# Waitemata District Health Board

## A Report by the

## Health and Disability Commissioner

## (Case 07HDC01804)

## Key parties

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| Mr A | Consumer (deceased) |
| Mrs B | Complainant/consumer's daughter |
| Mrs C | Complainant/consumer's daughter |
| Dr D | Consumer's granddaughter |
| Dr E | General physician |
| Dr F | Orthopaedic surgeon |

## Complaint

On 8 February 2007 the Commissioner received a complaint from Mrs B and Mrs C about the services North Shore Hospital provided to Mr A. The following issue was identified for investigation:

*Whether Waitemata District Health Board provided Mr A with appropriate services over a period of 8 weeks in early 2006.*

After seeking a response from Waitemata District Health Board (DHB) and discussions with the complainants about the option of mediation, an investigation was commenced on 22 August 2007.

## Information reviewed

Information was received from:

- Mrs B
- Mrs C
- Dr D
- Dr E
- Charge Nurse Manager
- Surgical Services Manager, Adult Health Services
- Associate Director of Nursing & Quality and Risk Manager
- DHB General Manager Adult Health Services

Mr A's North Shore Hospital clinical records and relevant Waitemata DHB policies were obtained and reviewed. Independent expert advice was obtained from Professor Carl Burgess.



*Names have been removed (except North Shore Hospital/Waitemata DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

## Overview

Mr A, aged 84, was admitted to North Shore Hospital for assessment of his deteriorating right hip function. Mr A had a complex medical history which included heart disease, colon carcinoma and transient ischaemic attacks (small strokes).

Mr A underwent hip surgery a week later. Postoperatively he had a complex recovery. Having been admitted under the orthopaedic team for his hip revision surgery, Mr A required referrals to surgical services and then medical services. He also needed specialty referrals at times and was transferred to a number of different wards.

Mr A's condition deteriorated and he developed a severe nosocomial (hospital acquired) chest infection which required high oxygen treatment. The combination of his multiple issues and complications, age and medical background meant that Mr A was not transferred to ICU for active treatment when his condition became severe. Mr A died two months after his admission to hospital.

## Information gathered during investigation

Mr A, aged 84, was admitted to North Shore Hospital by ambulance, on referral from his general practitioner. Mr A's problem at that time was recurrent dislocation of his right hip prosthesis caused by slippage of the acetabulum cup. Mr A's extensive medical history included:

- aortic valve replacement and coronary artery bypass grafting, July 2004
- paroxysmal atrial fibrillation[1]
- diverticulosis (inflammatory disease of the colon)
- adenocarcinoma of the sigmoid colon, December 2004
- peptic ulcer
- transient ischaemic attacks (TIAs — small strokes)
- peripheral vascular disease
- right internal carotid artery stenosis
- hiatus hernia
- ischaemic heart disease with significant coronary artery disease
- liver metastasis (cancer secondary).

Notwithstanding these health problems Mrs C described her father as well, sprightly and independent prior to his admission to North Shore Hospital.

[1] Rapid chaotic beat of the atria (upper chambers of the heart). The danger of atrial fibrillation is that stagnant blood in the atria may coagulate, break off and lodge in the arteries of the brain or kidneys.

*Emergency Department*

The St John Ambulance records show that Mr A was delivered to North Shore Hospital at 12.39pm. The initial assessments of Mr A's temperature, pulse, respirations and oxygen saturation levels were recorded at 1.15pm and he was assessed to be triage "category 3", ie, requiring assessment and treatment within 30 minutes. The Emergency Department electronic White Board record shows that Mr A was assessed by a doctor (assumed to be the on-call orthopaedic house officer) at 4.59pm. There is an untimed, unsigned medical assessment in Mr A's clinical records for that day which is believed to be the 4.59pm assessment. However, Mrs C and Mrs B recall that their father was not seen by a doctor until late in the evening.

The General Manager Adult Health Services acknowledged that Mr A's wait of over four hours before being medically reviewed was outside the desirable timeframe for a triage 3 patient.

The nursing notes record that the orthopaedic registrar was contacted at 6pm to ask whether Mr A could eat and drink. As it was expected that he would undergo hip surgery, Mr A had been instructed not to eat or drink anything following his arrival in the Emergency Department. The registrar advised the nursing staff that Mr A could eat and drink meantime and that he was to take his normal evening medications.

At 6.50pm Mr A had an X-ray of his pelvis and right hip. The X-ray confirmed that Mr A's hip was dislocated. Mr A's granddaughter, Dr D, was with him at this time and recalls that he was not given any replacement fluids or told that he could eat and drink until around 8.45pm. Mrs B was also concerned that her father was becoming dehydrated and stated that when he was allowed food, it had to be purchased for him by the family.

At 10pm the nursing notes record that, while Mr A was awaiting "review", he was "[j]oking with family + nurse. Denies discomfort." At 11.45pm the orthopaedic team house officer examined Mr A, noting the medication list sent in by Mr A's GP, and recording his plan to admit Mr A. An orthopaedic ward bed was booked, but as the ward was full Mr A had to remain in the Emergency Department.

The following morning, the Emergency Department nurses noted that Mr A was "eating and drinking, and self-medicating". However, he was told that he should not eat or drink until he was seen again by the registrar in case it was decided to schedule him for surgery. At 12.30pm the notes state, "Pts daughter waiting to speak to CCN [clinical charge nurse] re length of time father waited to be seen."

Mrs B was concerned about the length of time her father had been in the Emergency Department and the standard of care provided to him. She found when she visited that morning that her father was in pain and had not had a wash. She said he was "very careful about his hygiene", but his hospital gown was dirty and his teeth had not been cleaned. He wanted to go to the toilet, "but no one had seen to him". Mrs B spoke to

the Charge Nurse Manager, who agreed that it was too long for Mr A not to have been seen by a doctor. The manager gave Mrs B a feedback form.

Mr A was transferred onto a more comfortable bed. The notes show that although he admitted an increase in pain when he moved, he declined any analgesia. The hospital was at full occupancy, so Mr A remained in the Emergency Department until 3pm two days later, when he was transferred to a ward.

*Orthopaedic management*
Mr A was then seen daily by the orthopaedic team for four days, and reviewed by a physiotherapist, pharmacist and anaesthetic/Intensive Care Unit (ICU) consultant. The ward's Charge Nurse Manager met with the family to discuss management issues. Mrs B is concerned that Mr A was not seen by a physiotherapist during this time. She was told by doctors that the reason for the operation being delayed was that the hospital did not have the necessary part for his hip surgery and had to send away for it.

Mr A's son-in-law believes that Mr A's problems started from this point, as he had been lying without moving for four to five days, causing him to become constipated.

Six days after admission, Mr A had an abdominal CT scan which revealed that his liver metastasis (secondary growth) had increased in size. He had his hip revision surgery that day, performed by orthopaedic surgeon Dr F. After surgery, he was transferred to another orthopaedic ward.

Mrs B and Mrs C stated that the nurses (particularly in that ward) lacked empathy and compassion and did not adequately address Mr A's basic hygiene and nutritional requirements. Mr A was embarrassed that no one came to empty his urine bottles. At one time there were three full urine bottles on his bedside table. The family emptied them. Mrs B is also concerned that Mr A had to remain in bed because there was no physiotherapist available until four days after he was admitted.

Mrs B stated that her father complained of feeling nauseated post-surgery and three days after surgery started to vomit, which increased in intensity, but no action was taken to treat his symptoms until the family demanded to see a doctor.

The clinical records for that and the following day indicate that Mr A's nausea was being monitored.

Five days after surgery it was noted that Mr A had developed rapid atrial fibrillation. He was seen by the medical and orthopaedic registrars and treated with amiodarone.[2] His cardiac rhythm reverted to normal with this treatment.

[2] Antiarrhythmic agent.

At 2.30pm, the nursing note records that Mr A vomited his medication. The notes instruct staff not to give Mr A any further tramadol. His condition was reassessed that evening by the on-call registrar.

At 5.30am the following day, Mr A vomited 90ml of "brown appearing fluid". He was restless and anxious and trying to get out of bed. Mr A was seen by Dr F, who suspected he had suffered a transient ischaemic attack (a small stroke) and referred him to the medical team.

*Medical management*
Mr A was reviewed later that morning by a medical registrar, who considered that he was developing a chest infection. Blood cultures and a chest X-ray were ordered. Mr A was commenced on antibiotics and seen by a physiotherapist.

Mrs B is concerned that she had to stop one of the doctors pulling Mr A out of bed and advise him that Mr A had recently had hip surgery. She recalls the doctor replying that he had not had time to read Mr A's notes.

Mr A was taken to Radiology for an X-ray in the afternoon. While there he vomited 1600mls of "brown fluid? coffee ground". His haemoglobin was tested and found to be within normal limits (99mg/L).

Mr A had a further vomit of brown fluid at about midnight. He was seen by the on-call house officer at 12.45am. Mr A was reviewed by the orthopaedic house officer, who thought he might be suffering a pseudo-obstruction[3] and ordered abdominal X-rays. Mr A vomited twice in Radiology that afternoon. His condition continued to be monitored by the medical team until 10pm that day, when it was discussed with the surgical team. The films were reviewed and indicated that he was suffering from a sub-acute bowel obstruction.

The DHB advised that such obstructions are a common problem for patients immobile after having hip surgery, and that they usually resolve spontaneously without the need for surgical intervention. When the chest X-ray from the previous day was reviewed the likelihood of a chest infection was noted, as was the fact that Mr A was already receiving antibiotics. Mr A was seen by the medical and surgical registrars, who noted that he was dehydrated and in atrial fibrillation again. A nasogastric tube[4] and urinary catheter were passed.

The next day, Mr A was reviewed by the general surgeons and a physician. His heart rate had reverted to normal rhythm and he was noted to be making good progress. The nasogastric tube was removed.

[3] Non-mechanical obstruction of the intestine causing impaired gastrointestinal motility.

[4] Tube introduced into the stomach via the nasal passages.

Two days later, Mr A again went into atrial fibrillation. He was commenced on an oral medication, diltiazem.[5] He remained in atrial fibrillation despite the treatment, but was considered to be stable. The following day, Mr A was noted to have developed swelling (oedema) of the legs and scrotum. Further blood tests and a chest X-ray were taken. Mrs B visited Mr A that day and asked doctors to look at him as the family wanted to know what was going on. She recalls the doctor telling her that the reason for the confusion was that a full summary of Mr A's notes needed to be done.

Mrs B recalls that due to the treatment to relieve the congestion in his lungs, her father was urinating frequently. On one occasion there were no urine bottles in his room and he had to use a water jug, which upset him. Mrs B asked to see the hospital Duty Manager because she was "extremely upset". Mrs B recalls that the Duty Manager's first words to her were, "You will have to be quick, I'm busy." The Duty Manager spoke to Mrs B in the public area in front of the main hospital reception. Mrs B said, "My time spent with her was non-productive and achieved nothing. I felt and told her so, that it was just lip service. She wrote nothing down, but assured me that she would when she got back to her office, but she had to go off somewhere first." Mrs B requested that staff meet with her and her family in two days.

The next day, Mr A developed abdominal pain. A midstream urine specimen was taken to rule out cystitis, and a urinary drainage catheter was introduced. Later that day, Mr A's abdomen became distended and his urinary output decreased. He was seen by the medical registrar, who considered that he had contracted an infection. The registrar ordered blood cultures to identify the infection, and Mr A's central venous catheter[6] (which had been inserted in theatre) was removed and the tip sent to the laboratory for culture in a further attempt to isolate the source of the infection.

Mr A developed additional abdominal distention and his bowel sounds decreased. He was first seen by a consultant surgeon and then reviewed, jointly, by the medical and surgical teams. Mr A was started on oral amiodarone and aspirin by the medical team. The surgical registrar ordered a repeat abdominal X-ray and that Mr A's oral intake be recorded. A haematology registrar from another hospital was also consulted about Mr A's blood picture that day. The haematology registrar agreed that Mr A was suffering from an infection, but the source of the infection was still unknown.

The following day, Mr A's family arrived for a meeting to find that it had not been arranged by the Duty Manager. Mrs B recalls that the staff had to do "a mad scramble to arrange something". Mr A's family were able to meet with one of the medical staff to discuss their concerns about his condition and treatment.

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[5] Calcium channel blocker.

[6] A small flexible plastic tube inserted into a large vein above the heart through which access to the bloodstream can be made to allow drugs and blood products to be given and blood samples to be withdrawn.

That day, Mrs B wrote in an email:

> "My feelings are that … no one will take responsibility for my father's downward turn in health. Each doctor we see seems to have a different opinion and we have not seen the same doctor twice."

The next day, Mr A was reviewed by the surgical registrar, who consulted the medical service and an infectious diseases physician about Mr A's condition. The surgical registrar reviewed Mr A's oral intake and ordered that IV fluids could stop if he was eating and drinking well but that if he had any further abdominal distension he was to have only clear fluid. The infectious diseases physician advised that the test results were most suggestive of contamination but it was impossible to say when this occurred. Mr A became febrile and further tests were ordered.

The following day, Mr A had an echocardiogram[7] and was seen again by the orthopaedic team, who thought that he was improving. Mrs B was informed that her father's echocardiogram was normal. When Mr A complained of increased abdominal pain and distention later that day, he was seen by the medical officer, who ordered analgesia, IV fluid, an abdominal X-ray and insertion of a nasogastric tube.

The next day Mr A was again reviewed by the surgeon, who ordered that he remain on nil by mouth. The medical team planned to continue to involve the surgical team in monitoring Mr A's condition and planning his treatment. A series of investigative tests were ordered and morphine was prescribed to control his pain. This treatment plan was discussed with the ICU team. Mr A had a further episode of atrial fibrillation.

*Surgical management*

A CT scan of Mr A's abdomen showed that he had an acute inflammation of the gall bladder (cholecystitis). The surgical team's opinion was that Mr A would not survive extensive surgery, so he had a transhepatic procedure to drain his gallbladder instead of an open cholecystectomy.[8]

Mr A was transferred to another ward following the procedure. He had a drain inserted into the surgical wound to ensure that any fluid that collected at the surgical site passed to the surface. An ICU registrar was asked to review Mr A with a view to transferring him to ICU. The registrar's impression was that Mr A had systemic inflammatory respiratory syndrome, but it was decided that because of his co-morbidities it was not appropriate to admit him to ICU (but ICU staff could be contacted if he deteriorated). The family were informed of the situation that evening by the surgical registrar and told that Mr A was seriously unwell but expected to improve gradually.

[7] Ultrasound examination to investigate and display the action of the heart as it beats.

[8] Surgical operation in which the common bile duct is opened, usually to remove gallstones.

The following day, Mr A was reviewed by the surgical team and the nasogastric tube, which had been inserted in theatre, was removed. He was commenced on clear oral fluids and his antibiotics were continued. When Mr A was reviewed by the medical registrar, he was found still to be in atrial fibrillation, and his medication was adjusted accordingly. Mr A was seen by the physiotherapist and had compression stockings fitted to help relieve the swelling in his legs.

Mr A's condition then stabilised and appeared to improve. His progress was monitored by the infectious diseases, medical, surgical and orthopaedic teams. He was assessed by the Assessment, Treatment and Rehabilitation (AT&R) registrar, a dietician, a physiotherapist and an occupational therapist.

Ten days later, Mr A was noted to have renal impairment and developed severe fluid overload with swelling to both legs. He was reviewed by the medical and AT&R registrars. The medical registrar placed Mr A on fluid restrictions. His blood tests were repeated and his blood urea and creatinine levels[9] were found to be elevated. Over the weekend, Mr A's urea and creatinine levels remained elevated.

Three days later, Mr A was seen by the medical and AT&R registrars, a consultant surgeon, a physician, and a physiotherapist. The general physician, Dr E, considered that Mr A was suffering kidney impairment secondary to dehydration and ordered intravenous (IV) fluids.

Two days later, Mr A was transferred to Dr E's medical team. Mrs B remained concerned that Mr A was not receiving the physiotherapy services he needed and that this lack of activity was making his condition worse.

*Medical management*

Mr A was reasonably stable for a couple of days, although the gallbladder drain was leaking. Three days later, the swelling in Mr A's lower extremities increased. Mrs B expressed concern about her father's treatment, his increasing oedema and his shortness of breath, and requested a medical review. The house officer reviewed Mr A and recorded a plan to reduce the swelling (including compression stockings and elevation).

The following day Mr A's oedema was less but he was breathless at rest and his oxygen saturations had deteriorated. Mr A was reviewed by Dr E's medical registrar, who diagnosed pulmonary oedema[10] due to diastolic heart failure. Blood tests, an electrocardiogram and a chest X-ray were ordered, and later that day Mr A was commenced on a diuretic (frusemide) and his IV fluids were stopped. Mrs B recalls

[9] Breakdown products occurring in protein metabolism. An accumulation of urea in the bloodstream together with other nitrogenous compounds is due to kidney failure.

[10] Accumulation of fluid in the lungs.

that the doctor called for stockings for Mr A's legs, and asked why he had not been wearing them.

A mobile X-ray unit arrived while the blood tests were being done. Mrs B recalls that the operator left a short time later as she did not want to wait until the tests were finished, saying that Mr A would have to come to her. She recalls that getting Mr A onto the X-ray bed was "a horrific time" for him. The notes record an "uneventful transfer" to the radiology department but that Mr A was short of breath.

Mrs B asked for another family meeting to take place. However, when she and Mrs C arrived, they again found that no meeting had been arranged. Instead they met with the medical registrar to discuss their dissatisfaction with the care being provided to their father. Mrs B expressed concern that there was no consistency in diagnosis and asked for an explanation why Mr A's medications had been altered again. She also complained about hygiene standards and a lack of nursing care. Family members had found full urine bottles left on Mr A's bedside table on numerous occasions, and there were delays in nursing staff responding to requests for assistance and on some occasions no response. Mrs B said, "The hygiene of the hospital needs attending to, as father on more than one occasion has not had his bed made nor has he been changed. The ward itself is grimy and the floor filthy."

The Charge Nurse Manager stated:

> "Up until just prior to [Mr A's] transfer, [Ms B] voiced satisfaction at the care her father was receiving but the day before the transfer she voiced concern that her father had not received the optimum of care overnight and following this conversation I spoke with the staff at handover."

The following day, (after the cancellation of an oncology appointment), Mr A was seen by a surgical registrar who ordered that the gall bladder drain remain in place for a further three weeks. Mr A's oedema was resolving but he was not, at that time, considered fit for transfer to AT&R. He was referred for a cardiology opinion and transferred to a medical ward.

*The medical ward*

In the medical ward, Mr A was placed in MRSA[11] isolation pending the outcome of laboratory tests. He was seen by a physiotherapist and an AT&R nurse regarding rehabilitation goals. A cardiologist reviewed Mr A and advised that his shortness of breath and chest problems were not because of heart failure, and that his frusemide should be reduced and a respiratory opinion obtained.

Two days later, a further family meeting was held to discuss the issues around Mr A's condition, particularly his shortness of breath, nutrition and mobility. Mrs B described

[11] Methicillin-resistant *Staphylococcus aureus* — a highly infectious strain of bacteria resistant to common antibiotics.

the meeting as very successful and reported that the family's questions were answered and that they were given the registrar's contact details if there were further problems.

Mrs B stated that at this time her father was suffering from diarrhoea and dry retching, which was causing him a great deal of pain and discomfort. She said, "No treatment or relief was provided for twenty-four hours until [Mrs B] rang [the medical registrar]." The clinical records for the following morning note that Mr A had three episodes of diarrhoea overnight and a "very large amount bowel motion during shower". Mr A was reviewed by the medical registrar that morning and a faecal specimen was sent to the laboratory for testing. He was provided with incontinence pants and at 2pm the nurses recorded that there had been no further episodes of diarrhoea. The afternoon and night shift reports do not record any further diarrhoea.

Mr A was seen by the respiratory specialist, who noted that he was suffering from fluid overload and potential pleural effusion, and suggested pleural aspiration.[12] Mr A did not want to have this procedure (having undergone it previously in 2004) and it was agreed that it would be reconsidered in a week, after a chest X-ray. The respiratory specialist suggested increasing his diuretic dose and restricting his fluid intake, and discussed this with a medical registrar. The following day the nurses noted that Mr A was "washed at bedside, pt refused a walk as he feels tired and SOBOE [short of breath on exertion]". The medical registrar reviewed Mr A, noting that his diarrhoea had improved, and prescribed antibiotics for possible pneumonia.

The next day, Mr A's temperature rose to 37.7°C and he developed shortness of breath. Mrs B spoke to a junior doctor about her father's condition. She described being very concerned and having to use "rough tactics" to get a result. She believed he needed a pleural aspiration, stating that it should have been done some days earlier. Mrs B was told that this was not the treatment of choice at that time. The registrar was consulted, and frusemide (40mg to be increased to 80mg), antibiotics and an increase in oxygen flow were ordered.

Later that night Mr A went into fast atrial fibrillation. He was seen again by the junior doctor, who performed an ECG and discussed Mr A's condition with the registrar. Amendments were made to Mr A's medication, including the dosage of frusemide. The registrar reviewed Mr A at 6.45pm. The registrar noted that Mr A should not have a pleural aspiration "after-hours" unless he had "massive effusion", as it was difficult even to sit him up steadily, so aspiration would be "technically difficult". Mr A's daughters were asked about their wishes regarding resuscitation for their father if the need arose. They requested that their father be resuscitated, but resuscitation was to be limited to five minutes in the event of cardiac arrest.

[12] A procedure where a needle is placed through the skin of the chest wall into the space around the lungs (the pleural cavity) to remove fluid.

A portable chest X-ray was taken at 11.10pm. The results of all the tests (including biochemistry and full blood count) indicated that Mr A had developed large bilateral pleural effusions.[13]

In the early hours of the next day Mr A was reviewed by the registrar, who found that he was suffering from shortness of breath and left and right ventricular (heart) failure exacerbated by fast atrial fibrillation. Mr A was treated with frusemide with a view to changing this treatment to amiodarone if he had any further episodes of fast atrial fibrillation. He remained unwell throughout the day but was considered to be stable.

When the dietician called that day to see Mr A, his daughters gave her a list of concerns about the hospital food and discussed dietary supplements they knew were available in Australia. A plan was agreed which included vitamin supplements and some changes to his food.

A later assessment by the physiotherapist found that Mr A was very short of breath and in no state to get out of bed. He was seen by the ICU team to assess the appropriateness of commencing mechanical respiration assistance, but it was decided that these therapies were unlikely to benefit Mr A. He was also seen by a cardiologist, who advised that the treatment should focus on the lung infections and suggested a follow-up chest/abdominal ultrasound or CT scan. Dr E decided to change Mr A's antibiotic regime to a broader spectrum antibiotic and to perform a needle aspiration of his chest.

However, when Dr E saw the results of the abdominal/chest ultrasound performed on Mr A, he decided against the needle aspiration. Mr A was seen by a cardiologist, who recorded that his condition had deteriorated and recommended chest physiotherapy and ICU review. Mr A remained acutely short of breath, tired and lethargic. That afternoon the ICU team reviewed him, but it was considered that ICU care would not improve his outcome. Mr A was seen by a dietician, who recorded that the family were involved in the discussion about recommencing him on nasogastric feeds.

Three days later Mr A was seen by the cardiologist, the dietician and the medical registrar. His treatment plan continued unchanged and he was observed to be improving.

The following day, Mr A's antibiotics were again changed because his oxygen saturation levels had dropped overnight. The ICU specialist and registrar visited and had a long discussion with Mr A's son and daughter-in-law about his condition and why ICU care was not considered to be appropriate. Mr A's oxygen saturations dropped further overnight and the house officer on call examined him. After discussion with the medical registrar, it was decided that no further interventions were appropriate. The nursing notes for 1.15am the following day state that the nurse

[13] A collection of fluid in the pleural cavity.

telephoned Mrs B to advise her that Mr A's condition had deteriorated, and noted that Mrs B said she would inform her sister and brother. The nurse recorded that Mrs B and Mrs C arrived in the ward at 2.30am. However, Mrs B stated that this entry is incorrect. They were not telephoned to come into the hospital, as they were with their father the entire time.

*Deterioration and death*

The following morning Dr E and his team assessed Mr A and the events of the weekend. Dr E met with the family at 8.30am and explained to Mr A's daughters that their father was "unlikely to improve" and that "eventually we have to aim for comfort cares". Mrs B and Mrs C agreed with this plan and that "in the event of cardiopulmonary arrest [Mr A] should not be resuscitated as this would be futile".

For the next two days Mr A's condition deteriorated.

Mr A's family were concerned that he received little nursing or medical attention over this period. They felt that the nursing staff showed no compassion towards him. Mr A and the family were visited by the palliative care nurse specialist, who noted:

> "Discussed with family our role and importance of symptom control. Use of a [syringe]/driver now will be a good idea — morphine 15mg hyoscine 0.8mg & midazolam 7.5mg. Pts daughters very tired & coming to terms with their father's deteriorating condition. Meds for s/driver now charted. Objective now must be to aim for pt to die well & hopefully to stop antibiotics, fluids & remove NG tube."

The following morning, the family were concerned that Mr A was in pain and asked for his morphine to be increased. Mr A and the family were later seen by the palliative care nurse specialist and discussed discontinuing feeding and increasing his morphine dosage to 20mg. Mr A's morphine dose was increased to 20mg and nasogastric feeding was stopped (although the nasograstic tubing remained in place). Later that day, Mr A was medically reviewed after the family expressed concern about his comfort, and at 7pm his morphine was increased to 30mg. Dr D, who had arrived from overseas to be with her grandfather, recalls that it was difficult to get this medication increased and that she had to insist on the doctor being called.

The next day the family told the palliative care nurse specialist of their wish to have Mr A taken to the Whānau room after his death. Māori Health Services were to be contacted to arrange this.

Mrs B was unhappy with the lack of support provided to the family at this time and stated:

> "Even in his dying hours the staff did little. We asked for the tubes and drips to be removed. Nothing happened until my son, a trained senior nurse at [another] Hospital, was so disgusted and upset he removed the feeding drip. My daughter

> who is a doctor [overseas] came in the next day and also was very upset that the drips had not been removed. So she did this."

Mr A died that day and his body was taken to the Whānau room.

Mrs B commented:

> "Even in death they could not get it right. We had to leave father in the Whānau room as they had forgotten to remove his gall bladder drain. …"

Dr E's registrar spoke to the North Shore Coroner about the circumstances of Mr A's death. The Coroner contacted Mr A's family and, as a result of their concerns, decided to hold an inquest. A post-mortem examination was performed. The inquest scheduled for 27 February 2007 was postponed pending the outcome of this investigation.

**Family concerns**

Mr A's granddaughter, Dr D, summarised the family's concerns as:

"1. Inadequate Nursing care — a deficiency of registered nurses and generally poor patient care on the wards.
2. Poor medical care by Doctors — lack of adequate supervision of junior medical staff leading to unrealistic pressures and poor performance.
3. Not enough Doctors leading to large patient case loads resulting in a decline of individual patient care.
4. Poor allied health input into care of patients — physiotherapy etc again due to inadequate funding.
5. General lack of a team approach to care of patients — there is obvious separation between Nurses and Doctors where this should be part of complete patient care.
6. Poor communication between Nurses, Doctors, Patients and relatives as to matters pertaining to their inpatient care."

*Medical care*

Dr D stated that Mr A received "poor medical care" and that there was a "lack of adequate supervision of junior medical staff leading to unrealistic pressures and poor performance". She is also concerned that the doctors had large caseloads which resulted in a decline in individual patient care, a general lack of team approach and poor communication. Dr D also commented that there was "poor allied health input" from services such as physiotherapy, and considered that this might have been the result of inadequate funding.

*Communication*
Mrs B stated that the family's main concern is the lack of information they were given. She believes that the hospital staff knew her father was dying three weeks before the family was told. Mrs B stated that they were consistently told that their father was 84, and felt that staff were implying that "once you are elderly you don't count". She said that all her father wanted was to go home, but by the time they were advised of his true condition, it was not possible because he was oxygen dependent. Mrs B stated:

> "We feel as a family during the 8 weeks at North Shore Hospital, we were not given correct information about our father or were we given opportunities to discuss alternative treatments or treatments that were given to our father."

Mrs B stated that, when the family requested meetings with the staff responsible for their father's care, "these were always a disaster, as no one seemed to hand on dates". She felt that their concerns were not acknowledged and stated that a consultant walked out of one family meeting, and refused to discuss their concerns further.

Mrs B said that the clinical records do not reflect what actually happened in relation to the care her father received. She kept a contemporaneous record of events in her diary and provided my Office with a copy.

*Actions taken on the family's complaint*
Four weeks after Mr A's admission to hospital, the Honourable Tony Ryall MP forwarded a complaint from Mr A's family's to WDHB Chief Executive, Dr Dwayne Crombie. The complaint was that North Shore Hospital staff lacked compassion and failed to support them and provide the family with appropriate information during Mr A's illness. Dr Crombie provided Mr Ryall with a written response to the family's concerns two weeks later.

From 21 April to 5 September, hospital management prepared documents for the Coroner and Inquest Officers.

On 5 September, WDHB Surgical Services Manager Adult Health Services wrote to Mrs B and Mrs C formally inviting them to meet with hospital representatives to discuss their concerns.

On 8 October 2006, Mrs B and Mrs C met with the Surgical Services Manager, the Associate Director of Nursing for Adult Health Services, a general surgeon, and orthopaedic surgeon Dr F, for 2½ hours. The staff apologised and acknowledged that the family's concerns highlighted areas, in particular in relation to communication, that could be improved.

On 9 October the Surgical Services Manager wrote to Mrs B and Mrs C outlining the issues discussed at the meeting and the actions proposed to address the issues. On 10 October senior nursing staff met to discuss the concerns identified in the 8 October meetings regarding co-ordination of patient care, communication with family, and the

assessment and documentation of a patient's care plan. Three key areas for improvement were identified:

> "1. Increase the expertise and confidence of charge nurses and senior nurses in managing difficult communication through formal education programme.
> 2. Develop an escalation strategy for senior nurses/charge nurses and senior nurses to access the support of a senior person in situations that are not able to be resolved by the multidisciplinary team.
>
> 3. Review the processes for documenting and implementing nursing assessments and care plans in adult health services."

The Surgical Services Unit Managers undertook a study of patients who were in North Shore Hospital regarding the optimal time post-admission for family meetings to be held. The project continues to be under review and discussion.

On 10 January, the Surgical Services Manager wrote to Mrs B and Mrs C to advise them about the progress that had been made to address their concerns. WDHB advised that the following corrective actions had been made:

1. An agreement has been reached between the Emergency Department and the Orthopaedic Service to improve how the departments work together.

2. Charge Nurse Managers have begun implementing local processes to ensure that they are always aware of patient/family concerns and complex concerns are escalated to their managers.

3. Surgical patients with a stay of greater than ten days are identified and a meeting is arranged (which can include family) to discuss progress and treatment plans.

4. A cultural survey was carried out and provides a focus to revisit the vision and values of team members and the importance of care, compassion and kindness.

5. An initiative regarding the development of a case manager role is being considered.

*WDHB Emergency Department delays*

WDHB acknowledged that Mr A waited over four hours in the Emergency Department before being seen by one of the orthopaedic medical staff, and that this is clearly outside the desirable time frame for a "triage 3" patient. While it is "impossible" to say why the delay occurred, WDHB records apparently show a large number of orthopaedic referrals (14) were received that day, double the usual number.

The Surgical Services Manager advised that placement of patients from the Emergency Department into hospital beds has improved. She noted, "However, we do experience

times when this is not working as we would like and expect. These times are mostly relating to individual staff members and we are addressing these issues with them." The Surgical Services Manager advised that a draft agreement between the departments is being trialled to improve the transfer of patients between the Emergency Department and the wards.

*Staffing issues*
WDHB General Manager Adult Health Services stated that Dr D's concern that staff numbers were reduced on weekends and/or public holidays was not correct. She advised that staffing is not reduced and that as a higher numbers of patients generally present to hospital on statutory holidays and weekends Emergency Department medical and nursing staffing levels are often adjusted upwards to meet the expected increases in patient numbers.

*Communication and care issues*
The WHDB Associate Director of Nursing & Quality and Risk Manager stated:

> "[Mr A's] family obviously felt that the care provided in [Mr A's] last days lacked compassion and empathy. This is concerning as care and compassion are values that we promote; and their perceived absence will play on the minds of his family in times to come."

She advised that patients and/or family members with concerns about treatment and care need to be responded to as quickly as possible and practicable. In most cases, the ward or unit Charge Nurse Manager is the most appropriate person to manage this as they have access to other clinical team members, and in many cases the issues complained about can be resolved at this level. She advised that efforts are being made at senior nursing levels to reinforce "the importance of and our expectation that patients consistently receive good care and treatment, nursing staff demonstrate helpful attitudes and courtesy and that information is communicated freely and in an appropriate manner".

She commented that the keeping of appointments is a "common courtesy" and "should have occurred as promised". If a meeting arranged between the hospital staff and Mr A's family was unable to proceed, the family should have been advised of the reason and given an alternative date and time. She stated:

"We accept that the communication and sharing of information in a manner that was acceptable to [Mrs B] and [Mrs C] did not consistently occur. As a consequence of [Mr A's] case and the experiences of his family, we identified a number of opportunities for improvement; and we have started implementing these corrective actions and/or further developing our existing systems and processes."

## Independent advice to Commissioner

The following independent expert advice was obtained from Professor Carl Burgess:

"I am Professor of Medicine at the School of Medicine and Health Sciences, University of Otago, Wellington. My qualifications are MBChB, MD, FRACP, FRCP. I graduated from the University of Capetown, South Africa in 1970 and completed my training in Internal Medicine and Clinical Pharmacology in 1980. I was appointed as a Consultant Physician to Wellington Hospital, New Zealand in 1982 and still hold that position. I was initially appointed to the School of Medicine in Wellington as Senior Lecturer in Clinical Pharmacology/Medicine in 1982. I was appointed Professor of Medicine in 2001. I have been involved in Clinical Pharmacology research since 1976.

I have been requested to advise the Commissioner as to whether the care and treatment provided by Waitemata District Health Board to [Mr A] in 2006 was of an adequate and appropriate standard. In particular I have been requested to address the following:

1. Please comment generally on the standard of care that Waitemata District Health Board provided to [Mr A], If not answered above, please provide the following advice, giving reasons for your view.
2. Was the management of [Mr A's] cardiac condition appropriate?
3. Were the medication regimes, in particular the diuretic regime, appropriate?
4. Was [Mr A's] infection appropriately managed?
5. Were there any other interventions that should have been considered?

I have been provided with the following information.

1. Complaint from [Mrs B] and [Mrs C] (the daughters of [Mr A]) to the Commissioner dated 8 February 2007, marked with an 'A'.
2. Response received from Waitemata District Health Board with 31 enclosures including clinical records, staff statements, PM report and policies, dated 10 April 2007, marked with a 'B'.
3. Addendum to a response provided on 13 April 2007 marked with a 'C.'
4. Response from [Mrs B] (relating to the provision of Waitemata District Health Board's response) dated 9 August 2007, marked with a 'D'.

5. Notes taken during a telephone conversation with [Mrs B] on 22 August 2007, marked with an 'E'.
6. Further response from Waitemata District Health Board, dated 2 October 2007, marked with an 'F'.

The background to this complaint has been documented by the Investigator. These can be summarised as follows.

[Mr A], an 84-year-old man, was admitted to North Shore Hospital on [date] by his General Practitioner for assessment of a deteriorating right hip prosthesis. He had had two previous operations to his right hip and was due for further surgery. This surgery had been delayed on account of the fact that he was known to have had carcinoma of the colon with a metastasis in his liver. He was also known to have significant cardiovascular disease; this included a past myocardial infarction, coronary artery bypass grafting and aortic valve replacement. Since 2004 he had also had paroxysmal atrial fibrillation. There was a history of transient ischaemia attacks and he was known to have a hiatus hernia and diverticular disease. He was on a number of medications, these included digoxin, frusemide, spironolactone, diltiazem, paracetamol, omeprazole, simvastatin, lactulose, coloxyl and multivitamins.

There was a delay in finding a bed for [Mr A] as the hospital was full and he therefore remained in the Emergency Department [for two days]. Because of his co-morbidities his Orthopaedic Surgeon decided that [Mr A] should undergo elective surgery and that in the week before surgery his general condition should be maximised. A CT scan of the abdomen [four days later] revealed that his liver metastasis had increased in size. His hip surgery was performed [the following day] and was successful. He maintained good progress until [three days later] when he developed atrial fibrillation. In the early hours of [the following day] he was treated with amiodarone and he returned to sinus rhythm. [That day] it was noted that he had slurred speech but he recovered from this. He was seen by the medical team who diagnosed a chest infection and blood cultures and a chest x-ray were taken. He was commenced on antibiotic therapy for a diagnosis of pneumonia. It was felt that he had probably developed a chest infection following atelectasis following surgery.

[The following day] he had an episode of vomiting with one large vomit of brown fluid. He was seen by the surgical team who diagnosed a sub-acute bowel obstruction, dehydration and atrial fibrillation, a nasogastric tube and a urinary catheter were sited to enable the fluid balance to be closely monitored.

[The following day] the nasogastric tube was removed and it was noted that [Mr A] had improved. However the following day he went back into atrial fibrillation and required further treatment with amiodarone. His dose of

omeprazole was also increased. By the [next day] he was still noted to be in fast atrial fibrillation and diltiazem was restarted. He had further investigation including an ECG which was unchanged from his initial ECGs.

He developed oedema of the legs and scrotum. It is noted that the swelling of the right leg had started on about the [previous day] and it was felt that this may be related to aggressive fluid replacement for the pseudo-obstruction of his bowel. At that time renal function tests were normal but there was an elevated white cell count of 17.4. He was prescribed intravenous frusemide and also potassium, the latter by mouth. His IV fluids were withdrawn. On the [following day] he developed abdominal pain and it was noted that his abdomen was once again distended and his urinary output had decreased. An x-ray of his chest showed a left pleural effusion but this had been present previously. His white cell count remained elevated but troponin measurements were negative. A central line that [Mr A] had was removed and the tip was sent for culture. By [three days later] he still had some abdominal pain although it was improving and a request for further medical and general surgical opinions was made because of decreased bowel sounds and distension of the abdomen. Medical review noted inspiratory crepitations but no other abnormality. Surgical review was that there had been further pseudo which had resolved and further radiology was requested. It was also noted that his white cell count had risen, consultation with the haematology registrar resulted in the elevation of the white cell count being thought to be due to infection. In the meanwhile [Mr A] had been treated with a number of different antibiotics. At this time it was felt that the underlying infection was probably pneumonic. An echocardiogram was performed to rule out bacterial endocarditis and there was no evidence of valvular infection. Cardiac function was good and there was no evidence of left ventricular failure on the echocardiogram. [Three days later] a diagnosis of acute cholecystitis was made following further abdominal pain and a CT scan examination but because of [Mr A's] general condition it was felt that [Mr A] would be unlikely to survive an open cholecystectomy and transhepatic drainage of the gallbladder was recommended. A transhepatic cholecystostomy was performed. This procedure required a drain to be left in situ. [Mr A] was also reviewed by the Intensive Care Unit registrar and the decision was made that he was not suitable for management in the Intensive Care Unit however they would provide backup. His antibiotics were changed and his fluids were also altered as well. The following day he was noted to be improved and the nasogastric tube was able to be withdrawn.

He then began to improve following surgery and maintained this up until [ten days later]. At this time he had been referred for rehabilitation. He had been receiving physiotherapy and there had been input from dieticians and the Occupational Therapist.

Unfortunately his condition deteriorated [three days later] when once more he developed atrial fibrillation. There were signs of fluid overload with bilateral leg

oedema and blood tests showed that his creatinine and urea had begun to rise. His care was transferred from orthopaedics to internal medicine and rehabilitation. The physicians considered that the most likely diagnosis was some degree of renal impairment either secondary to or infection. Ultrasound of the kidneys was requested but was unable to show any signs of either renal or post renal disease.

During this period there was difficulty in deciding the underlying cause of this man's oedema. He was reviewed by cardiologists who felt there was no real evidence of heart failure and was also seen by a respiratory physician who suggested to [Mr A] that he have a pleural tap. [Mr A] refused this option therefore pleural drainage did not occur.

Between the [next few days] it was noted that [Mr A] was deteriorating and it was noted that [Mr A] was breathless at rest and that he required oxygen on a continual basis. A diagnosis of pulmonary oedema was made and further blood tests, ECGs and chest x-rays were done. By mid [month] his condition had not improved. Although there was no drainage from cholecystostomy the surgical team suggested that the drain remain in situ for a further 3 weeks. [A few days later] [Mr A] developed a further temperature. At this time he was still being treated with antibiotics but his inflammatory markers and white cell count had decreased. Frusemide was given at this time and [Mr A] required increased concentrations of oxygen. Because of the deterioration of his respiratory function, consultation was held with the Intensive Care Team to assess whether [Mr A] would benefit from assistance with respiration. However the opinion from the Intensivists was that results of echocardiography and the clinical picture were not suggestive of acute pulmonary oedema which may have responded to non-invasive ventilation. For this reason it was suggested that [Mr A] be given high flow oxygen. There was also concern that there may be an empyema and that it was essential that pleural fluid be sent to the laboratory. In the event a pleural tap was done, a small amount of fluid being taken off. This showed that there was no infection and indeed it was a transudate. By the following day it was noted that [Mr A's] condition had deteriorated further. By this stage [Mr A's] oxygen saturations were decreasing despite the increased concentration of oxygen being given to him. Eventually after discussion with the family, it was decided that palliative care would be the best form of treatment for [Mr A]. [Mr A] died on [date].

During the episode in the hospital there were a number of complaints from the family in regard to communication and other matters, for example, food and cleanliness in the hospital. I cannot comment on the latter complaints but at times it does seem that there might have been problems with communicating the condition of [Mr A] to the family.

The answers to the questions are as follows.

*1. Please comment generally on the standard of care that Waitemata District Health Board provided to [Mr A]. If not answered above, please provide the following advice, giving reasons for your view.*

In general the standard of care offered to [Mr A] was of an adequate and appropriate standard. It is noted that he had to spend 2 days in the Accident and Emergency Department waiting for a bed but this is not unusual in New Zealand at this time, particularly in the larger hospitals. This probably relates more to reduction of hospital beds in the face of an increasingly elderly population. This does not provide optimal care for patients but this is not a particular problem for the Waitemata DHB. However there is no doubt that [Mr A's] hip surgery preceded with the relevant investigations and was successful. It is very clear the complications all occurred post operatively. It should also be kept in mind that [Mr A] had previous illnesses which were severe and he required a fair amount of medication to keep his cardiac condition controlled. In addition there is evidence that he had a metastasis from his carcinoma of the colon. Under such conditions complications post surgery are likely to be more severe in such an individual than an individual who has no co-morbidities. One of the problems that was noted in regard to the standard of care was that many of the complications that occurred, occurred at night and it is plain that [Mr A] was seen by a number of different registrars both in internal medicine and in general surgery. On occasions the consultant physician or surgeon was requested to see [Mr A] the following morning, but this did not always occur, I am particularly thinking in regard to the episodes of atrial fibrillation and on occasions the diagnosis of fluid overload or dehydration. Continuity of care is important and perhaps this man should have been managed by a particular medical team once the first complication had occurred. There are some DHBs where patients who are elderly and undergo orthopaedic procedures are automatically reviewed by the medical team who maintain this monitoring until the patient is fit for discharge. This may have been of benefit to [Mr A]. I have no concerns in regard to the management of the cholecystitis or to the pseudo-obstruction that he developed. I note that in one of the communications from the daughters of [Mr A] that he did not seem to have adequate pain control in the terminal phases of his illness. This would be distressing for the family and perhaps a pre-registration house surgeon is not the individual who should be making the decisions on the correct treatment for such patients.

*2. Was the management of [Mr A's] cardiac condition appropriate?*

[Mr A] had had a previous myocardial infarction and a valve replacement. He had also had coronary artery bypass surgery. On admission it is noted that he was taking a lipid lowering drug (simvastatin), an antianginal agent (diltiazem), a diuretic (frusemide) and an antiarrhythmic agent (digoxin). In his initial stay in the hospital I note that the diltiazem was stopped but the frusemide and digoxin and simvastatin were continued. I note that the reason for stopping the

diltiazem was because of its antihypertensive effect. This man had recently had a fairly large operation and it wouldn't be unusual (as he was normotensive on arrival) to stop that agent. Diltiazem also has antiarrhythmic activity and may have had some effect in preventing the paroxysmal atrial fibrillation that [Mr A] was known to have. From that point of view it could be argued that it might have been continued or have been indicated when this man first developed atrial fibrillation. However amiodarone is an exceptionally potent antiarrhythmic drug and is often used as first line treatment in patients with acute atrial fibrillation. It was initially given as a single dose which then caused reversion of his atrial fibrillation. It is unlikely to be the reason for the reversion as paroxysmal atrial fibrillation can stop spontaneously. The reason for this is that the drug has specific pharmacokinetics which in this case requires a relatively large loading dose having a long lasting effect. It was only after the second episode of paroxysmal atrial fibrillation that [Mr A] was put on a regular dose of amiodarone. In regard to the peripheral oedema and pulmonary oedema, there was some confusion as to what would be the best treatment. On certain occasions [Mr A] was given more diuretic, at other times it was felt that he might be dehydrated and the diuretics were stopped. Echocardiography was performed and did not support the diagnosis of congestive cardiac failure. Even if it had the diagnosis would have been high output cardiac failure which may have suggested some other form of treatment. This latter condition occurs in patients who have severe anaemia, thiamine deficiency, thyrotoxicosis and some individuals with alcoholic cardiomyopathy. There doesn't seem to be any evidence for any of these underlying conditions but if it was thought that he had high output cardiac failure the treatment is to try and correct the underlying cause and decrease the cardiac output marginally to try and improve cardiac function. Could he have had other treatments to manage his cardiac failure? I am unsure whether he had previously had an angiotensin converting enzyme inhibitor such as quinapril or one of the other ACE inhibitors. If not, then one of these agents would have been indicated. In essence there seems to have been some difficulty in making a diagnosis in regard to [Mr A's] cardiac condition. As far as I can see the final cause for oedema was not found. However from the post mortem report there does not seem to have been any sign of a pleural effusion at death.

*3. Were the medication regimes, in particular the diuretic regime, appropriate?*

The regimes that [Mr A] had primarily involved those with diuretics, antibiotics (see next answer) and agents for pain. Prior to coming into hospital [Mr A] was taking frusemide 40mg, twice a day. He was initially given 40mg a day. I note that on the prescription on [date] the dose had been increased to his usual dose of 40mg twice daily but this was stopped [five days later]. In between times he had had an additional dose of frusemide 40mg intravenously on [date]. He required a further intravenous dose [a month later]. He also had a further dose

on that day. I note that he was then placed on intravenous frusemide on [date], at a dose of 80mg daily. The last dose of frusemide was given [two days before he died]. The doses used were generally given in accordance with the previous amount of drug that he had been given prior to coming into hospital. However there were obviously times when it was felt that [Mr A] had become dehydrated. Under such circumstances diuretics are not indicated and were duly stopped. In stable individuals it is usual for an individual to have a regular dose of frusemide, however [Mr A] was certainly not stable particularly in the latter half of [his hospital stay], where his condition changed on a daily basis. It is also noted that initially his renal function was normal, but he had a period when his creatinine and urea both rose. This may have been related to dehydration but it may have been related to renal disease consequent on infection and/or dehydration. Under such circumstances it is not unusual to alter the dose of agents such as frusemide. In regard to his analgesia, he was treated initially with paracetamol and tramadol and these seem to have kept him fairly well controlled. More terminally, he obviously became very distressed and required morphine rather as a tranquillizer than as an analgesic. This is not an unusual use of morphine.

*4. Was [Mr A's] infection appropriately managed?*

Cultures from the hip surgery and from the gall bladder allowed the prescribers to choose the most apposite agent. This man was also thought to have developed pneumonia and this was the prime infectious complication of his stay in the hospital prior to him developing the acute cholecystitis. The pneumonia was managed with a number of different agents, these primarily being the family of cephalosporins. These are the correct treatments for these varieties of pneumonia. Later on his antibiotics were changed to take into account the bacteria that were isolated from the gallbladder. The choice of antibiotics seems correct to me and indeed at post mortem there was no evidence of an acute infection, thus if there had of been an infection present then the antibiotics that were used were sufficient to control those infections. In essence I think the infections were appropriately managed.

*5. Were there any other interventions that should have been considered?*

The final diagnosis in this particular case was adult respiratory distress syndrome (ARDS). This condition has a very high mortality in individuals who have co morbid pathology. The usual treatment is to try and treat the underlying condition whilst maintaining oxygen saturation. It was obviously felt that the primary condition here was infection and an attempt was made to treat [Mr A] accordingly. In someone with no other co-morbidities it might have been apposite to have had them treated in an Intensive Care Unit where ventilation either invasive or non-invasive would have added to the opportunity for the individual to survive.

Carl D Burgess MD, FRACP, FRCP
Professor of Medicine"

## Responses to provisional opinion

*The family*
On 1 May 2008, HDC staff met with Mrs B and Mrs C. They reiterated their concerns about the care provided to their father and the inaccuracies they believe there were in the clinical records and the information provided by WDHB in response to their complaint. Mrs C stated that there needs to be accurate reporting, medically and personally, and accountability for what happened to their father.

*Waitemata District Health Board (WDHB)*
WDHB Chief Executive Officer Mr Dave Davies stated:

"Your Report contains important information; and it is essential to us that our team members are clear about the comments and/or actions taken, the expectations of the senior team members in the Provider Group and the findings of your Office.

We plan to distribute your published Report widely within Adult Health Services for discussion and reflection; and expect that the published Report will reference a small number of 'non-clinical' team members by job title. Given the roles, these individuals will be identifiable to both Waitemata District Health Board employees and those in the sector familiar with our Organisation. We are very comfortable with this. …

With reference to Professor Burgess's recommendations regarding the coordination of care, we agree that ongoing medical team monitoring for complex elderly cases is a good idea. Whilst this would seem simple to implement, it requires agreement from each of the specialty groups within the

> Organisation; and is not solely limited to Adult Health Services — for example Mental Health Services and Health Services for Older People. In order to ensure full involvement and subsequent investment from all specialty service groups, [the Acting Chief Medical Advisors] have been asked to manage this process. …
>
> With reference to continuing work with senior nursing staff to improve the complaints process and communication between staff, patients and families, Adult Health Services underwent a re-structure at the end of last year, and this is already reaping benefits with regard to the timely and appropriate management of complaints and family meetings.
>
> As a consequence of the re-structure, a number of new Unit Manager roles have been created within Adult Health Services. The Unit Managers report to one of the four Service Managers, who continue to report to the General Manager. The managers of each of the wards or units (the senior nurses), the medical staff and ancillary staff specific to each Unit Manager's portfolio now report to that designated Unit Manager. The creation of this level of management has produced a key resource to assist, monitor, coordinate and coach their teams with all quality and risk management activities.
>
> The Quality, Safety and Risk Management Team structure has also changed within the Provider Group. The previously site-specific Quality Advisor positions now operate as a single unit across the Provider Group; with each having responsibility for individual Service-Manager groupings. This ensures both an overview and consistent co-ordination of each group's quality activities; and clarity for all regarding their designated resource. The Quality Advisor team now reports to a newly created Adult Health Services Quality Manager 0.5fte position; and [this person] is a member of the Provider Groups Senior Management Team.
>
> Lastly but not explicitly referred to in your recommendations, is the commentary about Nursing Care. As previously stated in correspondence to your Office, this is disappointing and work is on-going to re-focus team members on the consistent provision of both good nursing care and an adherence to expected standards of behaviour. We would like to assure you that work continues with nursing staff to improve the patient's (and their family's) experience."

WDHB provided a letter of apology for the family.

## Code of Health and Disability Services Consumers' Rights

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

*RIGHT 4*

*Right to Services of an Appropriate Standard*

*(1) Every consumer has the right to have services provided with reasonable care and skill.*

…

*(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

*RIGHT 5*

*Right to Effective Communication*

*(1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided.*

## Opinion: No Breach — Waitemata District Health Board

*Clinical care*

Mr A's family complained about the overall standard of care Mr A received at North Shore Hospital. In particular they were concerned that there was a lack of adequate supervision of junior medical staff, which resulted in unrealistic pressures and poor performance, and a general lack of a team approach to care. One of the central issues considered in this investigation has been whether those involved in caring for Mr A responded appropriately to his postoperative complications and properly co-ordinated his care.

While Mr A was reasonably well prior to his admission, it is important to note that he had a complex medical history and multiple comorbidities. Professor Burgess advised, "It should be kept in mind that [Mr A] had previous illnesses which were severe and he required a fair amount of medication to keep his cardiac condition controlled. … Under such conditions complications post surgery are likely to be more severe in such an individual."

Professor Burgess advised that "in general the standard of care offered to [Mr A] was of an adequate and appropriate standard". He had "no concerns" regarding the management of Mr A's cholecystitis, pseudo-obstruction or infections. Nor did my expert express concern about the medication regimes (subject to the comments below).

Mrs B and Mrs C are concerned that the clinical records do not accurately reflect the treatment and care provided to their father. However, I am satisfied that the clinical records, along with Mrs B's emails from the period Mr A was at North Shore Hospital, provide an accurate reflection of the care he received.

I accept Professor Burgess's advice regarding the general standard of clinical care. It is clear that considerable effort and resources went into establishing the source of Mr A's infection, which was believed to be the cause of his complications and deterioration. In my view his family can be reassured that, in general, the medication regimes were appropriate and Mr A received appropriate care.

There were, however, other aspects of his care that were less than optimal. Professor Burgess noted that the medical teams appeared to have difficulty in making a diagnosis regarding Mr A's cardiac condition, and that there was some "confusion" as to the best treatment of his swelling (oedema). On certain occasions Mr A was given more diuretic (frusemide), and at other times it was felt that he might be dehydrated so the diuretics were stopped. I accept Professor Burgess's advice that Mr A's frusemide regime was altered appropriately in light of his unstable condition (particularly in relation to concerns about dehydration and renal function) and that appropriate antibiotic treatment was instituted in response to Mr A's infections. I note that at post mortem there was no evidence of an acute infection or a pleural effusion.

Mr A was seen by a number of different doctors from internal medicine and general surgery, because of his complex complications, which often occurred at night. On some occasions, when the consultant physician or surgeon was asked to see Mr A the following morning about these complications (in particular his recurring episodes of atrial fibrillation but also his fluid overload and dehydration), this did not occur.

As noted by Professor Burgess:

> "Continuity of care is important and perhaps this man should have been managed by a particular medical team once the first complication had occurred. There are some DHBs where the patients who are elderly and undergo orthopaedic procedures are automatically reviewed by the medical team who maintain this monitoring until the patient is fit for discharge. This may have been of benefit to [Mr A]."

I agree that Mr A may have benefited from a better co-ordinated approach to his care, for example in the management of his oedema and hydration levels. I also draw WDHB's attention to the family's concerns about the difficulty in ensuring Mr A had adequate pain control in the terminal phases of his illness. I note that WDHB has undertaken some initiatives to improve co-ordination of care, including a re-structuring

of Adult Health Services and an agreement between the ED and Orthopaedic Service on co-ordinating care.

Although I have concluded that, overall, the quality of WDHB's clinical care of Mr A did not breach the Code, I draw Professor Burgess's comments on areas for improvement to the Board's attention.

## Opinion: Breach — Waitemata District Health Board

*Delays and communication*

Mrs B and Mrs C complained that when Mr A was admitted to North Shore Hospital Emergency Department (ED) just after midday for assessment and treatment of his unstable hip prosthesis, he was not seen by a doctor until that evening, and did not have an X-ray of his hip until eight hours after arrival. They believe that throughout this time he was left in pain, was hungry and became dehydrated. They are also concerned that there was no ward bed available and that Mr A remained in ED until two days later.

My independent expert, Professor Burgess, advised that it is not unusual in larger New Zealand hospitals for a patient to wait in an emergency department for two days for an inpatient bed, and made the obvious point that "this does not provide optimal care for the patients". Mr A was assessed as needing to be seen within 30 minutes. He was seen four hours later. That is clearly unsatisfactory. The fact that there were twice as many orthopaedic referrals as usual does not explain why it took eight times longer than the WDHB's own timeframes for Mr A to be assessed. Accepting that the delays were due to more urgent patients taking priority, there are several aspects of Mr A's wait in the ED that I find concerning.

Given the considerable delay in Mr A being assessed and then admitted, it was important for him to be kept comfortable and informed of what was happening. It was recorded that he found it painful to mobilise but that otherwise he was comfortable and refused analgesia. However, Mr A was unable to eat and drink until it was certain whether or not he would be having hip surgery. Given that the orthopaedic ward was full, it is surprising that it took nearly six hours to establish that Mr A could eat and drink, and unacceptable that this was not communicated to him for almost a further two hours. His family then had to buy him food.

Mr A's family were concerned that he was not comfortable, that he had not been assisted with personal cares, and that he had to remain in the ED for so long while they tried to find out when he would be admitted. When Mrs B spoke to the ED charge nurse about her concerns about the care provided to her father, she was given a feedback form. This is a perfunctory way to respond to immediate and continuing

concerns. WDHB itself acknowledged the importance of responding to concerns about treatment and care as quickly as "possible and practicable".

An emergency department in a metropolitan centre is a high pressure unit. It is the gateway to the hospital. Patients and their families often wait for many hours in ED, watching staff come and go, frequently with no clear idea what is being planned and how long a decision is going to take. It is essential that patients are kept as comfortable as possible and are well informed and regularly updated about what is happening.

Once Mr A was admitted, the family continued to have difficulties in obtaining information from the hospital staff about his condition and treatment plans. Frequently when they expressed concerns about their father's condition they were either given an unsatisfactory explanation or their requests to meet were not followed up. I doubt that the situation was any clearer for Mr A himself, especially as his condition deteriorated.

I have already noted Professor Burgess's comments about the value of a more co-ordinated approach to managing patients like Mr A. I consider that the lack of co-ordination made it difficult for staff to explain his condition and treatments options to him and his family. Numerous doctors from different areas were consulted and involved in Mr A's care. Tests and investigations were constantly being carried out and frequent changes made to his medication. In such a situation it is very difficult for a patient and his family to understand what is happening. It is not surprising that Mr A's family became concerned about the care he was receiving.

When an elderly patient is becoming progressively unwell, it is important that there is also good communication with family members who are acting as advocates and support for the patient and may be called upon to help make decisions. Family members often play a key role in helping a patient understand what is happening.

I do not consider that WDHB staff communicated effectively with Mr A and his family regarding his care and condition. Mr A's family were understandably concerned about his deteriorating condition and felt that staff were not sufficiently concerned or taking necessary steps to treat him. In fact a lot was being done to address Mr A's deterioration, but it was not well communicated to him and his family.

It is very disappointing that on more than one occasion family members turned up to scheduled meetings with hospital staff to find that they had not been organised or that staff were not available. As WDHB has noted, keeping of appointments is a common courtesy and should have occurred as promised. There needs to be a better system to ensure that scheduled meetings take place.

Hospital staff may have suspected that Mr A would not survive the complications that occurred, but it is clear that he and his family did not expect that he would die in hospital. Mr A wanted to die at home. The family state that if they had been informed earlier that Mr A was not going to survive (which they suspect the medical and nursing

staff knew days before conveying this information to them) they would have had the opportunity to grant their father/grandfather his wish.

WDHB has accepted that its communication and information sharing did not meet the legitimate expectations of Mr A's family. It was not consistent and did not occur in an acceptable manner.

Overall, I consider that WDHB did not communicate effectively with Mr A and his family. It was difficult for him and his family to obtain the information needed to understand the complexities of his care, his treatment options and likely outcomes. Accordingly, I find that WDHB breached Right 5 of the Code.

I note that WDHB has taken a number of sensible corrective actions to address the communication issues raised by this case, including processes for ensuring Charge Nurse Managers are aware of patient and family concerns and arranging family meetings if a surgical patient is in hospital for longer than 10 days.

## Other Comment

*Nursing care*
This investigation has highlighted several issues of concern regarding the nursing services provided to Mr A.

Mr A's family noted numerous occasions when full urine bottles were left by his bed next to his head. Such a practice is unhygienic and unpleasant for patients. While in a busy ward there may be occasional delays, this should not happen on a regular basis. On some occasions no urine bottle was available and nurses did not respond when Mr A pressed the button for assistance, or there was a considerable delay in responding. It is distressing for immobile patients to wait for assistance and even more concerning if they receive no assistance at all.

According to Mr A's family, many of the nursing staff displayed a lack of compassion towards him. WDHB has expressed its concern at this observation and stated that care and compassion are values that it tries to promote. It is always troubling to hear that patients and/or their families feel that those caring for them do not actually "care". This perception almost certainly contributed to the family's concerns about Mr A's care and the communication difficulties.

## Follow-up actions

- A copy of this report will be sent to the Director-General of Health.

- A copy of this report, identifying only North Shore Hospital and the Waitemata District Health Board, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.