Crown Health Enterprise

Report on Opinion - Case 97HDC5699

Complaint

The Commissioner received a complaint about treatment the complainant's brother received at a Public Hospital Emergency Department. The complaint is that:

- *On a date in late August 1996, the consumer, a mild haemophiliac, was admitted to the Hospital with suspected torn muscles in his upper thigh and suspected internal bleeding in that area.*
- *Despite a long standing agreement that haemophiliacs be treated at the Haemophilia Centre at another hospital in the area, the consumer was not transferred to the other hospital until approximately five hours after admission.*
- *The consumer did not receive appropriate treatment at the first Hospital.*

Investigation

The complaint was received by the Commissioner on 1 May 1997 and an investigation was commenced. Information was obtained from:

The Complainant/consumer's brother
The Consumer
Haematology Registrar
Crown Health Enterprise/Provider/employing authority
Consultant Haematologist, Haemophilia Centre
General Practitioner

Relevant clinical records were obtained and viewed.

Outcome of Investigation

In late August 1996, the consumer, a mild haemophiliac, fell and sprained his groin. He was from visiting from a different city.

In the morning four days later, the consumer experienced the sudden onset of pain in his right buttock, groin and inner thigh and was unable to straighten his leg. He went to a medical centre and consulted a general practitioner.

Continued on next page

Crown Health Enterprise

Report on Opinion - Case 97HDC5699, continued

Outcome of Investigation *continued*

As part of his differential diagnosis, the GP suspected torn muscles and possible internal bleeding in the affected area. The GP referred the consumer to the provider hospital by ambulance. The consumer's brother said the consumer asked the GP why he was not being sent to the Haemophilia Centre at another hospital and was told that all injuries go to the provider hospital in the first instance for assessment.

During the investigation, the GP said he referred the consumer to the provider hospital, as it serves his practice area and he regarded the hospital's orthopaedic services as the most appropriate place to assess the consumer in the first instance. The GP considered the consumer had an unusual presentation which alerted him to possible musculo-skeletal problems so that haemophilia investigations were not the issue. The GP's referral note records:

> "*Please see/admit above visitor from* […]. *He is a haemophiliac/Hep C positive. He sprained right groin climbing steps 4 days ago. This a.m. he had sudden onset of pain in the right buttock groin/inner thigh. He is unable to straighten his leg; is very tender back of thigh/medial aspect of thigh and right buttock. Diagnosis:?Torn muscle/bleeding into muscle, ? Disc protrusion.*"

The consumer's brother said the consumer arrived at the Provider Hospital Emergency Department (ED) at 10.45am that day. The ambulance note records the ambulance was dispatched at 11.00am, arrived at the General Practitioner's surgery at 11.03am and departed for the Provider Hospital at 11.17am. There is no ambulance record of the time of arrival at the Provider Hospital.

There is no record in the notes of the time the consumer arrived at the Provider Hospital, but the time of triage at ED is recorded as 11.50am. The triage record states

> *"Known Haemophilia / Hep C, fall 4/7 ago. Pain R) groin and R) buttock. ? Muscular bleeding-Obs".*

Continued on next page

Outcome of Investigation ***continued***

At 12.00pm, before being given any medication, the consumer was sent for an x-ray. During the investigation, the Chief Executive Officer of the Provider Hospital informed the Commissioner that it is routine at the Hospital to send patients for x-ray after triage.

The consumer's brother said that during the x-ray examination the consumer's leg was rotated outwards while he was lying on his back and this caused him severe pain and may have aggravated the injury.

In his letter of early May 1997, the Haematology Registrar at the Provider Hospital states:

> *"I think that* [the consumer's] *presentation was atypical for someone who had a retro peritoneal bleed, and I think that given he has a Factor V111 level of 15% and there was a history of him stumbling while climbing stairs - I think it was reasonable to x-ray his leg. I do not think this would have aggravated the injury, provided the leg was not moved to cause pain.*"

The Consultant Haematologist at the Haemophilia Centre at the other hospital stated:

> "*There is no set procedure for performing x-rays. These are done on clinical grounds. In most instances when patients with haemophilia present with any event, it is treated as a bleed until proven otherwise."*

At 12.35pm, the consumer was seen by the orthopaedic house surgeon, who contacted the Haematology Registrar on call at the other hospital. She advised the house surgeon to contact the Haematology Registrar at the Provider Hospital. He was contacted at 2.30pm.

Continued on next page

Crown Health Enterprise

Report on Opinion - Case 97HDC5699, continued

Outcome of Investigation ***continued***

The Consultant Haematologist of the Haemophilia Centre said that the Haematology Registrar had recently completed an attachment to the Haemophilia Centre and advised the Commissioner:

> *"There is an arrangement whereby all patients with haemophilia are referred to the Haemophilia Centre. This was certainly done in this case from the very beginning of his management and even by the house surgeon who was the initial point of contact. It is very likely that the Haemophilia Centre staff, knowing that* [the Haematology Registrar] *was on site at* [the Provider Hospital] *and aware of his recent expertise, recommended that* [the Haematology Registrar] *see* [the consumer]*."*

The Haematology Registrar said he attended the consumer as soon as he was contacted, and that he contacted the Haemophilia Centre and requested the consumer's haematology notes. The Haematology Registrar examined the consumer, found tenderness in the groin and discoloration of the scrotum but no features such as back pain, to suggest a retro-peritoneal bleed. The Haematology Registrar diagnosed a bleed to the right groin without any significant swelling in that area.

DDAVP, also known as Minirin, is used in cases of mild haemophilia to concentrate the levels of Factor VIII that are present. The Haematology Registrar recorded charting Minirin for the consumer on that day, but there is no time recorded. Although there is a date space provided on the standard prescribing form 1 for STAT or once-only medicines, there is not a specific column next to the date to record the time medicine is charted by the prescribing doctor.

At 4.15pm, the nurse recorded that the consumer was given his dose of Minirin and at 4.35pm he was administered IV morphine. The consumer was transferred by ambulance to the other hospital at 5.30pm that day.

Continued on next page

Crown Health Enterprise

Report on Opinion - Case 97HDC5699, continued

Outcome of Investigation *continued*

In his letter of early May 1997, the Haematology Registrar says:

> "*I do agree… that there was a delay in this gentleman getting DDAVP after it was prescribed by myself. This has been a problem on previous occasions in patients with a bleeding disorder or haemophilia presenting to the Emergency Department at* [the Provider Hospital]. *Because the staff are busy and the nurses do not have any specific expertise in haemophilia care, they may not appreciate the urgency of administering blood products. On this particular occasion, I did however try to emphasise that this gentleman was a* ***mild*** *haemophiliac and that as he had unexplained pain, we could not exclude a bleed and an urgent administration of DDAVP was needed. I did not however, physically stand over the nurses while they were doing this. To my surprise I later found out that they did not administer DDAVP until an hour and a half later."*

The Haematology Registrar stated that the Provider Hospital does not always keep Factor VIII on site and says:

> "*Indeed we have seldom needed to use it in the last 10 years.*"

The Consultant Haematologist of the Haemophilia Centre informed the Commissioner that:

> "*DDAVP was an appropriate product in this case because the patient concerned was a mild haemophiliac who had previously received DDAVP and was known to respond. DDAVP is typically given to patients with mild haemophilia and particularly those whose factor VIII level exceeds 10%. It predictably results in a 3-4 fold rise in the Factor VIII level which is sufficient to achieve adequate haemostasis. In this patient's case, the predicted increase in the factor VIII level would have resulted in an increase in the factor VIII level to around 50% which is normally sufficient to achieve adequate haemostasis."*

The Consultant Haematologist went on to say:

> "*It is my view that DDAVP was appropriate for the initial management of this patient and was introduced in a timely fashion in the correct dose."*

Crown Health Enterprise

Report on Opinion - Case 97HDC5699, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

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

Opinion: Breach

In my opinion, the Provider Hospital breached Rights 4(3), 4(4) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(3)
There is a long-standing agreement that haemophiliac patients are sent to the second hospital where they can receive the required specialist treatment. The consumer was not transferred until five hours after triage. Despite the Haematology Registrar's recent experience at, and consultation with, the Haemophilia Centre, the consumer was not given appropriate treatment for his bleed until approximately 4 hours after triage. In my opinion, this is an unreasonable delay.

When the Haematology Registrar was consulted, he considered the consumer should be treated at the Haemophilia Centre at the second hospital and, after discussion with the Consultant Haematologist there, charted Minirin. The Haematology Registrar said he charted Minirin and the nursing staff did not administer it until 4.15pm, which was a delay of an hour and a half. However, there is no record of, nor is there facility on, the standard prescribing form to so record the time medicine is charted by the prescribing doctor. In my opinion, a one and a half-hour delay from when Minirin was charted to when it was administered was neither reasonable nor acceptable.

It is not possible to discover who was responsible for the delay because of the lack of information on the chart, but the delay was caused by an employee of the Provider Hospital. Therefore, the Provider Hospital has vicarious liability and is in breach of Right 4(3) of the Code.

Continued on next page

Crown Health Enterprise

Report on Opinion - Case 97HDC5699, continued

Opinion: Breach, ***continued***

The consumer was entitled to receive services consistent with his specialised needs. He is at risk of a bleed from any injury and any bleed can be aggravated by incorrect or inappropriate treatment. It is for this reason that a specialist service with specialist staff and expertise exists at the second hospital and this is where treatment is best provided.

The Consultant Haematologist of the Haemophilia Centre said that when a patient with haemophilia presents with an event then it is treated as a bleed until proven otherwise. The appropriate treatment for the consumer was early administration of Minirin to prevent bleeding. A person with an injury may well be triaged and x-rayed as part of a normal assessment, but a haemophiliac in the same situation requires specialised treatment to avoid any risk of aggravating a bleed. In commencing x-ray treatment before providing medication to attend to the consumer's bleed or any consultation with a haematology registrar, staff at the Provider Hospital did not provide services to the consumer that were consistent with his needs. The Provider Hospital advised me that it was routine to refer for x-rays, and therefore it is a result of a systems failure by the Provider Hospital that the consumer did not receive services in a manner consistent with his needs. Consequently, the Provider Hospital breached Right 4(3) of the Code in this regard.

Right 4(4)

There is a specialist regional service provided through the Crown Health Enterprise which administers the second hospital, and a long-standing agreement that all patients who have haemophilia are treated at that hospital. The Haemophilia Centre is located there and is contracted to provide haemophilia services to the region concerned.

The relevant regional division of the Health Funding Authority (HFA) provides a directory as an information resource for referring practitioners. The directory explains that a regional service for haematological disorders such as haemophilia is provided at the second hospital. The HFA directory describes the scope of the specialist haematology services at the that hospital to include *"disorders of sufficient severity and complexity which is outside the scope of primary and sub-regional services, e.g. arising from complex bleeding disorders including the management of severe haemophilia."*

Continued on next page

Crown Health Enterprise

Report on Opinion - Case 97HDC5699, continued

Opinion: Breach, ***continued***

The Consultant Haematologist of the Haemophilia Centre informed the Commissioner that there is a long-standing oral agreement that all patients with haemophilia are referred to the Haemophilia Centre in order to receive the specialised treatment required. The Consultant Haematologist said this generally applies to all haemophilia patients. He also said there was no contraindication for the early treatment of the consumer with Minirin at the Provider Hospital.

In my opinion, delays in administration of Minirin increased the possibility that the consumer would require Factor VIII at the other hospital and put him at risk from a more serious bleed due to aggravation of his injury. In failing to refer the consumer to the second hospital, the Provider Hospital failed to provide services in a manner that minimised the potential harm to the consumer, and breached Right 4(4) of the Code.

Right 4(5)
A Haematologist commented on suggestions in the Haematology Registrar's letter:

> "*We have made a decision that we will keep factor VIII on site at* [the Provider Hospital] *at all times - it has often been present in our Blood Bank in the past, but there has not been a clear policy with respect to this product.*"

The Haematologist commented that the HFA Directory clearly states that the specialist tertiary services for haematology are provided by the second hospital and the directory is available to all general practitioners. She also commented that one or two lines in a forthcoming newsletter for general practitioners in the area would be a good idea.

During the investigation, the Commissioner was informed that this had been done in October 1997 and the Commissioner viewed a copy of that newsletter. However, apart from a general reference to the Ministry of Health publication entitled "A Guide to Blood Transfusions and Informed Consent", there is no specific reference in the newsletter to patients with haemophilia, nor any advice for general practitioners needing to refer patients with haemophilia to the second hospital's Haemophilia Centre.

Continued on next page

Crown Health Enterprise

Report on Opinion - Case 97HDC5699, continued

Opinion: Breach, *continued*

The Code requires co-operation among providers to ensure quality and continuity of services. There is a long-standing agreement that all haemophiliacs are sent to the second hospital. This did not occur in the consumer's case. The General Practitioner referred the consumer to the Provider Hospital. While it may have been preferable that the General Practitioner refer the consumer directly to the other hospital, he also referred the consumer appropriately for hospital care. It was more appropriate for staff at the Provider Hospital to refer the consumer on to the second Hospital.

The Surgical Services Co-ordinator at the Provider Hospital advised:

> "*To ensure that in future the delays that occurred in* [the consumer] *receiving treatment for his condition do not occur again, I have added his haemophiliac status and instructions to contact Haemophilia Centre to his Patient Number.*"

While recognising this will be effective for the consumer, in future this is insufficient to convert this to policy in respect to every other person with a haemophilic status who is referred to the Provider Hospital. The absence of a clear policy and procedure regarding such referrals contributed to the delay in ensuring the consumer received appropriate treatment. In my opinion, the Provider Hospital breached Right 4(5) of the Code.

Actions

I recommend that the Provider Hospital take the following actions:

- Apologise to the consumer for breaching the Code. This apology is to be sent to my office and will be forwarded to the consumer.
- It is important that consumers with specialised needs receive appropriate treatment for their needs. As there is a regional Haemophilia service provided at the second hospital and a long-standing agreement that haemophiliacs with injuries are treated there, that is the appropriate place for referral. Improving the quality of health service provision underpins the Code of Rights. In future, in order to avoid any person with haemophilia experiencing the delays the consumer was subject to, I recommend that the Provider Hospital put into written form the policy for the transfer of haemophiliacs with injuries to the second hospital and advises clinicians accordingly.

Continued on next page

Report on Opinion - Case 97HDC5699, continued

Actions, ***continued***

- Once implemented, a copy of this policy should be sent to the appropriate providers including staff and general practitioners in the area. A copy is to be sent for the Commissioner's file. The Provider Hospital has given notification in its GP newsletter regarding referrals to specialist services. However, this notification does not specifically target persons with haemophilia and this policy should be notified.
- It is essential that the Provider Hospital have systems in place to ensure the delays in giving appropriate medication to the consumer do not occur again. In particular, I ask that nursing staff be reminded about the necessity to administer charted medication as soon as possible.
- The standard Prescribing Sheet 1 used by the Provider Hospital should be amended to include a column for the time the medicine is charted.
- I take this opportunity to remind the Provider Hospital of their obligations under Right 10 of the Code. While I did not investigate the actions taken by the Provider Hospital in response to this complaint, I am concerned regarding the delays in handling it. The consumer's brother had the right to receive all the information relating to his complaint and did not. Therefore, I request the Provider Hospital advise me of their complaint process.