] admission to Southland Hospital. This is the most significant issue of care identified during this admission. [Mr B] was admitted on the 2nd of April 2007, first seen by a consultant on the 5th of April and not subsequently physically reviewed by a consultant prior to his transfer to Dunedin Hospital on the 11th of April. The lack of consultant review within an acceptable period following admission, the lack of consultant review over the weekend of the 8th, 9th and 10th of April despite frequent review by junior medical officers and the inadequate handover of care when the consultant was unavailable, were all important failings.

The lack of senior medical officer oversight of care resulted in a lack of a cohesive care plan and a significant compromise in [Mr B's] care. For example, I note the chest X-ray performed on the 9th of April was said by junior doctors to be normal but was subsequently reported as showing a left lower lobe pneumonia. Frequent junior doctor review occurred over Easter weekend and the absence of senior oversight when [Mr B] was deteriorating with a delirium appears to have resulted in a compromise in the expected level of care. However, this may not have altered the eventual outcome given the severity of his medical problems.

In my opinion, Southland Hospital has acknowledged the failure to provide timely senior medical officer review and apologised for this. There is clearly a policy in place with regard to this matter. It is not clear to me how future unforeseen consultant absence with illness would be managed to prevent a similar occurrence. Presumably, there are processes in place.

Secondly, the failure to handover care and to initiate senior medical officer review during the subsequent days of admission on the 6th–10th of April has been acknowledged by Southland Hospital and institution of a weekend/public holiday handover process has been put in place. I expect such a process would identify patients such as [Mr B] who require frequent review by junior medical officers.

SUMMARY

In my opinion, Gore Hospital failed to provide specialist support for its medical officers in caring for complex medical patients. I consider this an oversight which has become apparent with this case and the subsequent mortality review by [Dr F].

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It is possible that the complexity and morbidity of cases for whom care is provided has gradually increased so that this need is only recently apparent. This issue is yet to be addressed.

Southland Hospital failed to provide senior oversight of care at a level one would expect of a secondary hospital. Processes were not in place to handover care or provide senior review for patients who deteriorated over a long weekend. Handover of care was inadequate and this was a significant failure of care. Southland Hospital has acknowledged these issues and has put in place processes to prevent recurrences."

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