# Hutt Valley District Health Board

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 08HDC10486)

## Overview

Mr A was a 35-year-old man with cerebral palsy and an intellectual impairment. Just before 9am in early 2008, Mr A presented at Hutt Hospital's Emergency Department (ED) with abdominal discomfort. He was accompanied by a community services worker, Ms D. Just after midday, Mr A was reviewed by an ED medical officer, who made a provisional diagnosis of constipation and referred him for a surgical review. Mr A was eventually seen at 9.30pm by a surgical registrar, who arranged for him to have an abdominal CT scan. This showed mildly dilated loops of the small bowel. In the early hours of the following day, Mr A was transferred to a surgical ward, and later that morning he had surgery.[1]

Two days later, Mr A had a further procedure to rule out the possibility of a bile leak. Over the next two days his condition fluctuated. Three days later, Mr A developed respiratory distress and stopped breathing. Attempts to resuscitate him were unsuccessful and he died. The post-mortem reported Mr A's cause of death as bronchopneumonia[2] as a consequence of gall bladder disease and gallstones which had necessitated surgical intervention.

This report considers the adequacy of the care provided to Mr A by Hutt Valley District Health Board.

## Complaint

On 26 June 2008, the Health and Disability Commissioner received a complaint from an IHC advocate, Mr B, on behalf of IHC, about the services provided to Mr A by Hutt Hospital.[3] The following issue was identified for investigation:

- *The appropriateness of the care provided by Hutt Valley District Health Board to Mr A over the period of a week in early 2008.*

An investigation was commenced on 23 September 2008. The investigation was delegated to Tania Thomas, Deputy Health and Disability Commissioner, and her opinion has been formed in accordance with the power delegated to her by the Commissioner.

Independent expert advice was obtained from emergency specialist Dr Garry Clearwater (Appendix 2) and surgical expert Dr Andrew Connolly (Appendix 3).

[1] Mr A had a laparotomy (exploration of the abdomen), an appendicectomy (removal of the appendix) and a cholecystectomy (removal of the gall bladder).
[2] A pneumonia involving inflammation of the lungs that spreads from and after infection of the bronchi.
[3] IHC is a provider of services for people with intellectual disabilities. Since 2005, residential support services have been provided through IHC's provider arm, IDEA Services Limited.

## Parties involved

| | |
|---|---|
| Mr A (dec) | Consumer |
| Mr B | Complainant / IHC Advocate |
| Hutt Valley District Health Board | Provider |
| Dr C | Consultant General Surgeon |
| Ms D | IHC Community Services Worker |
| Ms E | IHC Community Services Manager |
| Mr F | Registered Nurse (ED) |
| Dr G | ED Medical Officer |
| Dr H | Surgical Registrar |
| Ms I | Registered Nurse (ED) |
| Ms J | Registered Nurse (Agency) |
| Ms K | IHC Community Services Worker |
| Ms M | Registered Nurse (ED) |
| Dr L | ED Consultant |
| Dr O | Anaesthetic Registrar |
| Dr N | Anaesthetic Consultant |
| Mr P | IHC Service Manager |
| Dr Q | Surgical Registrar |
| Mr R | IHC Acting Community Services Manager |

## Information gathered during investigation

*Background*

Mr A was a 35-year-old man who was diagnosed with cerebral palsy when he was several weeks old. He also had an intellectual impairment. At the age of 20, Mr A had a cerebrovascular accident, which left him with right-sided weakness and moderately high support needs. In 1996, Mr A moved into the care of IHC. Mr A had no next of kin or welfare guardian.

Since 2004, Mr A had been living in Lower Hutt with four flatmates. They were supported by IHC staff. Community services workers assisted Mr A on a daily basis with personal care and other activities. Mr A's verbal communication was limited but he was fully aware of what was happening around him. Staff who knew him well were, to some extent, able to interpret his non-verbal communication and behaviour patterns.

In August 2006, Mr A was placed on a waiting list for a cholecystectomy (surgical removal of the gall bladder) after an abdominal ultrasound confirmed gallstones. In May 2007, he was reviewed at Hutt Hospital by a consultant surgeon, Dr C. Dr C discussed Mr A's condition with her colleagues and with Mr A's GP. As there were no symptoms of gall

bladder disease, the decision was made to take Mr A's name off the list for surgery. At this time, Dr C also discussed with Mr A's GP the need for "someone with Power of Attorney" to be appointed for Mr A.

*Sunday, early 2008*

On a Sunday in early 2008, community services worker Ms D went to get Mr A out of bed. She found him wet with sweat, with a hard and enlarged stomach, and reluctant to get up. Ms D contacted an after-hours medical centre just before 8.30am and, on their advice, called for an ambulance. She also contacted an IHC community services manager, Ms E. Ms D accompanied Mr A in the ambulance and Ms E joined them shortly after their arrival at Hutt Hospital, at 8.50am. Mr A was registered by an ED receptionist at 9.04am. He was triaged at 9.10am as category 3, using the Australasian triage scale.[4]

Registered nurse (RN) Mr F was allocated as Mr A's primary nurse. An initial set of observations was taken and it was noted that Mr A may not have had a bowel motion for four days. However, Ms D advised that she did not think he was constipated. RN Mr F reported that he performed visual and verbal checks at approximately 30-minute intervals throughout the morning, but did not document these.

Ms D reported that Mr A was indicating, using verbal signs, that he was in pain. Another IHC community services worker, Ms K, stated that just before midday a nurse asked about Mr A's usual pain relief.[5] After checking with a colleague, Ms K advised the nurse that this was liquid paracetamol. However, no pain relief was provided at this time. No clinical observations were recorded between 9.10am and midday. The observations taken by RN Mr F at midday were satisfactory.[6]

Mr A was seen by an ED medical officer, Dr G, at 12.15pm.[7] Dr G ordered blood tests and an abdominal X-ray. He discussed his findings over the telephone with a surgical registrar, Dr H, who said that he would review Mr A. The time of this call is not recorded but it appears that it was early afternoon. At this stage Dr G recorded a provisional diagnosis of habitual constipation, and noted that Dr H would review "[o]r could consider [discharge] back to supervised residence with laxative and see [as needed] (if inflammatory markers are [normal])".

[4] Triage 3 categorisation meant that he should have been seen by a doctor within 30 minutes of presentation.

[5] Ms D and Ms E were relieved by Ms K at 11.30am. Ms D returned to the hospital at about 3.00pm and Ms E at about 8.30pm.

[6] See Appendix 1 for record of ED observations.

[7] Dr G's notes were recorded electronically in the ED Electronic Discharge Summary. The notes appear under the name of another clinician, as the last authorised person accessing an unfinished document. Although Dr G did not recall his contact with Mr A, he considered that as the notes are written in a format consistent with his own, it is "more likely than not" that he was the physician responsible for Mr A's initial care in ED.

Ms K stated that at 2.45pm, she asked a nurse whether Mr A should take his usual reflux medication, domperidone. She also requested pain relief for Mr A. Ms K understood that the nurse went to check, but said she did not return with an answer.

At 3.00pm, RN Mr F handed over the nursing care of Mr A to RN Ms M. RN Ms M documented that Mr A was not acutely distressed, his clinical observations were satisfactory, and he was awaiting a surgical review. Ms D stated that she made a request for pain relief for Mr A at 3.30pm (when she returned to the hospital), but there is no record of any having been administered. Around 4.30pm Ms D recalled a nurse speaking with her about Mr A needing an enema for his constipation. Ms D expressed doubt that constipation was causing Mr A's pain and suggested that the enema be performed at the hospital so that he could be reassessed afterwards.

Soon after 4pm, Dr G handed over the medical care of Mr A to an ED consultant, Dr L. At 5.30pm, Dr L reviewed the abdominal X-rays and Mr A. She was concerned about a possible bowel obstruction and recorded that Mr A appeared dry and uncomfortable. Dr L inserted an intravenous cannula (IVC), and recorded a plan for further blood tests, intravenous fluids and a surgical review. Dr L is certain that there would have been a further attempt to page the surgical registrar after she had seen Mr A. There is an entry in the nursing notes to indicate this was done, although the time of the call was not noted.

Ms D stated that at 6pm, she again requested pain relief. She also advised a nurse that Mr A was vomiting but holding the vomitus in his mouth and then swallowing it.

Ms D provided staff with a page of written advice on caring for Mr A, including guidance on recognising both specific and general pain; how stressed he was likely to be in hospital; that he would try to remove his intravenous line and catheters (and how to deal with this); how he could be offered fluids; how to assist his mobility; and how to tell when he was happy. Ms D recalls writing this in ED and giving it to RN Ms M, although the DHB stated that it was produced after Mr A transferred to a surgical ward and was not available to ED staff.

At 7.40pm an intravenous infusion of normal saline was charted and commenced. Shortly after this, morphine (2mg) was charted and administered. Mr A's temperature rose from 36°C at 6.20pm to 38.3°C at 10pm. His blood pressure and pulse rates were checked at 6.20pm, 7.45pm, 8pm, 10pm and 10.16pm, and these also showed increases.[8] RN Ms M recorded that Mr A had made frequent attempts to pull out his IVC and that they had been unable to get a uridome[9] to stay on.

Mr A was seen by Dr H at about 9.30pm. Dr H subsequently said (to the ED nurse manager) that he found Mr A's condition worse than he had inferred from the information given to him. Dr H arranged for an abdominal CT scan to confirm his provisional diagnosis of possible infection. The results of the scan were consistent with a possible small bowel

[8] See Appendix 1.
[9] Latex sheath: part of an external catheter.

obstruction. Dr H discussed the findings with Dr C, and documented a medical plan for intravenous antibiotics, rehydration, insertion of an indwelling catheter (IDC), a nasogastric tube, and TED stockings.[10] Mr A was to be admitted under the surgical team and reviewed by a registrar in two hours' time, with a view to a possible laparotomy overnight.

Ms E recalled that Dr H spoke to her about the possible complications associated with surgery. She contacted the IHC area manager, Mr P. Mr P stated that he spoke with a nurse about Right 7 of the Code of Health and Disability Services Consumers' Rights (the Code),[11] although no ED staff member recalls this.

At about 11.30pm, IHC staff (Ms D and Ms E were present) recall that a nurse in a green uniform (thought to be RN Ms I) came in to insert a nasogastric tube and to catheterise Mr A. According to IHC staff, the nurse inserted the catheter fully but removed it after failing to get any drainage. This happened three times, and she then sought the assistance of another nurse (in a white uniform), RN Ms J. RN Ms J retracted Mr A's foreskin and found that the catheter was coiled around the glans under the foreskin. She then inserted the same catheter successfully. By this time, Mr A appeared to be in considerable pain.

RN Ms I recalls that she asked another nurse to perform the nasogastric insertion and catheterisation, as she was not able to perform these procedures.[12]

*Monday*

Although there is no clinical record to indicate that Mr A was reviewed two hours after Dr H's 9.30pm assessment, Ms D and Ms E noted that Dr H returned at 12.15am and explained that Mr A required fluid resuscitation and that if he responded well to this, surgery would wait until morning.

Mr A was transferred to a surgical ward at about 1.30am. There is a full record of nursing care provided by staff looking after Mr A for the rest of the night, including regular observations. A nurse aid stayed with Mr A from about 3am, when Ms D and Ms E left.

Mr A was seen by a surgical registrar, Dr Q, at 2.30am. Dr Q recorded a plan for continued fluid resuscitation and to review in 1–2 hours' time. He saw Mr A again at

[10] Elastic stockings worn to prevent a thrombosis.

[11] Right 7 outlines the right to make an informed choice and give informed consent. Right 7(4) concerns the provision of services where a consumer is not competent to make an informed choice and give informed consent.

[12] In my provisional findings, I noted that there were no notes from ED nursing staff in relation to the catheter insertion. In its response, Hutt Valley District Health Board advised that this was not correct. On further enquiry, it transpired that a page of the ED documentation originally provided to HDC, and subsequently sent to our experts, was incomplete. The DHB explained that the nurse performing the catheterisation had documented this in the ED notes, but that this occurred after the notes had been copied in preparation for Mr A's transfer to a ward. It was the copy *without* the information about the catheterisation and the nasogastric tube that was included in the notes that later went to the ward with Mr A.

4.15am and updated the medical plan. This included hourly observations, continued fluids and analgesia, and follow-up with regard to surgery in the morning.

At 7.45am Mr A was seen by Dr C. She confirmed the impression of a subacute bowel obstruction and the need for surgery. Dr C recorded in the progress notes that IHC management staff had confirmed that Mr A had no power of attorney, legal guardian or person able to consent to medical treatment. Dr C discussed the situation with the Clinical Head of Department of Surgery and the Chief Medical Advisor. They agreed that as Mr A's condition was now life-threatening, it was appropriate to proceed with surgery. This was discussed with the IHC staff present. Dr C arranged operating time for later that morning, which entailed negotiating with another surgeon to cancel the booking of another patient, who had been scheduled for elective surgery.

Hutt Valley District Health Board (the DHB) explained that, once Dr C confirmed that surgery was required that morning, Mr A proceeded to surgery as soon as an operating theatre could be made available. Dr C stated that while Mr A's disability made clinical assessment of his medical condition more difficult than usual and increased the risk of him developing complications, it did not mean that surgical treatment was delayed.

Mr A was taken to theatre; surgery commenced at 11.43am and was completed at 1.05pm. The operation notes indicate that there was no apparent small bowel obstruction but the gall bladder was inflamed with an impacted stone in the neck. Mr A's gall bladder and appendix were removed. The pathology report subsequently confirmed acute appendicitis.

Mr A returned to the ward at 4.15pm. A nasogastric tube was sutured to his nasal septum[13] to ensure it remained in place. Ms D stated that she had to ask the anaesthetist to explain to Mr A what had occurred during the surgery. The anaesthetist explained that the surgeon had removed his gallbladder and his appendix "just in case" he ever got appendicitis in the future.

*Post-surgery*

Following surgery, Mr A was seen regularly by the Acute Pain Management Service, the Surgical Team, critical care outreach nurses and a physiotherapist.

On Wednesday, two days later, Mr A had an Endoscopic Retrograde Cholangiopancreatogram[14] (ERCP) due to concern that there might have been a bile leak in the gall bladder bed. No leak was found. Later that day, Mr A developed a temperature and increased respiratory and heart rates. Possible atelectasis (collapse of all or part of the lung) was noted and IV antibiotics were prescribed.

By the following morning, Mr A had developed a "wet" cough, and chest physiotherapy was commenced. Following the operation, pain had been managed by way of an epidural. Later that day, the epidural was discontinued and the nasogastric tube removed. Mr A began

[13] The partition between the nostrils.
[14] A specialised technique used to view and/or treat the pancreas, gallbladder, and bile ducts.

having sips of water. He had some reflux, and his pulse and respiratory rates were raised later in the evening.

On Friday morning, the surgical registrar who saw Mr A thought he was looking better. The treatment plan was updated: antibiotics and antiemetics discontinued, IV fluids decreased, oral fluids increased and Fortisip[15] if tolerated. However, later in the day Mr A was reported to be hot and sweaty. This was reported to a house officer, who requested a chest X-ray and follow-up bloods. Mr A was reviewed at 2.30pm by a trainee intern, who thought Mr A was possibly dehydrated and/or had an infection. The recorded plan was for 500ml saline, a fleet enema[16], and follow-up of urine test and chest X-ray results.

Mr A's condition continued to deteriorate throughout the evening. At 8.10pm he was seen by another house officer, who consulted with a registrar and commenced nasal oxygen, restarted IV antibiotics and increased IV fluids. Mr A was to have repeat blood tests and an abdominal CT scan, and hourly observations.

At 11.20pm Mr A was seen by an anaesthetic registrar, Dr O, who organised for him to be transferred to the High Dependency Unit (HDU). Dr O then spoke with anaesthetic consultant Dr N, and recorded in Mr A's progress notes: "In view of medical and social background this man is not suitable for ventilation or HDU admission." The DHB subsequently explained that it was "[Mr A's] significant pre-morbid physical limitations (intellectual disability has no bearing on this) which were the determining factors in the decision not to offer invasive ventilatory support". The DHB explained that this decision was based on the physiological effects of the intubation and ventilation process coupled with Mr A's physical condition, meaning that ventilation would likely have significant long-term outcomes.[17]

Dr O reviewed Mr A again at 11.45pm and discussed his condition with Ms D and another IHC community services worker. The IHC Community Services Manager on call, Mr R, arrived in response to Ms D's concern. The nursing note entered at 1.30am records a discussion between Mr R and the nurse looking after Mr A at this time, about the "ceiling" on Mr A's treatment and the need for a review of his resuscitation status. The nurse noted: "That is a decision that needs to involve the [IHC] area manager and his carers so at this stage will hopefully do this morning." Mr R recalled that staff advised him that intubation had

[15] A drink used when nutritional requirements are not being met through ordinary food.
[16] A fleet enema is a manufactured enema formula.
[17] The DHB referenced the following articles as evidence of this: "Long-Term Outcomes of ICU-Acquired Neuromuscular Abnormalities" (Pedro A. Mendez-Tellez and Todd Dorman) *Contemporary Critical Care*, July 2005, Vol.3, No.2.; "Critical illness polyneuropathy and myopathy in patients with acute respiratory distress syndrome" (Sven Bercker, Steffen Weber-Carstens, Maria Deja, et al), *Crit Care Med* 2005, Vol.33, No.4.; "Characteristics and outcomes for critically ill patients with prolonged intensive care unit stays" (Claudio M. Martin, Andrea D. Hill, Karen Burns, Liddy M. Chen) *Crit Care Med* 2005, Vol.33, No.9.

been refused, as the duty management team considered it would be inappropriate in view of Mr A's intellectual disability and previous quality of life.

The DHB subsequently advised that in situations when any patient's condition is critical and the outcome of resuscitative events may be ambiguous, it is usual to establish "advance orders". It is preferable that such discussions occur before, rather than during, a critical event. The DHB stated that when IHC staff were asked about resuscitation, this was not in relation to Mr A's disability, but the likely outcome of resuscitation.

*Saturday*

Mr A was transferred back to the surgical ward at 2.45am. Soon after this, he developed respiratory distress and stopped breathing. Mr R was asked if Mr A was for resuscitation and advised that in the absence of any documentation, he was. An arrest call was made and CPR commenced. The arrest team arrived and resuscitation efforts continued, but Mr A remained unresponsive. At 3.25am resuscitation was stopped. Mr A died at 3.30am.

Mr R reported that hospital staff tried to comfort him after Mr A's death by commenting that Mr A had been released from "a poor quality of life". The DHB acknowledged that this was not appropriate and apologised for this comment.

*Cause of death*

The coroner was advised of Mr A's death that morning. The post-mortem concluded that the cause of death was:

> "[B]ronchopneumonia of aspiration type secondary to gallbladder disease which was appropriately treated surgically. His pre-existing neurological condition is likely to have predisposed him to aspiration."

**Response from Hutt Valley District Health Board**

*Staffing of ED*

The DHB provided details of medical and nursing staffing levels in ED on the day Mr A was admitted. There were six nurses and a charge nurse on duty from 7am to 3.30pm, seven nurses and a charge nurse from 2.45pm to 11.15pm, and one extra nurse from 12pm to 8.30pm. Medical staff consisted of one senior doctor (consultant or senior medical officer) and one junior doctor (senior house officer) from 7am to 3pm, and another senior doctor and junior doctor team 3pm to 11pm. Another junior doctor worked 11am to 9pm.

The DHB advised that at the time of Mr A's presentation, despite its recruitment efforts within New Zealand and overseas, permanent medical staffing numbers were around 60–70% below budgeted levels. The shortage of ED medical staff was discussed at a clinical heads of departments meeting shortly before Mr A was admitted, and an arrangement was made for gaps in ED rosters to be filled with specialist staff and junior medical staff from other departments. This continued until August 2008, when ED staffing reached its full

complement. The DHB therefore accepts that staffing levels were inadequate but states that reasonable steps had been taken to address the issue.

The DHB advised that there is no policy on the maximum length of stay in ED, but acknowledged that the length of time Mr A waited to be seen by the ED doctor and then by the surgical registrar was excessive. However, the DHB considered that the delay in Mr A's admission to a ward did not delay the start of appropriate treatment, although it acknowledged and apologised for the delay in providing pain relief.

On the day Mr A was admitted, 119 patients attended ED (including patients referred by GPs).[18] There were 10 patients in ED when Mr A arrived at 9am, including patients still in ED from the day before (when 104 patients had attended ED).

*Actions taken*

The DHB noted that the documentation by RN Mr F was not adequate. He has been counselled on his lack of documentation in Mr A's case, and a review of his documentation practice was undertaken. The DHB reports that there has since been a marked improvement in RN Mr F's documentation and physical observation note-keeping.

Although the DHB acknowledged that observations of Mr A's vital signs could have been taken more frequently while he was in ED, it advised that he was observed in between times. Moreover, the failure to take more frequent recordings did not impact on the state of his health and would not have changed his treatment. The DHB also considered that while it was unfortunate that the catheterisation of Mr A required several attempts, male catheterisation can be difficult, so it is not unusual for more than one attempt to be needed (although not with the same catheter). The DHB recognised that the nature of Mr A's illness affected his ability to respond, but advised that he received full resuscitative efforts.

The DHB has implemented several changes since Mr A's admission, primarily in relation to ED staffing. These include:

- An increase in consultant level staffing from 1.5 to 4 full-time equivalent (FTE) fellows of the Australasian College of Emergency Medicine.
- A full complement of Senior House Officers (SHOs) enabling two SHOs to be rostered on night duty.
- Improvements to roster patterns.
- Implementation of an ED Staffing Contingency Plan, whereby a Senior Medical Officer is on call in the event of unavailability of rostered staff or "excessive demand that outstrips available resources".
- ED nursing documentation is now audited on an ongoing basis as part of routine quality improvement.

[18] The DHB advised that the usual number of patient presentations was about 100 per day.

- An escalation plan has been introduced so that when ED is busy, supervising nursing staff can be redeployed and extra staff can be called in to assist.

In addition, the DHB advised that the development of a new ED due for completion by December 2011, which will be twice the size of the existing department, should improve patient flow and observation of patients in less cramped conditions. Similarly, the development of an Admission and Planning Unit (also due for completion by December 2011) will better meet the needs of patients needing more extensive tests and observation prior to admission or discharge.

## Independent advice to Commissioner

Independent advice was obtained from Dr Garry Clearwater in relation to the care provided to Mr A by the Emergency Department (Appendix 2) and by Dr Andrew Connolly in relation to surgical care (Appendix 3).

## 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 1*
*Right to be Treated with Respect*

*(1) Every consumer has the right to be treated with respect.*

*RIGHT 4*
*Right to Services of an Appropriate Standard*

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

*…*

*(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.*

# Opinion: Breach — Hutt Valley District Health Board

## Introduction

Mr A did not receive an appropriate standard of care at Hutt Hospital. My main criticisms are with the care Mr A received while he was in ED. Substandard care on the part of some clinicians was combined with unsatisfactory systems and inadequate communication between ED staff, and with Mr A and his caregivers. While I acknowledge that it was a busy day in ED and the department was understaffed, this cannot excuse what amounted to a collective failure to respond to the needs of Mr A. As my emergency medicine expert, Dr Garry Clearwater, advised: "He clearly had special needs and was unable to communicate clearly — such a patient usually warrants extra attention because the usual clinical clues are subtle."

It is not possible to determine the extent to which the shortcomings in Mr A's care at Hutt Hospital contributed to his death. Mr A's condition was serious and he required major abdominal surgery. His disability made clinical assessment of his medical condition more difficult and increased the risks of him developing postoperative surgical complications. My surgical expert, Dr Andrew Connolly, found that overall the surgical care provided was of a high standard. However, Dr Clearwater refers to substandard aspects of Mr A's care in ED.

In my view, the DHB failed to provide Mr A with an appropriate standard of care in the ED, and therefore breached Right 4(1) of the Code for the reasons outlined below. It is also apparent that the DHB failed to ensure staff treated Mr A with respect and provided services in a manner that was consistent with his needs. In this way, the DHB breached Rights 1(1) and 4(3) of the Code.

## Care in the Emergency Department

The care Mr A received during the time he spent in ED was substandard in several respects. Following an investigation into care provided to a patient by Canterbury DHB,[19] the Commissioner highlighted the threat posed to patient safety by overcrowding in ED. His comments in relation to that case apply similarly to Mr A's situation:

> "The heavy workload ED staff faced … impacted adversely on their standard of assessment, communication and documentation. A district health board has a duty to provide an emergency department that has sufficient staff and adequate systems to withstand fluctuating demands. While the DHB had recognised its staffing issues and taken steps to address these, these were not sufficient.

*Delays*

Mr A was in ED for more than 15 hours. While there is no policy on maximum ED stays at Hutt Hospital, this was unquestionably too long for Mr A to wait for surgical review. The

[19] See http://www.hdc.org.nz/files/hdc/opinions/07hdc14539dhb.pdf (12 December 2008).

DHB apologised for the unacceptably long delays Mr A experienced, attributing them to "…the busyness of the clinicians concerned and the requisite waiting for tests to be completed and reviewed by clinicians before proceeding to the next step".

On the basis of the information provided, ED does appear to have been understaffed for the workload on Sunday. However, this is not an acceptable explanation for suboptimal care. I am especially concerned about the length of time Mr A waited for his first medical assessment — more than three hours after triage — and for his surgical review — more than nine hours after that. Aside from the implications of this for Mr A's medical condition, it was particularly unsuitable for a person with needs such as his to remain in this environment for any longer than absolutely necessary. While it is not possible to know the extent to which Mr A's condition deteriorated as a result of the tardy medical review, the delays were inappropriate and certainly jeopardised the delivery of care.

As Dr Clearwater states:

> "It seems that ED staff did not consider that [Mr A] was unwell in the first few hours in ED. To some degree, it is understandable that they were reassured by the absence of a fever or obvious abdominal tenderness (the latter was first assessed 3 hours after arrival) but these signs have limited value in a disabled patient who cannot communicate verbally."

*Initial medical assessment*

I endorse Dr Clearwater's view that Mr A's initial assessment in ED was moderately substandard. The extent to which other patients in ED that day were similarly affected by the understaffing is not known, but what is known is that Mr A was a particularly vulnerable patient who did not receive the attention his condition warranted. In addition to the length of stay and documentation concerns, Dr Clearwater notes an apparent failure to consider the possibilities of gallstones and appendicitis. He suggests that an abdominal ultrasound should have been considered, as an abdominal CT scan "is not as effective as abdominal ultrasound in diagnosing gallstone impaction". The DHB subsequently pointed out that ultrasound may not have shown other possible diagnoses and suggested that it was safer to look for these before confirming the assumed one. I sought further comment from Dr Clearwater in relation to this (see Appendix 2). I accept Dr Clearwater's advice that, while ultrasound is indeed less effective in diagnosing some other intra-abdominal conditions, it should have been considered in this case because of Mr A's history and given that it is a simple procedure not involving radiation. There is no indication in the notes as to whether ultrasound was considered.

*Nursing care*

The nursing care provided to Mr A did not meet standards of acceptable care in several respects. Mr A's observations should have been taken more frequently during the morning. As Dr Clearwater states, this was particularly important for a patient with undifferentiated pain, who could not communicate well, and who was waiting for a medical assessment for

up to two and a half hours beyond the time recommended at triage. In addition, there is little indication that nursing staff responded appropriately to the clinical indications that Mr A's condition was worsening.

The nursing note at 3pm indicated that Mr A was in no acute pain. This is contrary to the account given by IHC staff and their requests to nursing staff throughout the day for Mr A to be given pain relief. IHC staff familiar with Mr A were better able to interpret his non-verbal cues and were with him throughout his time in ED. It is likely that the written information from Ms D was provided while Mr A was still in ED, although it may have been late in the day. Irrespective of this, IHC staff were available at all times and were a valuable source of information.

I agree with Dr Clearwater that "ED staff were misled by [Mr A's] limited ability to convey pain (with grimaces and subtle cues)… [and] … gave insufficient weight to the concerns of his caregivers who repeatedly conveyed that he was in distress and needed pain relief".

The DHB accepted that its staff should have explained to IHC staff that oral pain relief could not be given until Mr A had been seen by the surgical team. However, this does not explain why other, non-oral pain medication was not given earlier in the day. While pain relief was ultimately the responsibility of the doctor looking after Mr A at the time, I find no evidence to indicate that nursing staff communicated the need for this to the doctors. It was more than 10½ hours after Mr A's arrival in ED before he was given pain relief or fluids. This was clearly not acceptable.

Moreover, there is no indication that nursing staff informed medical staff that Mr A had vomited. Medication to alleviate nausea and vomiting could have made Mr A more comfortable, as well as possibly preventing the aspiration of vomitus.

There were also issues with the management and recording of Mr A's catheterisation. Staff who inserted the catheter and nasogastric tube had documented these procedures, although there is still no record of the size of the catheter, and the entry was not signed. However, the documentation from ED was copied into Mr A's inpatient notes before this note was made, so it was an incomplete record that accompanied Mr A to the ward and that staff caring for him there relied on. This raises yet another concern about ED systems, with the potential to result in serious harm if not addressed satisfactorily.

Aside from this, the nurse involved acknowledged that several attempts were made to insert the catheter. As Dr Clearwater states, urinary catheterisation is potentially a painful procedure with a risk of inducing permanent injury. He considers it should be uncommon to have to make more than one attempt and states that "[i]f a catheter cannot be inserted readily (maximum two attempts), a more experienced staff member should be consulted; it is risky to repeatedly attempt to re-catheterise a patient".

The DHB advised that all ED nurses performing male catheterisations must be trained to do this. What happened with Mr A — multiple attempts and repeated use of the same catheter — certainly indicates that the staff members involved need further training.

*Documentation*

The documentation of Mr A's medical care while he was in ED was not of an acceptable standard. Of note is the lack of clarity in Dr G's records, including the fact that he can only say it is "more likely than not" that he was the author of this record. The use of the electronic discharge summary as the sole record of medical input was clearly problematic. It was particularly unhelpful for a patient whose stay in ED was over 15 hours and whose care was provided by more than one clinician. As Dr Clearwater states, it is "… substandard to leave a 'work in progress' electronic discharge summary as the sole clinical note in a paper-based system".

In a recent report of another investigation into ED care at Hutt Hospital,[20] the Commissioner referred to the pros and cons of writing notes directly into an electronic discharge summary. Following that investigation, the DHB revised the ED guidelines on the use of electronic discharge summaries in conjunction with handwritten notes. These guidelines were not in place at the time of Mr A's attendance, but his experience clearly reinforces the need for a clinical record that details the full clinical situation and an explanation for the decisions and action taken. HDC was also advised at that time that the DHB was anticipating the incorporation of a free text function in the electronic record in June 2009, which will allow for more accurate contemporaneous recording within the electronic record, for the course of an ED stay.

The absence of nursing progress notes for six hours following triage is also not acceptable. There are blank spaces in the nursing records where times should have been recorded, and unsigned and untimed entries in the IV fluid record make it unclear as to whether two doses of IV saline fluids were actually administered.

*Conclusion*

While individual members of staff must consider their own practice in light of this case, in my opinion the ED clinical team as a whole let Mr A down. I am pleased to hear that significant improvements have been made to medical staffing levels in ED at Hutt Hospital, including specialist emergency medicine staff. However, it is clear that the staffing of ED on Sunday was not adequate. As a result, Mr A waited longer to be seen and treated by medical staff than was appropriate. The nurses responsible for Mr A's care in ED did not meet acceptable standards of care, by failing to take regular observations and failing to respond to requests for pain relief.

[20] See http://www.hdc.org.nz/files/hdc/opinions/07hdc10767dhb.pdf (25 September 2008).

Documentation of clinical observations and decisions is fundamental to patient care. Yet there were a number of gaps and ambiguities in Mr A's documentation, particularly the failure by nursing staff to fully document Mr A's condition and care adequately.

In my view, these deficiencies were primarily a result of overcrowding in ED. Staff were rushed, and decisions, assessments and medical interventions were rushed or truncated as a result.[21] In these circumstances, Hutt Valley District Health Board breached Right 4(1) of the Code.

**Surgical care**

I endorse the view of my surgical expert, Dr Andrew Connolly, that Mr A was provided with satisfactory surgical care aside from the delay in the initial surgical assessment.

*Initial assessment*

Although Mr A was referred to the surgical team for assessment after Dr G saw him at 12.15pm, the admitting surgical registrar, Dr H, did not see him until 9.30pm that night. Given Mr A's condition, this was not appropriate. As Dr Clearwater noted:

> "It is inadvisable for specialist services to unduly delay seeing patients that have been referred for assessment. It is unfair and unsafe for patients to wait a long time, their condition can deteriorate and it blocks beds in ED."

However, I accept Dr H's explanation that the information passed on from ED staff did not indicate Mr A should be reviewed urgently so, as he was in surgery all afternoon, he did not prioritise seeing Mr A earlier. I agree with Dr Clearwater that ED staff did not initially appreciate how poor Mr A's condition was and therefore "insufficient concern [was] conveyed initially to the surgical registrar about his condition". Once Dr H assessed Mr A, he took appropriate action by arranging a CT scan.

*Preoperative assessment*

I accept Dr Connolly's advice that the decision-making process regarding preoperative investigations and the timing of Mr A's surgery was appropriate. Dr Connolly advised that a period of IV fluid resuscitation is usually very valuable for patients where there is no clinical indication for immediate surgery.

*Standard of surgery, postoperative care and documentation*

According to Dr Connolly, Mr A's surgery was appropriate, beginning with an exploratory laparotomy and proceeding to the removal of his gall bladder and appendix. The decision to remove Mr A's appendix was reasonable on the basis of diagnostic uncertainty, and indeed the post-mortem confirmed that he had acute appendicitis. The operation record itself is detailed and thorough. However, a clearer explanation of this could have been provided to

[21] Ardagh, M. & Richardson, S. (2004). Emergency department overcrowding — can we fix it? NZMJ, 117 (1189).

Mr A and his caregivers. I appreciate that staff may have been attempting to communicate the outcome of surgery in a manner that Mr A could understand. However, the explanation provided (that they had removed his appendix "just in case" he ever got appendicitis) was not accurate and raised questions about the appropriateness of the treatment.

Dr Connolly advised that Mr A's care was of a high standard and that he was treated aggressively in the postoperative period. He noted that the emphasis placed on oxygen saturation levels post-surgery indicated an awareness of the potential for a person with an intellectual disability to have an increased risk of respiratory compromise following abdominal surgery.

It is concerning that Mr A's progress notes refer to his "medical and social background" as the basis for the decision not to admit him to HDU or commence ventilation, if his physical limitations were the determining factor for this decision. However, I accept Dr Connolly's advice that attempts to resuscitate Mr A were correctly carried out and the surgical team's documentation was acceptable.

*Informed consent for surgery*

A key issue in the complaint from Mr B and IHC was the extent to which Mr A's surgery was delayed by hospital staff adopting an overly cautious approach to establishing whether they needed to obtain informed consent to proceed with treatment.

Right 7(4) of the Code of Health and Disability Services Consumers' Rights outlines the process required where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available. It states that the provider may provide services where (a) it is in the best interests of the consumer; (b) reasonable steps have been taken to ascertain the consumer's views; and (c) provision of services is either consistent with the consumer's views or, if the consumer's views have not been ascertained, the provider "takes into account the view of other suitable persons who are interested in the welfare of the consumer and available to advise the provider".

The IHC staff who were with Mr A for much of his time at Hutt Hospital and *always* contactable were certainly "suitable persons" interested in the welfare of the consumer and available to advise the provider. It was therefore both necessary and desirable for IHC staff to be consulted in relation to Mr A's treatment, as well their assistance sought in ascertaining Mr A's views. There are a number of instances documented in Mr A's notes of discussions with IHC staff about his condition and treatment in the surgical ward, including prior to surgery and when he was transferred back to the ward in the early hours of the day he died.

Having said that, I can find no evidence to indicate that Mr A's surgery was delayed by the issue of consent. Once Dr C confirmed that Mr A required surgery, she sought the opinions of two senior colleagues unrelated to the direct care of the patient. The operation took place soon after the decision was made that this was in Mr A's best interests. Dr C's actions were

in accordance with the DHB's Informed Consent policy, and the process was documented clearly in the clinical notes.

However, the DHB's Informed Consent policy is not entirely clear that, where a patient's views cannot be ascertained, staff should take into account the views of those people who are available and interested in the patient's welfare. I also note that the DHB has a form for use with patients unable to give consent, but that the use of this has not been formalised. I suggest that the DHB revise the Policy and implement the use of the associated form, to ensure staff are able to clearly document the process prior to providing services to a patient not competent to consent.

**Consumer-centred care**

What is striking about this case is the failure of staff to listen to Mr A's voice (expressed with the assistance of his caregivers), and a systemic lack of responsiveness to Mr A's needs.

It is a core ethical principle in caring for patients that every patient should be treated with respect. Right 1(1) recognises this principle as a legal right under the Code, confirming "every consumer has the right to be treated with respect". I agree with the Commissioner's statement in Case 05HDC11908:

> "Patients who have been admitted to hospital because they are acutely unwell are especially in need of care, comfort and compassion. As well as suffering from their present illness, they are likely to be frightened by the unfamiliar hospital environment and fearful for their future."[22]

Care, comfort and compassion are particularly important for someone like Mr A, who was not capable of clearly expressing his needs, was unable to express the usual cues of pain and distress, and was known to dislike being in hospital. Furthermore, as Dr Clearwater noted, a patient such as Mr A "warrants extra attention and observation because the usual clinical cues are subtle". In my view, hospital staff did not make the most of the assistance available from IHC staff to ensure Mr A's care and treatment were provided in a manner that ensured he was treated with respect and that his distress and discomfort were minimised. IHC staff endeavoured to assist the hospital staff in their care of Mr A by interpreting his limited repertoire of communication skills, monitoring his temperature and conveying his need for pain relief.

I have previously noted several instances of less than adequate communication in relation to Mr A's care in ED and under the surgical team. This includes the failure of staff to clearly explain the reasons for some treatments (eg, withholding oral pain relief in ED and the reason for removing Mr A's appendix) to Mr A himself, or with his caregivers (who could

[22] See http://www.hdc.org.nz/files/hdc/opinions/05hdc11908dhb.pdf (22 March 2007).

have explained it to Mr A). Furthermore, concerns expressed by caregivers to ED staff were effectively ignored, resulting in Mr A:

- being left in ED with nothing to eat or drink until IV fluids were started 10 hours after arrival, by which time he was significantly dehydrated;
- not being given anything for nausea or vomiting — including his routine medication to prevent regurgitation, increasing the chances of regurgitation (and aspiration of gastric contents);
- not being given any pain relief, despite repeated expressions of concern by his caregivers until nearly 11 hours after his arrival in ED.

I am also concerned by the comment by a staff member shortly after Mr A's death that he had been "released" from a "poor" quality of life. There was also reference in Mr A's clinical record to his "social background" as the basis for decisions about his care. These are wholly inappropriate comments, and demonstrate a lack of respect for Mr A and a lack of understanding of his quality of life. From all accounts Mr A had a degree of independence, hobbies and interests, and a home with friends. He found much to enjoy in life and was, for the most part, living an 'ordinary life', no better or worse than the rest of us. I am also left with some disquiet about the reasons for not admitting Mr A to HDU for more aggressive treatment. To not admit Mr A to HDU was a significant decision, which should at least have been fully discussed with IHC staff (as suitable persons who were interested in his welfare) before the decision on which treatment option to pursue was made.

The DHB, as an organisation, is responsible for the attitude that its staff displays to patients.

While it is not possible to verify exactly what was said to, or about, Mr A during his time at Hutt Hospital, I am left with a clear impression that he was not accorded the basic dignity and respect that is the right of every patient. Staff clearly did not respond appropriately to concerns raised by Mr A's caregivers that he was in pain, was vomiting and needed his regular medication.

Accordingly, I conclude that in its treatment of Mr A, Hutt Valley District Health Board breached Rights 1(1) and 4(3) of the Code.

## Hutt Valley District Health Board's Summary Report on the care of a patient with a severe disability

In May 2009, the DHB released a Summary Report on the care of another patient with a severe disability, identified as Ms A. Ms A was admitted to Hutt Hospital in May 2008, and died 18 days later. The DHB considered that Ms A's disability needs may not have been considered as part of her overall care plan, and commissioned an independent external review. The Summary Report identifies a number of significant concerns with the care provided to Ms A, and concludes with 24 recommendations.

Several of the concerns identified and recommendations made are pertinent to Mr A's experience. I note the following in particular:

- Recommendation 3 — "That all staff attend disability responsiveness training to improve their competence to care for people with disabilities as stated in the Hutt Valley District Health Board's New Zealand Disability Strategy Implementation Plan 2006–2011."
- Recommendation 5 — "Working in partnership with disability providers and people with disabilities to develop processes that ensure staff have the information they need and people with disabilities are able to have their disability support needs met."
- Recommendation 10 — "Develop a process whereby patients with high and complex needs have an assigned senior nurse to provide an ongoing overview of the patient, nursing care planning and priorities within the multidisciplinary team."
- Recommendation 14 — "Consider developing a process whereby patients with high and complex needs are allocated a named individual to act effectively as an advocate/case manager during any admission, specifically to take a helicopter view of the patient's care and ensure issues not commonly encountered by acute ward staff in caring for patients can be addressed promptly and effectively."

I note also Recommendation 2, that a memorandum of understanding or protocol is developed between the DHB and the particular accommodation Trust involved in Ms A's situation, to specify each organisation's obligations when a resident is in hospital. It would be appropriate for this to be extended to other disability service providers.

The DHB has advised the Commissioner that while some changes have been made as a result of this review, some recommendations will take time to implement. The review is an important step and I commend the DHB for recognising the learning that can come from an honest and open appraisal. Furthermore, the decision to share the lessons learned with other DHBs ensures that the wishes of Ms A's family and supporters that Ms A's experiences should be a catalyst for change are realised more fully.

## Response to provisional opinion

The DHB has accepted all of the deficiencies of care outlined in this opinion. In particular, it recognises and accepts that the reduced numbers of staff in ED on the day he was admitted contributed to the poor care Mr A received. The DHB agrees that Mr A's needs as a disabled person were not appropriately addressed and has reiterated its commitment to implementing the changes recommended following the recent external review.

The DHB offers its sincere apologies to Mr A's caregivers and friends for the poor standard of care and communication provided to Mr A.

## Recommendations

I recommend that Hutt Valley District Health Board provide to HDC **by 30 November 2009**:

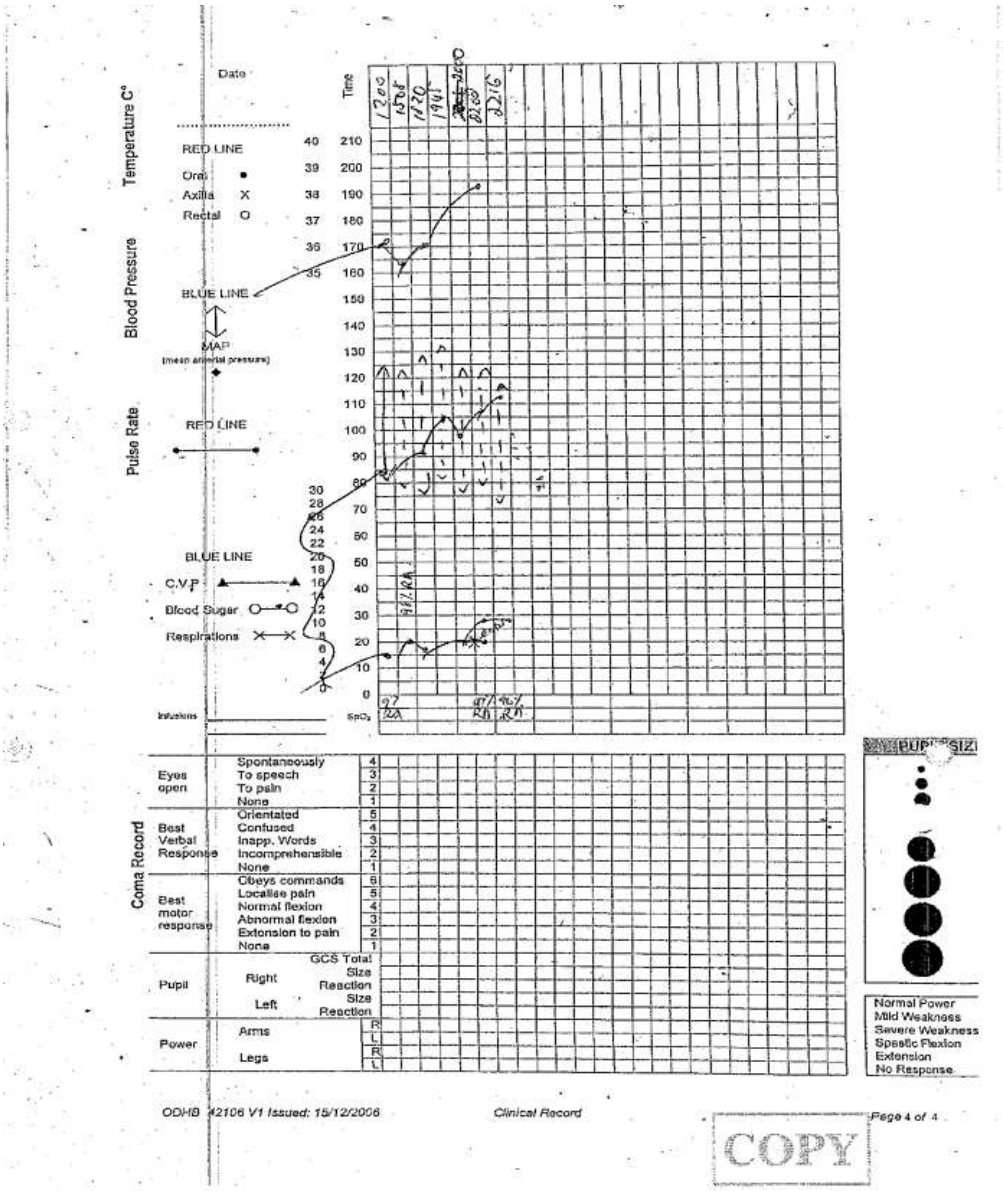
- An update on the DHB's consideration and implementation of the recommendations in the Summary Report outlined above.
- An update on the expected completion date for incorporating a free text function within the electronic record.
- A review of the acute surgical registrar role and policy in relation to the time taken to see patients in ED.
- A review of the training provided to nursing staff in relation to male catheterisation, including whether implementation of catheterisation guidelines would be appropriate.
- An update on the steps taken to ensure the duplicate records from ED that accompany patients admitted to wards are the complete and up-to-date record.
- A review of the Informed Consent policy and associated documentation in relation to patients not competent to give informed consent.

## Follow-up actions

- A copy of this report will be sent to the Chief Coroner.

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, IHC, Hutt Valley District Health Board and Hutt Hospital, will be sent to the Minister of Health, the Director-General of Health, the Medical Council of New Zealand, the Australasian College of Emergency Medicine, the Quality Improvement Committee, the Health Information Strategy Advisory Committee, all district health boards, the New Zealand Nurses Organisation, the New Zealand Medical Association, and the Association of Salaried Medical Specialists, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

# Appendix 1 — ED Observations






*Names have been removed (except IHC, Hutt Valley DHB/Hutt Hospital and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

## Appendix 2 — Independent advice from Dr Garry Clearwater

Thank you for asking me to review this case.

I have read and agreed to follow the Guidelines for Independent Advisors provided by the Office of the Health & Disability Commissioner.

I am an Emergency Medicine specialist, qualified MBChB in 1982 and a Fellow of the Australasian College for Emergency Medicine (FACEM) since 1999. I currently work as a full-time staff specialist in two Emergency Departments (EDs) at Waitemata District Health Board and I was Clinical Director of the Emergency Medicine service between 2000 and early 2006. I have previously worked as a GP in a semi-rural practice and as a Medical Officer of Special Scale at Middlemore Hospital ED. Our service employs specialists, Senior Medical Officers and registrars in training as well as locums. We employed Senior House Officers up until 2005 and have Senior House Officers on staff since November 2008.

I have been asked to provide independent expert advice regarding the standard of care provided to [Mr A] in the Emergency Department of Hutt Hospital during his admission on Sunday [in early] 2008, prior to his admission to the care of the surgical service of that hospital later that evening.

[Dr Clearwater noted here the documents he reviewed and a summary of events.]

**Questions raised by the Commissioner**

1.The general care provided by Hutt Hospital ED.

This was sub-standard in a number of ways.

Key concerns include:

**Significant delay to be seen by a doctor**: the first medical assessment was at 1215h, more than 3 hours after arrival in ED — despite a Triage category of 3 (should be seen by a doctor within 30 minutes).

**[Mr A] did not receive adequate attention for his condition.** He clearly had special needs and was unable to communicate clearly — such a patient usually warrants extra attention and observation because the usual clinical cues are subtle. His caregivers were familiar with his normal state and were appropriately concerned enough to seek hospital attention. Their concerns expressed to ED staff were not given appropriate weight, and I suspect that his underlying illness was underestimated because he could not express himself clearly.

- He was apparently left with nothing to eat or drink until IV fluids were started 10 hours after arrival — by which time he was significantly dehydrated. It was a very simple and standard process to chart intravenous fluids in ED for patients who cannot eat or drink.
- His routine medication to prevent regurgitation (Domperidone) was withheld, despite enquiries from the caregivers, increasing the chances of regurgitation (indeed, the caregiver documents him swallowing his vomitus). Aspiration of gastric contents is likely to have been a contributor to his death.
- He was not given anything for nausea or vomiting in ED although this could easily have been given as a dose of metoclopramide, used routinely in EDs for this problem.
- Pain relief was delayed, until 1945h (nearly 11 hours after arrival) — not even a simple analgesic such as paracetamol — despite repeated expressions of concern by his caregivers.

**The description of 3 attempts to insert a urinary catheter (as described by his IHC caregiver — there is nothing in the clinical notes) suggests that a staff member lacking full competency attempted the procedure.** The unidentified staff member was observed to make multiple unsuccessful attempts to insert the catheter; it was eventually deemed to be curled under the foreskin — from which I infer that the foreskin was not retracted when it should have been (a basic preparation); there was likely to be inadequate preparation and cleansing before insertion. Furthermore, the next staff member who successfully inserted the catheter (after retracting the foreskin) reportedly re-used a catheter that had been curled under the foreskin and reportedly had inadequate anaesthetic for the procedure.

2. Was [Mr A] adequately assessed in ED?

I support the concerns expressed by the IHC (particularly on pages 00008–9) that [Mr A] may not have received the same standard of care as a more able-bodied articulate patient would have received.

**Overall, his assessment seems to have been moderately substandard**: it was delayed, suboptimally documented, did not take into account the limitations attributable to his disabilities and was in some respects neglectful.

It seems that ED staff did not consider that [Mr A] was unwell in the first few hours in ED. To some degree, it is understandable that they were reassured by the absence of a fever or obvious abdominal tenderness (the latter was first assessed 3 hours after arrival) but these signs have limited value in a disabled patient who cannot communicate verbally.

My impression is that ED staff were misled by [Mr A's] limited ability to convey pain (with grimaces and subtle cues). ED staff gave insufficient weight to the concerns of his caregivers who repeatedly conveyed that he was in distress and needed pain relief.

**The possibilities of gallstones and appendicitis were not considered in ED.** [Mr A] was known to have gallstones (and was a previous candidate for cholecystectomy). He presented with abdominal distension and pain but no consideration seems to have been made for possible biliary colic (gallstone pain: cholelithiasis) or infection (cholecystitis) even when he developed fever and was noted to have an elevated white cell count.

Normally, a patient presenting with abdominal pain and known gallstones would have this possibility high on the differential diagnosis. It is unclear whether an abdominal ultrasound (a non-invasive diagnostic test) was considered at any time or (if it was considered) why it was not performed. Abdominal CT scan is not as effective as abdominal ultrasound in diagnosing gallstone impaction.

Symptoms and signs of appendicitis can be difficult to elicit in patients who cannot communicate clearly but this was also a possibility in a patient with abdominal discomfort, anorexia or vomiting, especially as he developed increasing signs of infection.

An impacted gallstone and appendicitis were both found at surgery the next day.

According to IHC staff, it was the caregivers who first recorded a fever in ED at 2010h and notified the nurses but this was not checked or recorded by nursing staff until 2202h.

It is difficult to know whether all patients in the ED were equally affected by heavy workload but this patient was especially vulnerable and warranted a higher level of basic care than was provided. His condition clearly deteriorated in ED such that he was eventually judged to be dehydrated, in pain, feverish, had vomited and may well have aspirated during that time.

3. ED workload and staffing levels.

Insufficient information was provided to judge this accurately.

Two staff members did not mention workload concerns in their responses (RN [Mr F] #00042, [Dr G] ##00043).

The Nurse Manager described the workload (#00056): 119 patients attended the ED on [the day Mr A was admitted]. However, supplementary data is needed to better assess workload. Some of these statistics constitute Key Performance Indicators for many EDs.

How many of these attendances were GP referrals to services other than Emergency Medicine? GP referrals typically constitute between 15–35% of cases presenting to ED [and] are primarily seen by other doctors from inpatient services.

Patient numbers presenting within time intervals (e.g. each hour). Workload may be reasonable for part of the day and then become heavy as patients present in clusters.

Distribution of patients amongst the triage categories. A high number of sick patients (triage categories1–3) take up more medical time on average than the same number of low-acuity patients (triage 4–5).

Average lengths of stay in the ED; a measure of delays and workload.

The percentage of patients seen within their target times in each triage category: a measure of how far the medical staff were falling behind the workload.

Admission rates: a threshold measure of how many patients were sick enough to need admission to a ward.

The number or percentage of patients who left without being seen.

Medical staffing levels stated by the Nurse Manager:

One Senior Medical Officer (SMO) and one Senior House Officer (SHO) between 0700–1500h (I suspect this was meant to be between 0700 and 1600h, judging by [Dr G's] comments #00043).

One SHO between 1100 and 2100h.

One SMO and one SHO between 1500–2300h (I suspect the start time was actually 1600h, from Dr L's comments #00044).

One SHO on the night shift (2300–0700h).

I presume that these staff numbers do not include inpatient team doctors who were assessing and admitting referred patients in ED.

Based on this limited data, one interpretation is that 119 patients were assessed by 6 doctors (providing 44 doctor-hours) over 24 hours: an average of 2.7 patients per hour per doctor, for all acuities. The standard processing rate for ED patients is 1–2 patients per doctor per hour (closer to 1 patient per hour for a busy metropolitan ED with high-acuity patients).

However, if the total of 119 patients included GP referrals, there may have been 77–100 patients to be assessed by Emergency Medicine doctors: an average of about 2 patients per doctor per hour.

The comments by the ED consultant on the afternoon shift were pertinent (#00044): "my other recollection of that day … was the exceptionally large workload — I had already attended the department for an extra 6 hours earlier in the day (0000–0300 and 1115–1415) due to the overwhelming workload. Both medical and nursing staff were struggling to maintain timeframes and optimal patient care."

**Thus, with the limited information provided, ED was apparently understaffed for the workload and suboptimal care was to be expected.**

**Note, in relation to the next question, I cannot comment on the workload for the surgical service.**

4. Length of stay in ED before transfer to the surgical ward.

The duration in ED was excessive, at more than 15 hours. There were a number of factors: delayed ED medical assessment, waiting for results of tests, initial underestimation of the patient's condition and perhaps insufficient concern conveyed initially to the surgical registrar about his condition (leading to lower priority and consequent delays by the surgical service).

The net effect was suboptimal patient care:

The ED environment is often chaotic and stressful for some patients who would be better served in the settled environment of a ward.

Compared to ward beds, ED stretchers are typically unsuitable for prolonged bed rest.

Overload in ED is primarily attributable to delayed access to inpatient beds. Patients who wait in ED take up resources (especially nursing time) that primarily should be used to manage acute patients. There is plenty of evidence that patient mortality and morbidity deteriorates when access to inpatient beds from ED is delayed.

5. Time taken to be seen by the surgical team to assess [Mr A].

This is difficult to determine because documentation is unclear as to when the surgical team were specifically asked to assess/admit [Mr A].

His first ED medical assessment was at 1215h followed by abdominal X-rays at 1300h. The surgical registrar was consulted (by phone) with the results of the X-rays but there is no indication of when this happened — presumably some time after the abdominal X-rays, early in the afternoon. It seems that there was low concern about the patient's condition ("habitual constipation"); a plan was discussed (to await blood test results) that did not necessarily require surgical assessment.

An ED specialist assessed [Mr A] at 1730h and took a second set of blood tests. The notes are over-written in such a way as to be unclear when these results were reviewed and when the surgical registrar was formally asked to assess the patient for admission. However, the ED consultant states in retrospect (#00044) that she was "certain" that an attempt was made to contact the surgical registrar at the time that she assessed [Mr A]: presumably somewhere between 1800 and 1830h (after assessing [Mr A]).

According to the ED Nurse Manager (#00057), the surgical registrar did not come to see the patient until "completion of surgery at approximately 9:30 PM" but then realised that, "[Mr A] was sicker than had been inferred from the handover information provided him. [Dr H] advised that if he had realised this he would have come to see [Mr A] earlier, between surgical cases." It is unclear whether [Dr H] was referring to the first discussion (by [Dr G]) or the later referral by the ED consultant.

This suggests that the surgical registrar could have reviewed [Mr A] earlier if he wanted.

It is inadvisable for specialist services to unduly delay seeing patients that have been referred for assessment. It is unfair and unsafe for patients to wait a long time, their condition can deteriorate and it blocks beds in the ED. Sometimes the severity of the patient's condition is underestimated at the time of referral by the ED doctor or only becomes apparent with time.

The ACEM Policy on the Definition of an Admission (2006) includes the following points:

2.4 The Australasian College for Emergency Medicine believes the emergency department is not an appropriate environment for the ongoing management of patients who require inpatient medical care.

2.5 Where a patient is assessed in the emergency department as requiring admission as an inpatient then a bed should be made available at the delegated receiving unit as soon as possible.

2.6 The Australasian College for Emergency Medicine believes retention of admitted patients in the emergency department is a failure of access to care and is detrimental to emergency department function.

3.2 The time admission is requested should be recorded to the nearest minute.

3.3 The time the admitted patient leaves the emergency department should be recorded to the nearest minute.

In summary, most of the delays in ED were attributable to serial delays by ED staff (delays to be seen and delays getting adequate lab samples) but there was a further delay of 3–4 hours for the surgical registrar to come to see [Mr A] after he was referred.

**Management at Hutt Valley DHB have acknowledged that the delay was unacceptable** (#00058): "we apologise… for the excessive wait [Mr A]… experienced in ED while waiting for the surgical registrar… we do accept that specialist staff should have seen him earlier and that he would have been more comfortable in a ward bed."

6. Documentation by Hutt Hospital's ED staff.

**The nursing notes (#00089, #00095–6) were substandard, to a moderate degree.**

There were no nursing recordings of vital signs between 0859 and 1200h: a gap of 3 hours, during which time no doctor had seen the patient.

There were no nursing progress notes between 0859h and 1500h: a gap of 6 hours.

The nursing record has blank spaces in the sections where times should be recorded (time of investigations, finish time for IV fluids).

In the IV fluid section, an unidentified staff member has recorded "IV saline" 2 litres to be given IV "stat" but this section is unsigned and it is therefore unclear whether or not the fluid was administered.

There is no nursing record of the information conveyed from [Mr A's] caregivers (as recorded on #00012), including their concerns that he was in pain, was vomiting and needed his regular medication.

The recordings between 1200h and 2200h show a steady rise in pulse rate: potentially an indicator of deteriorating pain or hydration or infection; there is no evidence that this evoked any response from nursing staff.

**The documentation by [Dr G] (#00090–91) was suboptimal to a moderate degree.**

In his response dated 21 July 2008 (#00043), [Dr G] provides an indictment of his own documentation when he states that he cannot be sure from the notes that he actually saw the patient. The electronic record had another doctor's name on it and he is not convinced that he was the author apart from his impression they were "written in a format consistent with my own." At best, "more likely than not," he admits that he was probably the author.

This is a basic failure of documentation. [Dr G] should have written or printed out his notes and signed them at the time of his assessment as a basic standard of medical care, before he handed over his patient and left the ED.

Instead, they appear to have been written into an electronic discharge summary without being printed out and signed. The EDS system has subsequently automatically over-written his name.

The time frames within his electronic clinical note are unclear and it appears that text segments were added through the shift: at one point it states that "CRP still pending" but in another part (in what was presumably an untimed addition) records the CRP value.

[Dr G's] notes give no indication when the surgical registrar was contacted (see the reference to ACEM policy 3.2, mentioned above).

The interim plan is equivocal: it states that the surgical registrar "will review" but then equivocates: "or could consider (discharge) … if inflammatory markers are (normal)".

The record records mild elevation of CRP but omits the white blood count. [Dr G] later stated that the latter sample had clotted and needed to be repeated. This was not documented anywhere in the notes and added to the delays in [Mr A's] care.

Regarding hand over, [Dr G] offers in retrospect that "I probably handed the patient's care over to [Dr L] to chase up the laboratory results…"

The issue of writing notes directly into an EDS (without separate clinical notes) was raised in respect to another ED case from Hutt Valley DHB that occurred in 2006 (07/10767). While this system is suitable for straightforward clinical problems where the same doctor discharges the patient, it is unsuitable for patients with complex problems where the case is being handed over to another doctor.

**The notes by [Dr L] (#00092) are of a good standard** and make it clear that a surgical opinion was requested although it does not indicate when this request was made.

**There were significant delays in ED pending the results of lab tests but documentation of this was mildly below standard**. There is virtually no documentation of what results were ordered and when. In his retrospective report (#00043), [Dr G] states that some of the samples had clotted, requiring repeat tests: this should have been documented in the notes.

**Regarding the urinary catheter, documentation was mildly below standard**. There was no clinical documentation of the catheter insertion time, catheter size or results of catheterisation.

7. The standard of communication by Hutt Hospital ED staff with [Mr A] and his caregivers.

It seems that his caregivers made a great effort to assist the ED staff in their care of [Mr A]. They were always present to support their client and to interpret his limited repertoire of communication skills. They actively assisted with his care, including apparently taking his temperature and conveying his need for pain relief.

An undated, unsigned clinical sheet (#00097–8), presumably written by his caregivers, has more than a page of detail "from [Mr A's] carers for nursing staff" regarding how he conveyed feelings of pain, how stressed he was likely to be in hospital, the anticipation that he would try to remove his intravenous line and catheters (and how to deal with this), how he could be offered fluids, how to tell when he was happy and how to assist his mobility. A contact number was given for further advice if this was needed.

The caregiver report (#00012) indicates that nurses were informed at arrival in ED that [Mr A] was indicating pain but this was not clearly documented in the nursing notes and the issue appears to have been ignored until a nurse asked at 1130h what type of pain relief he could have. The caregivers suggested paracetamol but no analgesia was given then.

Pain relief was reportedly requested by the caregivers again at 1530h — this was not documented in the nursing notes or actioned. Further requests for pain relief were made at 1800h (again, not documented) but analgesia was not started until 1930h.

They describe two occasions where nurses promised to return with answers to questions (at 1445h, 1930h) but did not return.

The communication from the ED staff was moderately below standard despite a high level of involvement and support by [Mr A's] caregivers.

8. Changes that Hutt Valley DHB staff have made since these events.

There seem to have been significant improvements in medical staffing levels on weekends (#00056) — when EM workload is typically busiest. An extra SMO works between 0900–1700h and an extra SHO on the night shift: effectively providing an extra 16 doctor-hours per 24 hours.

In the absence of data about typical presentation numbers on weekends, it is difficult to comment whether this is adequate for workload but it is certainly an improvement.

**Comments in the reply from Hutt Valley DHB indicate that some deficiencies were under-estimated:**

A. Urinary catheterisation is a potentially painful procedure with a risk of inducing permanent injury. I am concerned about the assertions made in section c on Page 00033 by the Service Manager of Acute Services regarding male catheterisation that, "it is not unusual for the need for several attempts." It should be uncommon to have to make more than one attempt — and I invite this issue to be reviewed by a urologist. If a catheter cannot be inserted in the first attempt, a more experienced staff member should advise and assist; it is risky to repeatedly attempt to re-catheterise a patient.

At the very least, the staff member who made the initial attempt needs to be identified and educated. There may be a systems problem (of education, guidelines and credentialing) that needs wider attention.

B. Recording vital signs. Later, in the same page, there is the statement that "3 hourly observations of vital signs" were adequate in ED and "the failure to take more frequent recordings did not impact on [Mr A] (sic) state of health and would not have changed any of the subsequent actions."

This is not an acceptable standard in ED, particularly for a patient with undifferentiated pain, who cannot communicate well and was awaiting medical assessment by a doctor, up to two and a half hours beyond the time recommended at triage.

9. Recommendations

ED staff may need education about how to assess and assist disabled patients, including education that:

Some disabled patients do not convey standard cues to distress or pain;

Caregivers who know the patient well are a very useful source of advice for interpreting the needs of individual patients.

Documentation standards could be improved to provide an accurate record of assessment, initial differential diagnosis and management plan — ideally updated in a sequential manner with key information as it comes to hand.

A guideline is recommended about when it is appropriate to write clinical notes into the electronic discharge summary for this ED that uses a mixture of hand-written clinical notes and electronic discharge summaries. I suggest that each patient who is handed over to another doctor (or is referred to another service) should have a printed record in the notes, timed and signed by the doctor who assessed the patient. It is substandard to leave a "work in progress" electronic discharge summary as the sole clinical note in a paper-based system.

Shift scheduling may be unrealistic. The shift times provided by the ED Nurse Manager (#00056) did not match the information provided by doctors (as discussed in Question 3.)

Of concern, if they are correct, the intervals do not account or allow for systematic review and handover of patients at each shift time. One shift is apparently scheduled to finish at 1500h, the next starts at 1500h: it is unrealistic to think that staff on one busy shift can suddenly finish all their tasks and leave at the exact time as a new shift starts.

There should be a minimum of 30–60 minutes of shift overlap to allow for systematic handover. I presume that time is actually being taken for this but it would be disappointing if roster scheduling does not recognise this basic requirement.

There is no evidence as to whether a guideline exists regarding urinary catheterisation. There should be a service guideline (with input from the Urology service) that includes:

Urinary catheterisation should be performed by a credentialed staff member.

If a catheter cannot be inserted readily (maximum 2 attempts), a more experienced staff member should be consulted; it is risky to repeatedly attempt to re-catheterise a patient.

The time, size and type of catheter should be documented as well as the amount of fluid drained.

10. Additional comments

A. The ED consultant seems to have worked excessive hours that weekend (as mentioned in Question 3). Hopefully this was exceptional; error rates increase when doctors work excessive hours at a busy pace.

B. The staff responses provided by [Mr F] (#00042) and [Dr G] (#00043) indicate that they may not have been adequately informed that they were involved in the investigation of a significant incident. I wonder whether they were advised to contact their professional indemnity advisor before tendering their responses.

It should be part of departmental policy to advise key staff members to consult with their indemnity and/or professional advisors when giving reports about serious incidents.

C. There is no indication in the records provided to me of [Dr G's] level of experience or expertise: he is simply described as "an ED Medical Officer."

It would be useful to know more about his level of ED experience and training as well as whether he was a supervisor or was under supervision of a more senior doctor.

**Additional comment from Dr Clearwater in relation to the need to consider an abdominal ultrasound.**

I am not an expert in surgical problems or radiological investigations. My comments were based on the fact that [Mr A] was known to have gallstones and had been considered for surgery for these prior to his acute visit. Our radiology service has pointed out in the past that an ultrasound is most effective for diagnosing impacted gallstones and cholecystitis (inflammation around the gallbladder). In my experience, if a patient has unexplained abdominal pain and a known history of gallstones, an ultrasound will be suggested because it is a simple procedure, not involving radiation.

However, ultrasound is indeed less effective in diagnosing some other intra-abdominal conditions and requires an expert operator so is not as simple to organise in some departments, compared to CT scan — especially after hours. I do not know how easy it would have been to organise either test in this department. It is reasonable that a CT scan will be performed first — it has a good chance of detecting a range of other possible conditions that could be causing acute abdominal pain such as diverticulitis, abscess or even tumour. Neither CT nor ultrasound are reliable in diagnosing appendicitis which [Mr A] also was found to have at surgery the next day.

At this stage, [Mr A] was under the care of a surgical service and I would defer to a surgical specialist to advise on the appropriate tests (or otherwise) after the initial CT scan was performed and found to be non-diagnostic. My comments were based mainly on the absence of any indication in the ED notes of whether an ultrasound was considered at all.

# Appendix 3 — Independent advice from Dr Andrew Connolly

Thank you for requesting my advice on a major complaint received by the Commissioner regarding the care of the late [Mr A]. I have been supplied with a very detailed set of notes and scans. I have read all the documentation supplied.

**Professional Qualifications**
I hold a Bachelor in Human Biology (BHB) University of Auckland (1984) and a medical degree (MBChB) from the University of Auckland (1987). I am a Fellow of the Royal Australasian College of Surgeons (1994). I have formal post-fellowship training in colorectal surgery in the United Kingdom. I am vocationally registered with the Medical Council of New Zealand in General Surgery. I am a full member of the Colorectal Surgical Society of Australia and New Zealand.

The Counties Manukau District Health Board (CMDHB) employs me as a full-time General & Colorectal surgeon. I am the Head of the Department of General Surgery at CMDHB. I have previously served 12 months as the acting Clinical Head of Plastic & Reconstructive Services at CMDHB.

I have had a formal 18-month period of clinical research investigating the effects of, and treatment options for, severe intra-abdominal infection and I have had a number of papers published in peer-review journals on this and related topics. I continue to be actively involved in clinical research, particularly in the area of enhanced recovery after major abdominal surgery.

I have served on the Board of Basic Surgical Training, Physiology subcommittee, for the Royal Australasian College of Surgeons. I have served on the National Advisory Board regarding the screening of at-risk groups for colorectal cancer. I provide independent clinical advice as a Clinical Expert to the Accident Compensation Corporation. I am on the Ministerial Advisory Group on Clinical Leadership and Governance to the Minister of Health.

**Conflict of Interest**
I trained in General Surgery at the same time as [a] Consultant Surgeon, Hutt Hospital.

**Brief Clinical Summary**
[Mr A] was a 35 year old man with significant intellectually disabilities who presented acutely to Hutt Hospital [in early] 2008.

[Mr A] was noted by his care givers to be non-specifically unwell. He appeared to have cool peripheries, was sweating, and had a distended abdomen.

[Mr A] was assessed in the Emergency Department at Hutt Hospital and ultimately admitted under care of the General Surgical Department.

After a number of investigations including CT of the abdomen, [Mr A] underwent an acute laparotomy at which time his gallbladder was removed along with his appendix. Post-operatively, due to concern about a possible bile leak, [Mr A] underwent an ERCP — this was normal. [A week later], [Mr A] suffered a cardiac arrest and died. A coronial autopsy examination revealed the cause of death as bronchopneumonia.

The Advocate for the IHC (Mr B) has complained about a number of aspects of the care [Mr A] received. I have read the complaint, the supporting documentation, responses from the Hutt Valley DHB, and the clinical notes.

The complaint is complex, and the Commissioner has asked 11 specific questions. I have endeavoured to avoid repetition wherever possible.

**General Standard of care by the Surgical Team**

Overall in my opinion the surgical care given to [Mr A] was of a high standard, but I believe he was not initially assessed in a timely fashion and that intravenous fluid replacement was not commenced as early as would be desirable in a patient with acute or suspected intra-abdominal pathology. This criticism covers both the Surgical Department and the Emergency Department and is discussed more fully under point 2 below. However, it is very important to note that I do not believe these initial delays made any significant contribution to his death.

The time to theatre for the laparotomy was quite appropriate given the CT scan did not show any need for an emergency operation. The scan showed a possible bowel obstruction, but this does not mandate an immediate operation — indeed many times such an appearance would not result in an operation at any point in the acute illness. There was no evidence of free air or free fluid. The gallbladder was not markedly abnormal, and the appendix was not obviously inflamed. In the initial hours, it is quite appropriate for intravenous fluids with or without antibiotics to be used as definitive treatment. I note that [Dr C] (Consultant Surgeon on call) was contacted and the case discussed thoroughly with her. I believe her decision making was of a high standard and that a deferral of any operative intervention until a period of fluid replacement had taken place was appropriate.

I believe the clinical team reacted appropriately in the post-operative care — again, this is more fully covered below (point 5).

**Timeliness and Standard of Pre-operative Assessment**

As noted above, I have concerns about the timeliness of the initial ED and Surgical reviews. [Mr A] arrived in the ED at approximately 0900 hours, but was not medically assessed until 1215 hours ([Dr G], Emergency Department). At that point a surgical referral was made, but the admitting surgical registrar did not see [Mr A] until 2130 hours. In the interim, [Dr G] handed care on to his ED senior colleague, [Dr L]. At 1730 hours [Dr L] assessed [Mr A]. It was only after the review by [Dr L] that IV fluids were commenced. Once the surgical registrar, [Dr H], saw [Mr A], a CT scan was arranged, as [Dr H] believed [Mr A] to be septic from an unknown, but possibly intra-abdominal, source. Following the scan, which

raised a small bowel obstruction as a possible diagnosis, [Dr C] (Consultant Surgeon on call) was contacted. A decision was made to continue fluid rehydration and to keep a close clinical eye on [Mr A] overnight. Should [Mr A] not be significantly better by morning, a laparotomy was likely. [Mr A] was assessed medically at least twice after the discussion with [Dr C]. In addition, regular nursing observations were performed on the ward. [Dr C] reviewed [Mr A] at 0745 hours and advised a laparotomy. Because of issues surrounding the correct consenting procedure in a patient judged not to be of a capacity to give informed consent, [Dr C] discussed the case with two senior colleagues unrelated to the clinical care of [Mr A]. The unanimous view of the senior staff was that [Mr A] required acute surgery and the operation commenced later that morning.

In my opinion, the decision-making regarding pre-operative investigations and the timing of the surgery was appropriate. A period of IV fluid resuscitation is usually very valuable in patients who do not have a clinical indication to undergo immediate surgery. Neither the clinical signs nor the CT scan showed an unequivocal indication for immediate surgery. I therefore believe [Dr C's] decision to delay any surgery until the morning was very appropriate. I believe the timing of surgical review *after* the initial surgical review at 2130 was appropriate, but I do not believe [Mr A] should have waited from 1215 hours (the time of referral) until 2130 hours for the first surgical review. However, there is no evidence at all that this delay contributed to [Mr A's] death.

Similarly, the delay in the first medical assessment in the ED was well outside the guideline times. This again is regrettable, but in my opinion, did not in any way contribute to [Mr A's] death.

I note the apparent busy state of the ED on the day in question along with the ED staffing levels. I believe the staff in the ED were working in an under-resourced clinical environment that day. I have made further comment in point 10.

Despite the delays, I do not believe [Mr A's] life was put at risk by the time he spent waiting for reviews and decisions made prior to his operation. There is no evidence he aspirated during his time in the ED. There is no evidence earlier assessment or the earlier introduction of IV fluids would have influenced the eventual outcome. But the time taken to see and instigate treatment was too long from a "Quality" rather than clinical safety perspective.

**Standard of Surgery**

[Mr A] had an appropriate operation — exploratory at first, then targeted to the two most important organs — the gallbladder and the appendix. Whilst the appendix was visibly normal, the decision to remove it was appropriate given the diagnostic uncertainty. The gallbladder was also appropriately removed. I note the operation record is both detailed and thorough and of a standard expected of a consultant surgeon. I also note the Coroner found no evidence of any "complications" in the surgical sites.

**Adequacy of Clinical Observations**

Preoperative: [Mr A] had a set of observations performed and documented at 0910 hours — this is well within acceptable timelines. However, after these initial recordings, the next set recorded was at 1200 hours. It can be argued that a more regular set of recordings should be obtained in an acutely unwell patient, but the timeline is not poor. There are no nursing notes for the period following triage at 0910 to the start of the next nursing shift. This is not acceptable and I note the comments by [the] Charge Nurse (ref. page 086). I agree with [the] C/N that the standard of record keeping by Nurse [Mr F] was substandard. However, in my opinion this made no contribution to [Mr A's] death. I am unable to find any record written by [Dr G] referring to the 1215 assessment. I interpret some of the comments in the notes as suggesting the record may have been purely electronic and therefore "merged" with the ED discharge paperwork after Surgery accepted [Mr A] as an in-patient. Whatever the issues may have been, in my opinion there should be a hand written note especially on acute patients. The lack of one creates significant problems with thorough and effective clinical communication.

Post-operative: These appear to have been regularly and appropriately performed. The documentation is clear and concise. I note particular emphasis was placed on oxygen saturation levels — this indicates an awareness of the potential for a person after abdominal surgery and with an intellectual disability to an increased risk of respiratory compromise.

**Standard of Post-operative Care**

In my opinion the standard of post operative care was high. [Mr A] was clearly noted to be at increased risk of complications due to his intellectual disabilities. The staff (both medical and nursing) regularly reviewed him. I believe the surgical staff acted appropriately when the possibility of a bile leak was raised. The ERCP was an appropriate test. Fluid and antibiotic use appear to be appropriate and within accepted guidelines.

There is a detailed record of the nursing cares, particularly the turning of [Mr A] on a regular and frequent basis. I believe this also indicates a heightened awareness of staff to the issue of intellectual disability and recovery from major surgery.

**Documentation**

The documentation of the surgical team was of an acceptable standard.

**Communication with Care Givers**

The hospital has detailed a number of times where hospital staff spoke with and updated the IHC caregivers. I do not feel I need reach a "judgement" on this issue given that none of the IHC staff appear to have been legally entitled to information — none were [Mr A's] legal guardian. Under the Privacy guidelines that govern hospital staff and the dissemination of information, I do not believe any greater degree of information should have been passed to IHC staff, nor do I believe the transfer of greater information was required to allow the hospital staff to care for [Mr A].

**Informed Consent Procedures**

In my opinion the issue raised in regard to who had the legal responsibility and right to grant consent for any invasive procedure had no part to play in [Mr A's] death. Given I believe the timing of the operation was appropriate and that [Dr C] has stated she was unable to identify any one via IHC who had a legal right to act for [Mr A], [Dr C] did what is well established in the Profession — she sought the opinions of at least two colleagues unrelated to the direct care of the patient. The operation took place soon after the decision was made to operate. The findings at surgery were *not* indicative of sepsis in the abdomen that had gone untreated for an inappropriately long time. In summary, the consent issues did not significantly delay [Mr A's] arrival in the operating theatre, nor did any issue in obtaining consent contribute to his death. There is no evidence at all that [Mr A] aspirated in the pre-operative period.

I believe the DHB had appropriate policies and guidelines in place. The "Informed Consent" guide, "G12-Informed" of May 2006, is clear in stressing the need to discuss a case with a senior colleague if the patient is incapable of giving consent. I also note the "Form for Incompetent patients", dated April 2005. This seems appropriate, although specific reference to it in the section of the G-12 paper relating to "Unable to Give Consent" would have alerted staff to the Form for Incompetent patients. A written record of consent is generally expected and is sensible to obtain in all but the most immediate operations. But as noted in point 9, I cannot personally locate a completed consent form.

**Changes in Policy and Process made by HVDHB**

I believe the DHB has made positive improvements in some areas in response to the complaint about [Mr A's] care. I specifically refer to the ED Staffing contingency plan and to the increase in medical staff numbers in the ED. These steps should ensure greater access to medical care in a timely fashion. I believe the ED senior nursing staff responded appropriately to the issue of poor initial nursing documentation.

I cannot find the written informed consent sheet (the Form for Incompetent patients) in the notes supplied to me. There is a standard consent form present with [Mr A's] patient label attached, but it has no other documentation on it (ref page 180). As noted in point 8, I believe specific direct linkage to this sheet in the G12 document on informed consent would be sensible.

I can find no specific reference to any other changes the HVDHB has made. I would advise the DHB to review the acute Surgical registrar role and policy in relation to the time taken to see [Mr A] in the ED. As with ED medical staff, it is apparent that the surgical registrar was "busy elsewhere" for much of the day, but the Department of General Surgery needs to have a contingency for this problem. Whilst I find no evidence to suggest the time waiting for the first surgical review contributed to [Mr A] death, the time was nonetheless excessive.

**10 & 11. General Comments**

[Mr A] died of aspiration pneumonia. He was at risk of this due, amongst other things, to recent major abdominal surgery and intellectual impairment. However in my opinion his care was of an acceptable standard and whilst there were delays in the initial assessment and problems with poor documentation in the ED, neither of these factors contributed to his death.

In my opinion, [Mr A] was treated aggressively in the post-operative period and attempts to resuscitate him were correctly carried out and documented. I do note there is reference to some comments regarding quality of life, but there is no evidence that staff reduced the level of expected care or clinical standards on the basis of [Mr A's] intellectual impairment.

I believe the HVDHB has responded appropriately to the staff issues in the ED. I believe the DHB needs to confirm it has robust policies in place regarding the availability of timely clinical review from the in-patient acute services including General Surgery. The balance between workload demands and realistic staffing models is often difficult to achieve, but contingencies for situations where workload exceeds the designated staff levels need to be in place.

I trust this opinion will be of assistance to the Commissioner. Please do not hesitate to contact me if required.