Crown Health Enterprise

Report on Opinion - Case 97HDC6556

Complaint

The Commissioner received a complaint from the complainants about the treatment that their mother, the consumer, received from the intensive care unit at the hospital. The complaint is that:

- *It may not have been appropriate to put the consumer on a ventilator or to administer her with morphine.*
- *After the consumer was taken off the ventilator, no further treatment was recommended or provided.*
- *The staff did not comply with proper consent procedures regarding the treatment and medication given to the consumer.*

Investigation

The complaint was received on 12 June 1997 and an investigation was undertaken. Information was obtained from:

The Complainants (sons of the consumer)
The Consultant Physician
The First Medical Registrar
The Second Medical Registrar
The Anaesthetic Registrar
The Consultant Anaesthetist
The Medical Director
The Anaesthetist in Charge

The consumer's relevant hospital records were obtained and viewed.

The Commissioner was advised by a specialist in intensive care and anaesthetics and a physician.

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Information Gathered During Investigation

One morning in early April 1997, the consumer was taken by ambulance to the emergency department at the hospital suffering from a severe asthma attack. The consumer, who had a longstanding history of asthma, had been suffering from an unproductive cough for about a week, with worsening shortness of breath over the last two days. The morning of admission her symptoms had worsened and were unresponsive to medications from her GP. The consumer was admitted by the second medical registrar, the night shift medical registrar, at 9.00am. In the emergency department he found her alert, but acutely short of breath, not capable of speaking more than a few words and considerably distressed. The consumer had a fast breathing rate of 32 per minute, a fast heart rate and a mildly elevated blood pressure. Blood gas examination showed acute respiratory failure, with her arterial tension of carbon dioxide (PCO) at 5lmmHg (normal 38-42). A chest x-ray revealed a left basal shadow. The second medical registrar diagnosed an exacerbation of the consumer's asthma associated with infection of the lower lobe of the left lung. He treated her with continuing oxygen, anti-asthmatic medications including further steroids, and antibiotics. As it was hand-over time, the second medical registrar transferred the consumer's care to the first medical registrar who admitted her to the intensive care unit (ICU) under the primary team of the consultant physician. The first medical registrar notified the consultant physician of the admission and advised the anaesthetic registrar of the possible need for assistance should the consumer deteriorate further.

The consultant physician and the first medical registrar agreed on a management programme of bronchodilators and antibiotics for the time being, but the first medical registrar informed the Commissioner that at this stage emergency intubation seemed very likely. According to the first medical registrar, the question of a possible need for ventilation was raised with one of the consumer's sons at this time. In addition, the anaesthetic registrar recalled *"seeing* [the consumer] *and having a conversation with her regarding her current status at the time (not a formally requested consultation). I recall that her son had been present and chatting to him too. I do recall mentioning to him some of the difficulties involved in the ventilation of asthmatics ...".*

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Information Gathered During Investigation, *continued*

The first medical registrar continued to monitor the consumer throughout the day, during which her respiratory rate was recorded as staying at about 32 per minute. There were some indications that the consumer was improving slightly and she was also able to eat *"half dinner plus dessert"* that evening. The evening chest x-ray had improved from the morning one. However, the consumer's wheeze continued and there was worsening fatigue and shortness of breath. In the evening artificial breathing by mechanical ventilation (IPPV) was discussed by the first medical registrar with the consultant physician, who considered it to be appropriate treatment, if necessary. The first medical registrar informed the Commissioner that at approximately 8.15pm she "*...did a full assessment of* [the consumer] *and the results to hand. Experienced nursing staff were very concerned that* [the consumer] *was becoming fatigued and requested a review with regards to elective ventilation."*

The first medical registrar advised that she clearly remembered discussing with one of the consumer's sons, at the consumer's bedside, that overnight the consumer may deteriorate and that ventilation might become necessary. The nursing notes indicate that a discussion did take place. The first medical registrar further advised that she "... *had the impression from him that everything that could be done for* [the consumer] *should be done and that prior to this illness she had a good quality of life."*

The anaesthetic registrar saw the consumer at 11.05pm and, although she still had a fast respiratory rate and was using all her accessory respiratory muscles, she seemed to be improving. Her chest was less tight and she was less tired. The anaesthetic registrar stated at this time:

> *"I explained to* [the consumer] *that I had been asked to intubate her for ventilation. She acknowledged this and made no comment to suggest that she did not want to be ventilated. However after reassessing her condition and discussion with* [the consumer] *it was decided to delay ventilation for the present but that it could be reconsidered should her condition deteriorate. She agreed to this and the medical team was happy to go along with this".*

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Information Gathered During Investigation, *continued*

The consumer's condition had worsened again by 2.30am. She was only able to speak three to four words, although she was maintaining a good sense of humour. The consumer was alert and orientated and still able to maintain good blood gas results, e.g. PCO_2 38 at 4.40am, but her blood pressure was elevated at 161/1 O9mmHg and she was becoming increasingly tired.

The second medical registrar saw the consumer at 8.10am on the following day. Her PCO_2 was 48 and it was recorded she was *"beginning to feel worn out now"*. The second medical registrar notified the anaesthetic registrar, who recorded that the consumer had obviously deteriorated from the night before. The consumer's breathing was more difficult and she was increasingly breathless. She felt tight in the chest and, as an index of how fatigued she was, she said she felt *"unable to continue on like this"*. Intervention was held off in the meantime, with the anaesthetic registrar to review the consumer in one to two hours time, but later an urgent call was made from the ICU for an anaesthetist *"to come and intubate* [the consumer] *as she was exhausted and barely able to breathe"* (from the anaesthetic registrar's statement). The anaesthetic registrar was occupied with other patients and asked the consultant anaesthetist to intubate the consumer. This was done at 11.15am. IPPV (mechanical ventilation) was set up for her on the grounds of the PCO_2 rise at 7.30am and the consumer being *"very anxious, tired* [and] *exhausted"*.

There are no particular early problems documented with ventilating the consumer, who was sedated and periodically paralysed until after midday next day. There are no ventilator recordings on the "*intensive care servo ventilator chart*" for the first 4½ hours after intubation. Inspection of recordings made after 4.00pm on the servo chart confirms no difficulty with ventilation.

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Information Gathered During Investigation, *continued*

For the morning of the fourth day after the consumer had been admitted to the hospital the nursing and medical notes stated an attempt was made to wean the consumer (while still intubated) from ventilatory support to spontaneous breathing on a "CPAP" circuit. This is not recorded on the servo (ventilator) chart so the attempt must have been short-lived. When this attempt failed the consumer was returned to ventilatory support and resedated. The anaesthetic review was to *"continue"*. Until 8.15pm 9x2mg doses of morphine were used/required. The difficulty seemed to be that there was still persistent, moderately severe bronchospasm (spasmodic contraction of the smooth muscle of the bronchi).

By the following day the consumer could not be managed without muscle relaxants and the wheezing was still prominent. In discussion with the consumer's son, the first medical registrar explained that a further two days of ventilation would need to be provided because of the lack of progress and a reassessment would then be made about further treatment. The medical records noted: *"Anaesthetics happy to continue"*. The problem at this stage for the consumer was persisting bronchospasm, in the face of which she was unable to establish her own adequate respiratory pattern.

By the next day the consumer's white count had gone up to 33 (from 28 the day before, and 20 on admission), so *penicillin* was charted for an infected looking site, from a previous intravenous cannula. She was still wheezy, but the chest x-ray was entered in the notes as being clear.

Following the use of *propofol* (a short acting intravenous anaesthetic) during the previous night to sedate/control her, the consumer came off a ventilatory mode with a set number of breaths delivered by the ventilator (SIMV/PC, on servo chart for 10/4), beginning at 10.00am. She was weaned to *"pressure support"*, a ventilatory mode of breathing assistance which was entirely self-triggered. The notes written by the first medical registrar and the second medical registrar record the consumer as being *"on CPAP"* (continuous positive airway pressure), but my intensive care advisor, after inspecting the servo ventilator charts, noted she was still always receiving ventilatory assistance.

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Information Gathered During Investigation, *continued*

The medical notes for this day indicated concern that, unless sedation was maintained, the patient's wheezing increased. The *"anaesthetic staff"* were consulted and seemed able only to *"recommend* if *we extubate that we do so rapidly".* Pressure support was progressively decreased throughout the day with the aim to extubate. The first medical registrar recorded that if following extubation the consumer required re-intubation then that should be done, but discussion with the family should be undertaken.

The degree of pressure support was reduced progressively to 5cm the following morning, but put up again during the day. The consumer's morning shift nurse recorded:

> *"Not for extubation until ?Monday as patients* [sic] *gases indicated she will not cope."*

The teams looking after the consumer were unable to wean her onto a spontaneous breathing circuit, so long as she was intubated. Her breaths were her own breaths but the depth of breathing was augmented by the pressure support assistance from the ventilator; i.e. meaning that the breaths the consumer was able to manage herself against CPAP were inadequate by themselves and required supplementing. Pressure support continued until 8.00am.

Apparently the problem was failure to wean. The recorded impression of the primary team was that a need for reintubation following extubation was *"unlikely to be successful in the long term and if the family wanted to discontinue* [treatment] *then this is fine by us."* Accordingly, a decision was made that in the event of cardiac arrest the consumer would not be defibrillated and the ventilator would be removed. Also, if the consumer woke up after extubation and expressed a wish not to be ventilated again if that was needed, she would not be reintubated. The medical notes further stated that the family were aware of the current situation and that:

> *"Son reassured that she can be kept comfortable if* [treatment] *withdrawn."*

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Information Gathered During Investigation, *continued*

There are no hospital medical notes, such as "*examination and progress*" notes, recorded for this day. The ICU servo chart indicates a moderate level of pressure support throughout that day. The nurses' record in the "*patients condition and progress*" notes noted that the consumer was in *"*[d]*rug induced sleep. Not opening eyes, no response to pain."*

On the following day the consumer was managed during the morning with three doses of *propofol*. The *propofol* lowered her elevated blood pressure only by a *"short lasting response"* (as noted in the nursing notes for that morning). This was changed to occasional bolus doses of *morphine* between 11.00am and 2.10pm, totalling l8mg. The change of sedation to an agent, which is a respiratory depressant, occurred following discussion with the medical registrar. The only medical entry in the notes for the whole day is the on-call night medical registrar's short note at 11.30pm, which referred solely to the consumer's serum electrolytes. He returned at 1.10am and noted the consumer had persistent inspiratory and expiratory rhonchi (abnormal noise produced by air passing through narrowed bronchi heard through a stethoscope).

There is extensive documentation by the medical team for the following day, the consumer's last day, starting with the problems noted at 8.10am by another anaesthetics registrar:

> *"1) severe asthma/CORD, intub since 6/4 day 9*
> *2) chest infection".*

The consumer's blood pressure was elevated at 215/84 and she had peripheral oedema. Her respiratory rate was down to 22 per minute and although there was no obvious wheeze, expiration was noted as prolonged. At a lower level of pressure support she now had raised PCO_2 levels of 54, which were no better.

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Information Gathered During Investigation, *continued*

My intensive care advisor noted that at this time:

> *"The residual sedative effect of nine 2mg doses of morphine since* [11.00am on a date in mid-April] *had the nurses recording she "appears more relaxed". Actually she was unconscious, with no response to painful stimulation (last recorded as being tested at* [5.00am] *on the morning of the* [following day]*). However, throughout the rest of her last day no further coma scoring is recorded by the nurses or the doctors who wrote extensive notes at* [8.10am- 8.30am] *and later* [10.30am]*."*

Another anaesthetics registrar recorded that the consumer was *"for trial of extubation"* and that she discussed with the first medical registrar *"re policy of reintubation - for reintubation only at her wish if she can communicate"*. Accordingly, the consumer was extubated at 9.15am. She was incapable of talking and a high flow oxygen mask was supplied.

One of the consumer's sons informed the Commissioner that he and his brother had asked staff to notify them if the consumer was to be extubated as they wished to be present when this occurred. One of the consumer's sons said they were phoned by ICU staff that day and were told the consumer had already been extubated.

The consultant physician saw the consumer at 10.30am when it was noted that she was not tolerating CPAP at all and the PCO_2 was elevated (however, on pressure support the night before it had been high at 58, whereas at this time it was 57 post extubation). The consumer was *"not talking just shaking head* [sic]*".* She remained wheezy with prolonged expiration and her breathing was moderately distressed. Several decisions were reached. The consumer was not to be reintubated, because it was considered if that happened *"there is no end point"*. One of the consumer's sons was concerned that his mother did not suffer and "*comfort care*" was arranged by the medical staff. Accordingly, the consumer was kept comfortable with nine successive doses of *morphine* from 10.00am onwards. She developed periodic breathing and eventually cardiac arrest. The consumer died at 7.15pm. No autopsy was performed.

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Report on Opinion – Case 97HDC6556, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to the complaint:

RIGHT 4
Right to Services of an Appropriate Standard

...

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

...

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

a) An explanation of his or her condition; and

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and

...

e) Any other information required by legal, professional, ethical, and other relevant standards; and

...

2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

...

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Report on Opinion – Case 97HDC6556, continued

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

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

1) 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.

2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

4) 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.

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Report on Opinion - Case 97HDC6556, continued

Opinion: Breach

Right 4(2)

In my opinion, the consumer's admission, initial treatment and subsequent ventilation all complied with professional standards. The medical team was correct in anticipating that ventilatory assistance may have been required for the consumer. Accurate assessments were made of the consumer from the time she was admitted until the time ventilation occurred. The decision to intubate the consumer on the basis of exhaustion, anxiety, a slight rise in the patient's arterial carbon dioxide tension, and that the consumer had felt *"unable to continue on like this"* was appropriate in her clinical situation. Without ventilation, the consumer's chances of survival would have been greatly compromised. In addition, the *morphine* the consumer received after extubation was appropriate, when the consumer was receiving comfort care.

However, the consumer was not provided with care of a professional standard with regard to:

(i) Deciding that the consumer's state was irretrievable;
(ii) Administering *morphine* in circumstances where doing so would decrease the likelihood of extubation being successful;
(iii) Not using a morphine antagonist such as *naloxone* prior to extubation;
(iv) Not investigating the use of a better tolerated airway such as a tracheostomy;
(v) Not documenting any consultation with an intensive care specialist;
(vi) Not referring the consumer to a hospital with intensive care specialists.

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Report on Opinion – Case 97HDC6556, continued

Opinion: Breach, *continued*

Therefore, in my opinion, the CHE breached Right 4(2) by failing to provide the consumer with services that comply with professional standards. The above errors can be attributable to the fact that the hospital's ICU staff were not adequately trained and did not have the requisite experience to deal with the consumer's complex ventilatory problems. For example, the consumer was not given care by either a properly constituted intensive care team, or a primary team competent enough for appropriate decision making for a patient requiring complex intensive care skills, together with an assistant anaesthetic team competent enough to advise in difficulties of both IPPV and weaning from IPPV complicated by bronchospasm and excess bronchial reactivity. Although the care provided by the medical team was commensurate with their training, experience and understanding of intensive care medicine, the hospital failed to provide its staff with the necessary resources and support to enable them to effectively care for the consumer.

I also note that during the consumer's care, there was a medication/IV error where she received twice the dose of *aminophylline* she was prescribed. The drug was discontinued until her levels were normal. An incident report was appropriately actioned and recorded that no side effect occurred. While the consumer's condition was not affected by the incident and was not subject to a complaint, it is another example of the overall standard of care which reflects unfavourably on the CHE.

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Report on Opinion – Case 97HDC6556, continued

Opinion: **Right 6 and Right 7**

No Breach

I acknowledge that from the complainants' point of view, some misunderstandings arose with regard to the communication between the medical team and the family. For example, it was unfortunate that neither of the consumer's sons were notified when the consumer was extubated, as they had requested. However, in my opinion, the CHE did not breach Right 6 or Right 7 of the Code of Heath and Disability Services Consumers' Rights.

The consumer was involved in discussions about her treatment and received explanations about the treatment and of the escalations of treatment which might be required for her in the future. For example, the anaesthetic registrar discussed the possible need for intubation with the consumer on at least two occasions. Although the beneficial effects of intubation may have been emphasised during these discussions, this can be attributed to medical staff wanting the consumer to have a positive attitude. In my opinion the consumer received all the information that was reasonable in the circumstances, and upon which she could give informed consent. In addition, the consumer gave informed consent to intubation when she indicated she was *"unable to carry on like this*". This was after a discussion with the anaesthetic registrar the previous night when the consumer did not indicate she did not want to be ventilated, and had agreed that, although ventilation would be delayed for the time being, this decision could be reconsidered if her condition deteriorated.

There was also consultation with the consumer's sons with regard to extubation and her subsequent decline. For example, the medical notes record discussions with the consumer's son(s) about the lack of progress, ventilation continuing, and what would happen if treatment was withdrawn. Comfort care was arranged by medical staff after concern was expressed by one of the consumer's sons that his mother did not suffer.

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Report on Opinion – Case 97HDC6556, continued

Response to Provisional Opinion

The hospital responded to the Commissioner's Provisional Opinion and raised the following issues. I considered each of the issues raised in finalising this opinion. I obtained further advice from my independent advisor on intensive care medicine.

(i) Deciding the consumer's state was irretrievable

The CHE stated that the medical notes indicate that considerable thought was given by the medical team to the consumer's outlook and strategies for extubation, as well as possible responses to any failure to wean from the ventilator. It is further stated by the anaesthetist in charge that the strong impression gained from relatives subsequent to initiation of ventilation was that the consumer had more limitation of lifestyle as a result of chronic lung disease than had been thought at the time she was put on the ventilator.

Commissioner's Comment

The notes do indicate that considerable thought was given by the medical team to the consumer's outlook. I also agree that thought was given to strategies for extubation, but there is no indication given in the notes that treatment plans were adequately developed to deal with failure to wean from the ventilator.

The notes reviewed conflict with the anaesthetist in charge's statement:

1) The second medical registrar, who admitted the consumer, described her, in his response to the Commissioner, as *"*[w]*hen well she had a good exercise tolerance and was not particularly disabled by her asthma"*.
2) The first medical registrar said in her response to the Commissioner: *"I had the impression from* [one of the consumer's sons] *that everything that could be done for* [the consumer] *should be done and that prior to this illness she had a good quality of life."*
3) The consultant physician stated in his medical report that *"*[t]*he impression given was that she was not particularly disabled by her asthma"*.
4) The second medical registrar stated in his review of the consumer the day after she was first admitted that she is able to be independent and has a good quality of life. *"Exertion leads to SOB* [shortness of breath] *but able to walk distances on flat … confirmed by son"*.

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Report on Opinion – Case 97HDC6556, continued

Response to Provisional Opinion, *continued*

There is no evidence to support the assertion that the consumer suffered from chronic lung disease.

1) The consumer did not have a chronic cough.
2) The radiologist's report makes no mention to any chronic changes indicative of chronic lung disease.
3) The consumer did not produce sputum indicative of a chronic problem during her stay.
4) The consumer's blood gases on admission did not demonstrate a chronic base excess.
5) The chest x-rays are consistent with asthma and a chest infection.
6) The servo charts indicated that despite her asthma IPPV was not particularly difficult and was effective.
7) The consumer's peak expiratory flow rate was recorded by the first medical registrar on admission, during an attack of acute asthma, at 200-300 litres/minute.
8) The consultant physician's medical report in June 1997 recorded that the consumer was suffering acute asthma precipitated by a reversible cause rather than *"some severe chronic chest disease like CORD".*

ii) Administering morphine in circumstances where doing so would decrease the likelihood of extubation from being successful

The CHE stated during the seven days of respiratory assistance the consumer was never able to be weaned from the ventilator for even short periods. They noted that 2mg doses of *morphine* were administered seven times on one day in April, but only at 1.20am and 2.10am on the following day. The CHE commented it is most unlikely that there was any significant respiratory depressant effect as a result of this drug still present at time of extubation 7½ hours later at 9.30am. They further stated the doses were relatively small.

Commissioner's Comment
Morphine has a persistent effect on the respiratory function and consciousness in the elderly, even long after a time when one may expect its actions to have dissipated. The only effective way of demonstrating this dissipation is to give a morphine antagonist.

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Response to Provisional Opinion, *continued*

In addition, the effect of the consumer's renal function on the retention of morphine (and particularly of the potent metabolite, morphine-6-glucuronide) must be taken into account. The consumer had a normal serum creatinine however, in the elderly there can be significant renal impairment despite these figures. The first medical registrar appreciated this and administered the potentially nephrotoxic antibiotic *gentamicin*. The creatinine clearance she calculated demonstrated that the consumer's renal function was performing at less than half normal. For a full dose of gentamicin to be added to this would probably even contribute to the retention of part of the 18mg of morphine administered over the day in April and into the early hours of the following day.

Finally there is the neurologic status in evidence. My advisor noted that despite the printed chart for EMV scoring used by the ICU recording *descriptions* incorrectly, it can be seen that the consumer's neurologic state was so far towards coma that, without other attributable cause, it must be regarded as mostly due to morphine.

iii) Not using morphine antagonists such as *naloxone* prior to exubation

The CHE stated there was no indication to administer a morphine antagonist given their comments under ii) above.

Commissioner's Comment
See comments in ii) above.

iv) Not investigating the use of a better tolerated airway such as a tracheostomy

The CHE commented that a tracheostomy would have been a considered option if weaning from the ventilator appeared to be achievable. They further commented that since this was clearly not the case for the consumer, the question of this procedure was not pursued.

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Report on Opinion – Case 97HDC6556, continued

Response to Provisional Opinion, *continued*

Commissioner's Comments

I am advised that it is far easier to get a difficult patient converted to spontaneous breathing with a tracheostomy than with an endotracheal in site, especially as the consumer's reactivity to the latter seems to be what led to the charting of morphine for her last weekend. A tracheostomy would have allowed this patient to have all residual sedation (i.e. morphine) effects wear off, while still having ventilatory support before trying to establish spontaneous breathing.

v) Not either consulting with intensive care specialists or referring her to a hospital with such specialists

The CHE stated the anaesthetist in charge discussed the consumer's management with the then director of ICU at another hospital. The CHE commented no further options were suggested, and it was not considered that a transfer would be helpful. They further stated the consumer did not have multi-system problems which are often determinants of the need for transfer.

Commissioner's Comment

I had not been informed that the anaesthetist in charge had consulted with the director of ICU at the other hospital at any time prior to forming my Provisional Opinion. In addition, there is no entry in the notes, either by the anaesthetist in charge after receiving an expert opinion from the director, or by the physician, or by any other medical, nursing or anaesthetic personnel that the other hospital had been consulted.

Status of the ICU

The CHE stated they do not accept my comment that its ICU *"currently does not meet the minimum standards for a level one adult intensive care unit"*. They commented that neither the guidelines from the Faculty of Anaesthetists (presumably meaning the Faculty of Intensive Care), nor those from the Australian and New Zealand Intensive Care Society, specify a time limit for ventilation. They further commented that to give guidance to their clinicians, the CHE has instituted a policy to establish a formal process for the review of all patients who have been ventilated for 48 hours.

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Response to Provisional Opinion, *ontinued*

The CHE reported that their ICU does meet the level one standard according to the Australian and New Zealand College of Anaesthetists ("ANZCA"), and in March 1998 an audit carried out for the Health Funding Authority by the New Zealand Council on Healthcare Standards confirmed this compliance.

The CHE stated they did not accept my comment that ICU staff did not have the requisite experience to manage the consumer's chest condition. They stated that consultant anaesthetists were closely involved throughout and any decision regarding ventilation was only made after discussion with them. They reported the anaesthetist in charge oversaw the ventilation of the consumer, and neither he, nor his colleagues, had any doubts about their ability to manage this patient. They also noted the majority of nursing staff in the unit have postgraduate ICU diplomas.

The CHE also commented that few hospitals of a comparable size in New Zealand have a dedicated specialist intensivist. They stated they are fortunate to have a tertiary centre nearby and benefit from the specialist advice and ability to transfer patients to the other unit.

They further commented they have an ICU committee which consists of a physician, surgeon, two anaesthetists, the director of medicine and ICU charge nurse which meets regularly to oversee the unit and to initiate a regular audit.

Commissioner's Comment
The policy document "*IC-1, Review IC-1"* (1997) of the faculty of intensive care, ANZCA defines the minimum standards for a level one adult intensive care unit.

Article 3.2 of this document (amended from the 1994 version) specifies: *"A medical director who is recognised by JSAC-IC as a specialist in intensive care".* Accordingly, the CHE's ICU does not have the credentials for a level one ICU facility.

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Report on Opinion – Case 97HDC6556, continued

Response to Provisional Opinion, *continued*

Item 3, *"Level 1 adult intensive care unit"* in IC-1 stated that:

> *"The patients most likely to benefit from level 1 care include:*
> *...*
> *(d) patients requiring short term mechanical ventilation."*

The length of a "*short term*" is indicated in the same paragraph where it defines this as *"a period of at least several hours."* Further, IC-1's guidelines for level one units stated that patients requiring ventilation for more than a short time, and, by inference, critically ill patients, should be transferred to a level two unit.

The CHE can be commended for establishing *"a formal process for the review of all patients who have been ventilated for 48 hours"*. This review should take place each morning for patients admitted and ventilated overnight and those in for more than twelve hours of IPPV.

The CHE is to be congratulated if the majority of nursing staff at the hospital ICU have postgraduate ICU diplomas, and for forming an ICU committee that is multidisciplinary. However, the importance of the role of a specialist intensivist in an ICU environment should be noted. I am advised that use of an intensivist is preferable to use of an anaesthetist, called in as a technician, at the decision of a physician. In stating this, I acknowledge the difficulties in recruiting qualified specialists in intensive care medicine.

The CHE disputed my opinion regarding the standard of care and capability of the ICU. While I accept that medical staff were concerned to minimise the consumer's suffering, having considered the response to my provisional opinion I have not altered my view that the intensivist care at the CHE does not comply with professional standards. I note that I took further advice and have made my advisor's reports available to the hospital.

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Report on Opinion – Case 97HDC6556, continued

Actions

I recommend that the CHE apologise in writing to the consumer's sons for the breach of the consumer's Rights. The letter should be sent to this office, and I will forward it on.

In addition, as the hospital currently does not meet the minimum standards for a level 1 adult intensive care unit (as prescribed by Faculty of Intensive Care, ANZCA), I recommend that the CHE undertakes an independent review of its ICU with the aim of either:

(a) upgrading the ICU to either a level 1 or level 2 unit; or
(b) accepting that its unit can only be used for short-term overnight stays and that it should function as a "*resuscitate and ship out*" establishment.

As part of the review, it should also be considered whether the ICU could be accredited as a training institution in intensive care medicine. This would raise the academic level of the ICU and allow for rotation with intensive care registrars at the other hospital.

Until the CHE meets the standards for a level 1 adult intensive care unit, it should be pro-active in seeking advice from the other hospital. Such advice and comments must be documented in the notes.

Other Actions

A copy of this opinion will be sent to the Health Funding Authority, the Ministry of Health, the Crown Company Monitoring Advisory Unit and the Australian and New Zealand College of Anaesthetists.