Crown Health Enterprise

Report on Opinion - Case 98HDC21365

Complaint

On 23 November 1998 the Commissioner received a complaint about the services provided to the complainant's late wife ("the consumer") at two hospitals. The consumer's husband outlined a number of concerns as follows:

- *The consumer was admitted to the first Hospital in mid-December 1997. This admission was a lengthy process which contributed to her pain and suffering. She had heart problems and her condition was unstable and she needed to be transferred to the Coronary Care Unit urgently. She received physiotherapy but no other investigations were carried out. Her constipation and pain were ignored. The consumer was sent home in a state of exhaustion but there was no physical assessment prior to her release.*
- *The consumer was admitted to the first Hospital again in early January 1998, to Medical Services where she remained for three days before being transferred to Surgical Services. She was subjected to numerous enemas and physical examinations and she suffered excruciating pain. Her abdomen was visibly distended and she was vomiting persistently but a diagnosis of cancer of the pelvis was not made.*
- *A CAT scan was requested but this was not performed. No rectal examination was undertaken and an x-ray showed a craggy mass to the left side of the pelvis. A referral to the surgical team was not actioned until late on the fourth day after her admission.*
- *The consumer's blood test results all recorded normal but these blood tests could have belonged to another patient.*
- *The first Hospital did not refer to the Surgeon who had treated the consumer's vascular problems for background information although she had been under that Surgeon's care for some time.*
- *Concerns raised by a doctor who had made a home visit prior to admitting the consumer to Accident and Emergency appear not to have been taken into account.*
- *The equipment used in the hospital was faulty and added to patient discomfort and posed a risk to patient safety. It took five days for the consumer's bed to be changed, the electronic calling system was not working, and two wheelchairs collapsed on the consumer while she was in the shower.*

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Complaint, *continued*

- *Emergency surgery performed three days after admission in January 1998 (48 hours before the first Hospital closed) could have been performed at the second Hospital. The first Hospital was disorganised and in disarray and the consumer was subjected to substandard care.*
- *The consumer's colostomy did not operate properly and her pain was not relieved by this procedure.*
- *The consumer was left gasping for breath for a period of 50 minutes with fluid on her lungs before an injection was administered.*
- *The medical team failed to fully recognise the consumer's limitations, particularly with her need to pass urine frequently, but a urinary catheter was not inserted.*
- *There was delay in the administration of pain relief and the consumer suffered considerable pain as a result. The second Hospital's staff were unable to adequately prescribe pain relief and it was not until the consumer was transferred a Hospice that she received appropriate pain control medication.*
- *The case notes state that the consumer's stoma was dusky but there was no action taken in regard to this.*
- *The consumer was administered Penicillin when it was clearly stated in her medical notes that she had an allergic reaction to Penicillin.*
- *The consumer requested copies of her medical records and x-rays but these were not made available to her.*
- *The consumer's family were distressed about the decision to operate on the Friday evening when the patient had known heart problems. The consumer had been in hospital since Tuesday and it was unreasonable for her to be rushed to surgery on a Friday evening.*
- *The consumer's family was not told she had cancer prior to the operation and her husband feels the staff failed to communicate what was happening with her during her time in hospital both before and after the operation.*

The consumer's husband made a complaint to the Crown Health Enterprise but attempts to resolve the issues were unsuccessful.

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Investigation

The Commissioner received the complaint on 25 November 1998 and sought clarification from the consumer's daughter who responded in writing on 23 February 1999.

On 3 May 1999 the Crown Health Enterprise ("CHE") advised the Commissioner that they had been informed that a complaint had been made by the consumer's husband. The CHE offered to send all the consumer's documentation to the Commissioner. This information included the consumer's medical records and correspondence between the complainant and the CHE.

On 5 May 1999 the Commissioner received additional information from another of the consumer's daughters, which included the Coroner's report and a police report.

Outcome of Investigation

The consumer had a long history of cardiac and vascular problems as well as other medical conditions.

First Admission
In mid-December 1997 the consumer was admitted to the first Hospital with a fast irregular heart rate and chest pain. It was noted that she had constipation and treatment commenced but no other particular bowel problems were noted. The records show that she was in the Emergency Department for one hour before being sent to the Coronary Care Unit (CCU). The consumer's investigations and treatment focused on her heart condition and she was discharged after seven days.

Second Admission
In early January 1998 the consumer was again admitted to the first Hospital this time with bowel problems. Her GP's referral letter is in the notes. The admitting doctor recorded *"review old cx-ray's? will need CT Thorax."* This scan was not performed. The consumer was treated initially for constipation but a rectal examination two days after admission revealed a pelvic mass and she was referred to the surgical team. This surgical follow up occurred the next day.

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Outcome of Investigation, *continued*

Three days after admission the consumer was seen on two separate occasions by the surgical registrar and a General Surgeon. They concluded that the consumer might have cancer of the ovary or bowel. The consumer was known to have diverticular disease but this seemed a less likely cause. The possible diagnosis was discussed with the consumer who requested that if this was the case she did not want prolonged treatment. Because of the discomfort she was suffering the consumer was taken to theatre for a laparotomy later that day. At surgery it was found she had a large tumour and a colostomy was performed. These findings were discussed with the consumer on the next day and with her family three days after that.

On the fifth day after admission, at 11.15pm the consumer was short of breath and a doctor attended at 11.55pm. The consumer had a return of her heart failure and was treated with medication. The medication caused an increase in urinary output but the consumer had a catheter at that time. Every day her fluid levels were assessed and attempts made to maintain her fluid balance.

The consumer's pain control was administered by epidural medication until the seventh day after admission and her pain estimated and recorded hourly. After that she received Voltaren, Morphine and Panadol. There are two recorded administrations of Morphine on days seven and eight after admission but no vomiting is noted. The consumer received two doses of Augmentin on two dates in mid-January 1998. There is no indication that the consumer was sensitive to any drugs noted on her medication chart. Sensitivity to Penicillin is noted on her emergency admission record.

During the course of these two admissions the consumer had numerous tests performed at the laboratory. A review of these test results indicate that they are consistent with her health status.

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Outcome of Investigation, *continued*

The consumer was initially assessed on the day of her admissions to hospital in mid-December 1997, and early January 1998 and daily thereafter. Each assessment included a complete assessment of her ability to perform daily living tasks independently. It is recorded that she needed assistance with household cleaning and meal preparation. On the seventh day after admission in January 1997 it is noted *"daughter finding it difficult to cope with care of [the consumer]. Is looking after father as well (fractured spine – elderly), daughter also has two young children. Query district nurse referral on discharge."* It is also noted that a family meeting was held with the social worker. The consumer was referred for oncology follow-up.

Eight days after her admission in January 1998 the consumer was visited by the stoma therapist in relation to her colostomy and a week later the stoma therapist noted that the consumer's colostomy was dusky. It is noted that the family was present at the time. While she was in hospital she was regularly seen by the physiotherapist and occupational therapist.

After two weeks, one day in the early hours of the morning the consumer suffered a return of her heart problems and medications were given. There is no indication of vomiting until two days after that. At that time it was thought to be due to Morphine which had been given the night before. Later that day the surgical registrar noted *"visited by ostomy nurse notes stoma looking dusky has not moved. Visited by hospice nurse OT contacted re possible home visit can go on leave if wishes, but doesn't like husband's driving Fusimide 40mgs orally increased to BD PT also seen by social worker. Sedation changed.* The next day the consumer was seen by another General Surgeon in the absence of the first Surgeon. He noted *"a colostomy mucosa looks dusky a little bit colostomy bag removed to examine the stoma. Stoma looks dusky is also protruded out more than usual. But it's not sloughy."*

Two weeks after her admission, in preparation for her transfer to the hospice, the consumer's catheter was removed. However later that day she became short of breath, which distressed her daughter who was visiting. The consumer was exhausted at having to frequently pass urine and a catheter was re-introduced.

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Outcome of Investigation, *continued*

The consumer was referred to a hospice for palliative care. The referral letter indicates that: *"So far pain has not been an issue for her."* The consumer had home leave in mid-January 1998 and on this visit she was accompanied by the occupational therapist.

Family Complaint to the Crown Health Enterprise
On 23 November 1998 the consumer's husband made a complaint to the CHE about the services provided to his wife. On 3 March 1999 the Chief Executive Officer acknowledged the problems they were having with the closure of the first Hospital and transferring patients to the second Hospital and stated, *"With all this disruption to our normal routine, we accept that we may have failed to give [the consumer] all the care and attention (in regard to the facility issues) that we would have liked. Again we apologise for this.*

With regard to the broken bed, while we could not find any written evidence to support it, there is nothing in the notes to deny it. On that basis, we wish to apologise to the family for any inconvenience caused by any faulty equipment. We have toilet chairs, (not wheelchairs as the family suggested), in varying states of repair. Some are new, and some are not so new. The Unit Manager considered that all these toilet chairs were in safe condition.

The consumer was allergic to Penicillin and this was known to our staff. There is no excuse for having given her Penicillin at all. We unreservedly apologise to the family as we expect a high standard of care to be given by our staff."

With regard to the consumer's request for medical records the Chief Executive notes *"given the time that has passed, we cannot give any explanation for this. Our managerial staff are well aware of a patient's rights to access all information we hold about them. If [the consumer] was denied this right, we can only apologise once again. We understand the family, in making their request for information if needed to lodge their complaint, were given free access to [the consumer's] health records."*

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Outcome of Investigation, *continued*

The Chief Executive Officer also invited the family to discuss the issues still outstanding with them.

On further enquiry the CHE advised the Commissioner that they were unable to find the consumer's signed request for her medical records at either Hospital.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

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

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Crown Health Enterprise

Report on Opinion - Case 98HDC21365, continued

Opinion: No Breach

In my opinion the Crown Health Enterprise did not breach Right 4(2) of the Code of Rights with regard to the following:

The consumer's Surgery in January 1998

The consumer had a long history of cardiac problems as well as other medical conditions which had been treated by her General Surgeon and GP. She was admitted in mid-December 1997 with a fast irregular heart rate and chest pain. She was treated for constipation but her records show that this was not her main problem. The consumer was in the Emergency Department for one hour before being sent to CCU and in my opinion this delay was reasonable. Given the consumer's long history and medical problems it was reasonable that her constipation not be too vigorously treated at that time. On discharge the consumer was referred back to the care of her general practitioner.

The consumer was admitted in early January 1998 with bowel problems. The admitting doctor recorded that a CT scan of the thorax may be necessary. This was not performed because a CT scan of the chest is unlikely to show abdominal problems. The consumer was initially treated for constipation but an examination two days after admission revealed a pelvic mass and she was referred to the surgical team. This surgical follow up occurred the next day and she was taken to theatre that evening. The consumer had multiple known health problems including an abdominal aneurysm and diverticular disease. In my opinion the length of time from admission, diagnosis and surgical intervention was not excessive.

The post mortem report shows no evidence of infection, obstruction or non-union at the colostomy site. There is no indication that the time of surgery adversely effected the outcome of the surgery. The dusky colour of the colostomy was noted by the stoma nurse and reviewed by the surgeon. The surgery was discussed with the consumer before theatre and surgical findings discussed with her and with her family.

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Opinion: No Breach, *continued*

Inadequate pain control

The consumer's pain control was administered by epidural medication for a week and her pain level was assessed and recorded hourly by the staff attending her. Once the epidural was removed she received regular medication. There is no indication in her notes that she remained in excruciating pain and the referral to the hospice indicates that pain had not been a problem until then. Palliative care pain control is special area of medical practice and the consumer's referral to palliative care was appropriate.

Delay in providing medical records

The consumer filed a request that her medical records be forwarded to her family. The Crown Health Enterprise have advised me that they are unable to find the consumer's signed request for her medical records at either Hospital. This is a matter within the jurisdiction of the Privacy Commissioner. However, I note that the CHE supplied all records for the purpose of this review.

Failure to provide community care

The consumer was initially assessed on the day of her admission to hospital in December 1998 which included a complete assessment of her ability to perform daily living tasks independently and her independence level was assessed by the nursing staff daily. It was recorded that she needed assistance with household cleaning and meal preparation. On discharge a referral summary was mailed to the consumer's general practitioner with a request that her care be followed up at community level.

Incorrect Laboratory Results

As Commissioner I am unable to require blood to be re-tested. It is also very unlikely that the specimens are still available. I note that the consumer's pelvic tumour was thought to be secondary to cancer of the ovary and therefore would not have been detectable in a cervical smear or mammogram.

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Crown Health Enterprise

Report on Opinion - Case 98HDC21365, continued

Opinion: Breach

In my opinion the Crown Health Enterprise breached Right 4(2) the Code of Health and Disability Services Consumers' Rights in regard to prescribing and administering penicillin to the consumer.

The consumer was given penicillin when it was recorded on her medical record that she had an allergy to penicillin. This is acknowledged in the Crown Health Enterprise's response and an apology was given.

Actions

The Crown Health Enterprise has already acknowledged and apologised for any pain and discomfort caused to the consumer and her family resulting from the first Hospital's closure and the consumer's transfer to the second Hospital.

I recommend that the Crown Health Enterprise review its policies and procedures on recording drug sensitivities to reduce the risk in future of consumers receiving drugs to which they are allergic.