General Practitioner, Dr C

Registered Nurse, Ms D

Registered Nurse, Ms E

A Rest Home

A Report by the

Health and Disability Commissioner

(Case 05HDC09852)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Ms B	Complainant/Consumer's daughter
Dr C	Provider/General practitioner
Ms D	Provider/Registered nurse
Ms E	Provider/Registered nurse
A Rest Home	Provider
Dr F	General practitioner
Ms G	Site manager
Dr H	General practitioner
Ms I	Registered nurse

Complaint

On 4 July 2005, the Commissioner received a complaint from Ms B about the services provided to her mother, Mrs A, by a rest home. The following issues arising from the complaint were identified for investigation:

Dr C
The appropriateness of the care general practitioner Dr C provided to Mrs A on 23 March 2005.

Ms D
The appropriateness of the care registered nurse Ms D provided to Mrs A on 20 and 23 March 2005.

Ms E
The appropriateness of the care registered nurse Ms E provided to Mrs A on 21 March 2005.

The Rest Home
The appropriateness of the care the rest home provided to Mrs A between 20 March and 25 March 2005.

An investigation was commenced on 14 September 2005.

Information reviewed

Information was received from:

— Ms B
— Dr C
— Dr F
— Ms D
— Ms E
— Ms G, Site Manager, the rest home.

Mrs A's clinical records were obtained from the rest home.

Independent expert advice was obtained from Dr Tessa Turnbull, general practitioner, and Ms Jan Featherston, a registered nurse with expertise in the care of the elderly.

Information gathered during investigation

Overview

Mrs A was admitted to the rest home on 21 August 2000 and transferred to the dementia unit on 3 April 2003.

On 20 March 2005, Mrs A (then aged 89 years) complained of head and neck pain which was only partially relieved by the administration of paracetamol. Her head and neck pain was initially reported to one of the rest home's medical officers, who considered these symptoms were due to migraine. Three days later Mrs A was found to have bruising to her left arm and hip and was having difficulty weight-bearing. Another of the medical officers assessed her, queried the possibility of hip fracture and arranged for an X-ray. The X-ray showed no abnormality. Mrs A continued to complain of head and neck pain and was referred back to the initial medical officer on 25 March. An examination and X-ray identified a cervical spine fracture.

The Rest Home

The rest home is part of a rest home group which cares for 145 older-aged residents with various levels of care needs. The rest home includes a hospital-level care facility with a secure dementia unit, with a one to six staff to patient ratio.

The policies and procedures the rest home provides to guide staff in the care of the elderly residents (relevant to this matter) are under the following headings:

- Assessing Unwell Resident
- Pain Assessment Record/Initial Assessment
- Pain Management
- Incident and Accident Reporting
- Falls Policy
- Assessment and Care Planning.

The rest home has a process for ensuring that registered nurses are aware of changes to policies and procedures. There is an orientation workshop for all new staff at the rest home and an in-service training programme.

Three medical officers provide care to the residents. They are each responsible for their own patients, but also take turns on the weekend roster when they provide telephone advice or visit residents if requested to do so by the on-duty registered nurse. If the on-call doctor is not available, the registered nurse calls the after-hours medical service as a back-up.

The rest home ensures that all medical officers providing care to its residents are aware of the terms of the "Contract to Provide Medical Services to [the rest home]". Point 11 of the Contract specifies that all medical practitioners shall provide "such services to meet clinical and ethical standards approved by the Royal College of General Practitioners and the New Zealand Medical Association".

The "Schedule of Services" which accompanies the Contract specifies that all visits to a resident "must be entered into the resident's clinical records. This includes findings, treatment given or ordered."

Chronology

20 March 2005
Ms B stated that on the morning of Saturday, 20 March 2005, she visited her mother to find her in a "terrible state, sitting on the bed, holding her head and screaming with pain". Because Mrs A has dementia, she was unable to say what had happened to cause the pain. The nursing staff informed Ms B that the on-call doctor had been contacted, as Mrs A's own general practitioner, Dr H, was on leave.

The clinical records show that the night staff on duty on 19/20 March reported that Mrs A was complaining of earache and appeared "more unsteady than usual when she was walking".

At 7.15am on 20 March, the morning registered nurse, Ms D, took Mrs A's pulse and blood pressure. They were within normal limits. Mrs A was unable to tell Ms D the location of the pain, but on movement it was noted that she stiffened her neck. At 9am Mrs A was still complaining of a stiff neck and was unable to move her neck freely. Ms D recorded that Mrs A moved with a "jerking movement", and described a "'feeling' (as she explained) through to her eyes … similar to migraine?" Ms D noted

that Mrs A was unable to explain exactly what was happening and seemed more confused than usual. At 9.30am Ms D left a message for the on-call medical officer, Dr F, regarding Mrs A's condition.

It appears that Dr F did not respond to Ms D's message, as the records show that at 10.15am Ms D left a further message for Dr F to call her. Ms D noted that Mrs A's family was visiting and that Mrs A "screamed out when staff assisted her daughter [in] trying to settle her into bed".

At 10.25am, Dr F telephoned to speak to Ms D. Dr F stated:

> "I recall specifically enquiring about symptoms or signs of infection (all negative) and also was told that no injury was known to have occurred. I ordered paracetamol and regular blood monitoring (blood pressure, temperature) and to contact me that day if there was no improvement. As it was thought that she had woken up with the pain that morning, I wondered if it was acute torticollis [persistent head turning] and suggested that a heat pack may also be of benefit."

Ms D noted that she was unable to find a heat pack in the unit, but she gave Mrs A two paracetamol at 10.30am, which partially eased Mrs A's discomfort. At about lunchtime Mrs A got up to the toilet and reported that her pain and the "feeling" was better. Ms D stated that her plan was for staff to perform regular clinical observations of Mrs A's vital signs as she allowed, administer the prescribed analgesics, document all events and outcomes, and notify the doctor if there was any change. Ms D stated:

> "I was unable to use the pain scale for pain monitoring (from the Pain Management Policy) as [Mrs A] was unable to answer the questions with regard to the pain, as scores."

During the afternoon shift, registered nurse Ms I noted that Mrs A was still experiencing pain on movement of her neck. Ms I gave Mrs A her third dose of paracetamol for the day at 8pm and applied a heat pack which Mrs A stated was "nice and comforting". Mrs A settled to sleep in a lazy-boy chair at 9pm.

The night staff recorded that Mrs A was up and about most of the night, "whistling, talking, crying and holding her head, neck and ears". She was offered tea and biscuits several times, which she accepted, but she did not settle.

21–23 March 2005

Ms B returned to see her mother on the morning of 21 March and found that her mother was still in great pain every time she tried to move. She held her ears and cried and yelled out in pain. Ms B was concerned that the doctor had not visited and had suggested by telephone that her mother might be suffering from migraine. Ms B stated that her mother "had never had a migraine in her life". She recalled that she insisted a doctor visit and review Mrs A and authorise X-rays. Ms B was convinced that her mother had hurt her neck or head.

Registered nurse Ms E recorded that Ms B had visited and said she would like her mother to see a doctor. However, Mrs A responded well to the Panadol given at 7.30am and was able to go on an outing to the theatre, and on her return ate a "good lunch".

Ms E stated:

> "I expect that [Mrs A] wanted to go on the bus trip. She could be quite determined when she set her mind on something. … Her daughter did ask for her to be seen by a doctor. I made a note of this in the ward diary for Monday so that [Dr F] could see [Mrs A]. [Dr F's] usual arrival time at the site on a Monday is 1pm. … I did not see [Mrs A] as an urgent referral for the doctor that day."

The following day the notes show that Mrs A went out for a walk with the activities co-ordinator and the paracetamol given to her at midday was effective in controlling her neck pain.

The night-shift health care assistant recorded that she had discovered Mrs A had a "large bruise on left hip also left upper arm". The night-shift health care assistant asked Mrs A if she had fallen. Mrs A could not recall falling. The night-shift health care assistant recorded that Mrs A was still experiencing head and neck pain on movement and was holding her head.

Injury to hip

During the morning of 23 March, Mrs A went to another part of the facility to participate in an activities programme. On the way back to the unit, in the company of the activities co-ordinator, Mrs A suddenly had to be assisted as she was unable to weight-bear on her left leg.

Ms D telephoned the on-call doctor, Dr C, on his mobile telephone to ask him to visit and review Mrs A. Ms D then contacted Ms B to inform her of the incident, that the on-call doctor had been called to examine her mother, and that she would call Ms B back after the doctor had visited. Ms D stated:

> "I told [Dr C] there had been no report of the resident having a fall. When [Dr C] arrived in the unit he was given [Mrs A's] file to read which includes all her clinical notes. I gave him a short review of the occurrences over the past few days which included what we had done for Mrs A. Then we went to the resident in her bedroom. I again explained and showed him the areas of concern with regard to [Mrs A's] health status (these included her neck area, her hip and leg). He then proceeded to examine [Mrs A]."

There is a conflict in the evidence about the availability of Mrs A's clinical records when Dr C arrived at the unit. Dr C stated that the notes were missing when he saw Mrs A. He recalled:

> "I wrote on a free sheet of paper as her notes were unavailable at the time, with instructions to put it in the file when it turned up. I don't know where that had gone. It wasn't in her file. …
>
> If I had seen the file I would certainly have ordered an X-ray as it has her holding her head to support it, indicating a possible fracture cervical spine."

Dr C said that he was told that she had fallen and been complaining intermittently of neck and hip pain and had been limping since the fall. She had been out to a concert and was mobilising. Dr C stated:

> "I examined her neck range of movements and hip range of movements. I observed her moving about the lounge. I palpated her neck feeling for spasm of the muscles. I found a good range of movements but some tightness in the paraspinal muscles on the left side. She also had bruising on her left arm.
>
> I thought she had a soft-tissue injury to the neck and a possible undisplaced fracture of the neck of femur, left side. I gave instructions for regular pain relief and an X-ray of the left hip."

In response to the provisional opinion, Dr C stated that he has now located his record of assessment that he performed on Mrs A on 23 March, and provided a copy. He had misplaced the assessment in the clinical records for another resident. The entry is dated 23 May and appears following a series of May 2005 entries for the other resident. The misplaced entry records:

> "23.5.05 Hx [history] of sore neck for 4 days plus sore left hip and visible bruise and bruise left upper arm.
> No Hx trauma
> O/E [on examination] Neck ROM [range of movement] good
> Non tender C [cervical] spine
> Uncooperative
> Bruise L hip
> Not standing
> No shortening
> Pl [plan] hip X-ray
> Observe for neck ROM
> Pain relief as charted."

Ms D said that when Dr C palpated Mrs A's neck, he asked her about pain but Mrs A denied that she had any pain. Dr C looked at the bruising and did an examination for a fracture of the neck of femur (assessing whether there was any alteration to leg length) while Mrs A was sitting in a chair, "as she refused to lie down".

Ms D noted in the clinical notes that Dr C had examined Mrs A, completed an ACC form and ordered an X-ray. The ACC Injury Claim Form completed by Dr C noted

Mrs A's date of birth and her NHI (National Health Index) number, and that the accident occurred at 2300 (11pm) on 20 March.

Ms D noted that Ms B had been informed that her mother had been seen by the doctor, and was to be kept informed of developments.

At 4.30pm, Ms I recorded that the radiographer performing the X-ray of Mrs A's hip reported that there was no obvious injury, and would fax the results to Dr C. Ms I stated that Mrs A was agitated during the afternoon and that this appeared to be caused by pain.

At breakfast the following day, Ms D noted that Mrs A was again uncomfortable and holding her head. She was given paracetamol, which appeared to be effective.

25 March 2005
During the night of 24/25 March, the health care assistant noted that Mrs A appeared to be "in a lot of pain, has been holding her head". The health care assistant stated that Mrs A stayed in bed for only a short period of time during the night. The health care assistant recorded, "at the time of report still appears distressed".

Ms D reviewed Mrs A on her arrival in the unit at 7am. Ms D observed that Mrs A denied any pain, but her pain appeared to come in spasms. Ms D telephoned Dr F to ask her to visit Mrs A.

Dr F stated:

> "[Ms D] was concerned that [Mrs A] still had neck/head pain although [Dr C] had seen her during the week.
>
> On examination I found [Mrs A] to be obviously in pain with the neck held in rotation to the left. All passive movements were restricted and I did not attempt active movement. My clinical impression was a C-spine fracture (? Compression fracture) and I ordered an urgent portable X-ray.
>
> [The radiologist] then contacted me with a verbal report (odontoid peg fracture). I immediately contacted [the rest home], ordered a cervical collar for the patient and asked them to call an ambulance for transfer to [the public hospital]. I also asked them to advise the ambulance staff that [Mrs A] had a confirmed C-spine fracture and to take all the necessary precautions. I then spoke to the orthopaedic registrar on duty at [the public hospital], discussed the findings and gave him [the radiologist's] mobile number so he could obtain a verbal report directly from the radiologist as the written report had not been prepared."

Dr F recorded her examination and provisional diagnosis in Mrs A's clinical notes. Ms D noted the X-ray results, Dr F's orders, that Mrs A's family had been left messages regarding her condition, and the arrangements that were made to transfer Mrs A to the public hospital.

Dr C subsequently apologised "for any delay in diagnosis and treatment that occurred" as a result of the missed diagnosis of cervical fracture.

Independent advice to Commissioner

General practitioner advice
The following independent expert advice was obtained from Dr Tessa Turnbull, a general practitioner with expertise in the care of the elderly:

"Comment on the standard of care provided to [Mrs A] by [Dr C].

Was [Dr C's] examination and assessment of [Mrs A] on 23[3]/05 of an appropriate standard?

There are three sources of information with which to gauge this:

1. Registered Nurse, [Ms D], dated 23/9/05:

   [Ms D] reports that she told [Dr C] that [Mrs A] had had 'headaches in the past few days and was now complaining of a sore leg.' [Dr C] was 'given the resident's file to read which includes all her clinical notes'. Further, [Ms D] has stated that [Dr C] examined [Mrs A] including inspection of her ears, palpation and movement of her neck, and looked for shortening and internal rotation of her left leg.

2. [Dr C] reports 27/7/05 and 21/9/05:

   [Dr C] said that he elicited a good range of movement in [Mrs A's] neck (27/7/05). In his report of 21/9/05, he said the clinical notes were missing at the time he saw [Mrs A]. He reports that he found a good range of movements in the neck but noted some tightness in the parasternal muscles on the left side. [Dr C] went on to say that if 'I had seen the file I would have certainly ordered an X-ray as it has her holding her head to support it, indicating a possible fracture of the cervical spine.'

3. The Clinical Record:

   [Dr C's] examination is not recorded in the clinical notes. It is stated that an ACC form was completed. Although there is no formal record of an injury there was evidence of one in the form of bruising.

[Dr C] examined [Mrs A] as requested on 23/3/05. He appeared to be unaware of the history of significant ear/head and neck pain over the preceding three days. He focused on the left hip/leg pain which was of very recent onset. Examination of

the hip was not really adequate as [Mrs A] appeared reluctant to lie down and was examined sitting in a chair. [Mrs A's] neck pain appears to have been spasmodic, as recorded in the clinical notes, so it is possible that [Dr C] examined [Mrs A] at a time when the pain was less apparent.

However, it seems evident that the fracture probably occurred on 19/3/05 prior to [Mrs A's] first complaint of earache. An adequate clinical examination would have elicited some loss of movement or pain with movement of the neck. [Dr C] did not examine [Mrs A's] clinical record, nor did he record his examination findings in this record, as is usual practice in this and other rest homes/hospitals. [Dr C] says the clinical notes were missing at his visit on 23/3/05, and [Ms D] says [Dr C] was given the resident's file to read which included all the clinical notes.

In conclusion, [Dr C's] examination of [Mrs A] was not adequate on 23/3/05. He should have elicited a better history, some signs of the neck injury are likely to have been apparent and an X-ray of the neck should have been taken at the same time that the X-ray of the hip was undertaken. This reduced standard of care would be regarded with mild to moderate disapproval by [Dr C's] colleagues.

If not, what else should he have done?
[Dr C] should have examined the clinical record, or elicited a more thorough history from the registered nurse accompanying him. [Mrs A] was not in a position to supply this herself because of her severe dementia. The examination may not have been adequate although there is conflicting evidence about this and the absence of a formal record makes judgement of this aspect difficult.

Are [Dr C's] clinical records of an appropriate standard?
There is only one record to judge this by ie 9/5/05 and this appears adequate. [Dr C] was asked to assess an infected wound on [Mrs A's] forearm.

What information/advice, if any, should [Dr C] have given the nursing staff regarding [Mrs A]?
With the preceding history of significant head and neck pain, if the examination did not throw up any significant findings, [Dr C's] advice should have been to monitor this.

Are there any aspects of the care provided by [Dr C] that warrant additional comment?
Perhaps examination of the ACC record would shed some further light?

BACKGROUND
[Mrs A] was a resident at [the rest home] from August 2000 under the care of [Dr H]. She had previously had a left hip replacement and was suffering from memory loss and confusion. Medical cover at [the rest home] and [rest home hospital unit] is provided by [Drs C, F and H] doing rounds on different days with one acting as duty doctor for emergencies. In December 2002, [Dr H] asked the mental heath

services at [the public hospital] for an assessment because of [Mrs A's] increasing confusion, a recent aggressive outburst towards another resident and wandering behaviour. She had had a few 'turns' which were investigated at that time. In April 2003, [Mrs A] was transferred to [the hospital care secure dementia unit]. On 20/3/05, the night staff reported that [Mrs A] complained of ear ache and seemed more unsteady than usual when she was walking. The registered nurse examined [Mrs A] and recorded that [Mrs A] said she had a stiff neck and that she was unable 'to move her neck without an almost jerking movement.' [Mrs A] was unwilling to lie down and screamed out when staff assisted her daughter to resettle her into bed.

[Dr F], the duty doctor, was phoned and [she] asked for regular observations and recordings to be done and to be re-contacted if [Mrs A] did not settle. [Mrs A] appeared to improve with regular paracetamol although pain was reported that evening when she changed into her nightwear. During that night, she appeared comfortable although she was still in pain when her head moved. Ongoing pain was apparent the following night when she was said to be 'up all night wandering, whistling, talking, crying, holding her head/neck and ears'.

On 23/3/05, the overnight staff report recorded a large bruise on [Mrs A's] left hip and left upper arm and noted that she was still holding her head and neck when moved. The morning report then records that that [Mrs A] was suddenly 'not able to weight bear well on the left leg'. The duty doctor was [Dr C] who ordered an X-ray of [Mrs A's] hip which was reported to be normal. [Mrs A] continued to be distressed by head and neck pain with movement both night and day and to support her head with her hands. This was recorded as being intermittent and spasmodic. [Dr F] reviewed her on 25/3/05, noted pain with neck movement which was limited and suspected a compression cervical fracture. The X-ray showed an odontoid fracture.

[Mrs A] was transferred to [the public hospital] for further management."

Nursing advice

The following independent expert advice was obtained from Ms Jan Featherston, a registered nurse with expertise in the care of the elderly:

"I have been asked to provide expert advice in relation to an event which happened to [Mrs A] at [the rest home's] secure dementia unit in March 2005.

Please give your opinion on the standard of care provided to [Mrs A] by [Ms D].

Was [Ms D's] assessments of [Mrs A] between 20 and 23 March 2005 of an appropriate standard?

[Ms D's] first documentation of the issues was at 7.15 hrs on the 20 March soon after the start of her shift. She documented that the night staff had concerns re

[Mrs A], she took the patient's Blood Pressure and temp all of which were within normal limits. At 9am she reported that [Mrs A] was complaining of a stiff neck and was not able to move without a jerking movement. Also documented was that [Mrs A] appeared more confused than usual.

At this time [Ms D] contacted [Dr F].

At 10.15 hours [Ms D] again left a message for [Dr F].

[Dr F] phoned back and verbally ordered analgesic and her instructions were to keep assessing BP and Temp. Panadol was given at 10.30. The evaluation in the clinical notes stated that the patient felt slightly better.

The final entry into the clinical notes on that day instructed staff to keep the patient under close observation.

[Ms D's] next entry into the clinical notes is on 23.3.05

[Mrs A] was wandering around the facility when it was reported that [Mrs A] had a 'turn' and was not able to weight bear. [Mrs A's] daughter was contacted.

At this time [Mrs A] was seen by [Dr C] who assessed [Mrs A] and ordered X-Ray of [Mrs A's] hip. He examined her neck and did not assess her as needing an X-Ray of the neck. The hip X-Rays were negative.

[Ms D] was again on duty when further X-Rays were taken and # spine was identified and [Mrs A] was sent to the public hospital.

It is my opinion that the care provided by [Ms D] was of an appropriate standard.

There is evidence that she undertook an assessment and not finding anything obvious she then referred this to the medical officer of the facility.

A care plan was not documented for this incident; it is common practice to use the clinical notes and this was used in this case.

Observations were ordered and the clinical notes show that they were not undertaken on a regular basis.

Pain assessment in the demented elderly is very difficult to identify and what may have assisted the nursing staff gauge an earlier pattern was a pain chart which the facility used — or rather was included in the information (pack G page 141).

It is my opinion that the lack of care planning and more thorough, documented assessment could have been documented, but it is my view that this omission would be viewed very mildly by peers working in aged care.

Care provided by [Ms E]

[Ms E] was on a morning shift on the 21.3.05. She has documented in the clinical notes that [Mrs A] was still complaining of neck pain at 7.30am she administered Panadol and has documented that this had a good effect. The clinical notes also state that the daughter visited and that she asked that she would like her mother to see that doctor.

[Mrs A] went on an outing to the theatre that day.

The clinical notes are brief and there is no evidence of ongoing assessment. This can be because [Ms E] did not have any major concerns for [Mrs A] and I can only assume that this was the case as [Mrs A] did attend an outing.

There is nothing in the clinical notes as to what action [Ms E] took to the request from the family to have [Mrs A] seen by the medical officer.

There was very little in the way of a management plan documented on this shift, and again no pain assessment chart was used.

I can find no other entry in the clinical notes written by [Ms E]

The clinical notes are typical of what one would find in an aged care facility.

It is my view that the lack of thorough assessment would be viewed very mildly by peers.

Overall care provided

As stated, the clinical notes are adequate and are what one would find in an aged care facility. The registered nurses do sign and list their designation beside the signature.

In my opinion, they could have ensured that an X-ray be taken sooner than what it was by:

a. A documented assessment of [Mrs A's] pain — pain in the demented elderly is always difficult to gauge. Many patients present pain in very different ways, some become more demented and their behaviour becomes more aggressive, verbally they may not be able to express what they are feeling but any change in behaviour should alert staff that something is amiss

b. A full physical assessment of the patient should be done when the patient presents with specific complaints. [Mrs A] did complain of neck pain, staff treated this with heat packs and regular Panadol, the clinical notes would

indicate that at times her pain was relieved with this intervention. It was not consistent and she continued to present signs of distress.

A nursing care plan could have been documented which would have ensured the care and evaluation on a daily basis is visible for all staff to see. Documenting in the clinical notes is adequate but what usually happens is that staff do not read back more than a page so although there was an adequate plan it may not have been visible and therefore not read by all staff.

The general nursing care plans were out of date and many of the last reviews were done in June and July 2004. It would be expected that regular up dates of care and evaluations would be done more regularly.

Staff did contact medical officers and [Mrs A] was seen on two occasions.

I did not view the medical officers' notes or their assessments. In the clinical notes a stamp is used to indicate that either the medical officer was contacted or viewed the patient. There is no medical officer's signature.

Policies and Procedures

I have reviewed the information supplied and it is my view that all documentation presented meets the requirement for certification. Policies are thorough and well documented.

Overall

I am of the view that the care that was provided to [Mrs A] was of an adequate standard. The areas I have highlighted which may have quickened the diagnosis were when viewed by peers I believe to be of very mild disapproval."

Responses to Provisional Opinion

The rest home
Ms G responded to the provisional opinion for the rest home as follows:

"This investigation has provided us with a learning opportunity. Audits were undertaken of all residents' clinical files and as of 1 December 2005 all resident care plans were up to date. We have implemented a system of evaluating six care plans a week to ensure that all are done at least twice a year.

We have regular Care Assessment and Planning sessions scheduled for 2006 and will use this case study as a teaching tool to ensure that our registered nurses document short-term care plans for acute conditions and update care plans as

resident status changes. We will also continue with Pain Management training. I will continue to highlight to registered nurses (in my individual meetings with them) the importance of using our Pain Management documentation."

Dr C
In response to the provisional opinion, Dr C stated:

"After a lot of searching, I have found my notes [for the examination of Mrs A] that I had mistakenly wrote in someone else's file. I hope this clears up some misunderstanding.

As you may know hip and pelvic fractures are not always obvious and clinical examination unreliable, so I have a low index of skepticism for X-raying hips especially in demented people.

Neck fractures are comparatively uncommon and X-rays often unhelpful in evaluating neck injuries, so I don't often order them in the elderly."

Additional expert advice

Dr Turnbull
Dr Tessa Turnbull was asked to review her advice in light of Dr C's response. Dr Turnbull advised that Dr C's notes of his visit to Mrs A on 23 March 2005 "make clear the detail of the examination" and commented:

"[Dr C] was aware of a history of neck pain over the preceding few days and the very recent onset of left hip/leg pain. Examination of the hip was limited as [Mrs A] appeared reluctant to lie down and was examined sitting in a chair. However, [Dr C] did note that there was no leg shortening.

[Mrs A's] neck pain appears to have been spasmodic, as recorded in the clinical notes, and it is clear that [Dr C] examined [Mrs A] at a time when the pain was less apparent. He looked for and noted no local bony tenderness and a normal range of neck movements. It seems likely that the neck fracture occurred on 19/3/05 prior to [Mrs A's] first complaint of earache. The clinical examination did not find the expected loss of movement or pain with movement of the neck.

In conclusion, [Dr C's] examination of [Mrs A] was adequate on 23/3/05. Maybe he should have elicited a slightly fuller history and had an X-ray of the neck taken at the same time as the X-ray of the hip. However, the neck examination on 23/3/05 reassured him sufficiently. [Mrs A] was not in a position to supply an adequate history herself. … [Dr C] asked the nursing staff to monitor the neck range of movements and ongoing pain. This appears to be adequate.

> The late finding of the clinical record in the wrong file has changed the picture dramatically. Although, [Mrs A] sustained a significant neck fracture which was diagnosed later than ideal, [Dr C] cannot be held to blame for the delayed diagnosis."

Ms Featherston
Ms Featherston was telephoned for further advice and asked whether there was any issue with the registered nurses not noticing that Dr C's examination was recorded in the wrong notes. Ms Featherston commented that if the general practitioner was a visitor as opposed to the regular doctor visiting the home, it was possible that it would not be picked up, especially if the resident in whose notes the findings were incorrectly recorded was stable.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

Other relevant standards

New Zealand Medical Association's "Code of Ethics" (March 2002) states:

"*Responsibilities to the Patient*

…

4. Doctors should ensure that every patient receives appropriate investigation into their complaint or condition, including adequate collation of information for optimal management.

5. Doctors should ensure that information is recorded accurately and is securely maintained."

Opinion: Breach — Dr C

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A had the right to have services provided with reasonable care and skill, in compliance with relevant standards. Fundamental to the provision of services of an appropriate standard is a provider's adequate assessment and treatment of his or her patient's condition and the appropriate recording of his or her observations, the treatment plan and discussions.

Documentation
There is no record of Dr C's assessment of Mrs A on 23 March 2005 when he was asked to examine her, principally in relation to her inability to weight-bear on her left leg. Dr C recalled that when he visited Mrs A on 23 March 2005 her clinical record was not available. His initial recall was that he wrote on a "free sheet of paper" which was to be attached to the file "when it turned up". However, this record was not produced.

My independent expert, Dr Tessa Turnbull, concluded that Dr C's examination of Mrs A was not adequate because he was unable to provide evidence of his clinical findings or that he had thoroughly examined Mrs A, not only for any possible injury to her hip, but also her range of neck movement.

In response to the provisional opinion, Dr C produced evidence to show that he recorded Mrs A's assessment in the wrong resident's file. A review of this record revealed that Dr C entered this record two months later, on 23 May 2005. Dr C was unable to account for this delay, but it seems likely, given his initial explanation that he wrote on a "free sheet of paper", that the loose record was later located and he was reminded to transfer the record into the file. Dr C was not able to explain why he recorded his assessment of Mrs A in the incorrect file.

I have been advised that, if the other resident was stable and did not require registered nurse review, it was understandable that the incorrect entry was overlooked. Fortunately, the nursing staff followed Dr C's verbal orders to monitor Mrs A.

All health professionals are obliged to keep accurate patient records. A patient's records contain vital information relevant to the patient's history, care and treatment. This may be needed if the patient subsequently receives care from other health professionals, as indeed Mrs A did two days later when Dr F was called to see her and discovered that the cause of her symptoms was a neck fracture.

In my opinion, Dr C's documentation in this case fell below professional standards and, therefore, he breached Right 4(2) of the Code.

Opinion: No Breach — Dr C

Assessment — 23 March 2005
During the night of 19/20 March 2005 Mrs A, who suffered from dementia, was noted to be complaining of earache and to be more unsteady on her feet than usual. Mrs A appeared to be in a great deal of pain, holding her head. The following day, her symptoms were discussed with the on-call general practitioner, Dr F. Dr F gave orders relating to pain relief and monitoring. Over the next two days Mrs A's pain was observed to be variable in its intensity, usually able to be controlled by paracetamol, but was not sufficiently bad on 21 March to prevent her from attending a concert outing.

On the morning of 23 March the night staff reported that Mrs A had a large bruise on her left hip and another bruise on her left upper arm. The registered nurse, Ms D, telephoned the on-call general practitioner, Dr C, to ask him to visit to assess Mrs A.

Physical examination — neck injury
Ms D recalled that, when he arrived at the rest home, she briefed Dr C on Mrs A's recent problems, her neck pain and bruising, and gave him Mrs A's file to review. Dr C examined Mrs A's ears, and palpated and checked the movement in her neck as part of his overall assessment.

However, Dr C advised that Mrs A's clinical record was not available when he assessed her. He stated that he would "certainly" have ordered an X-ray of Mrs A's neck if he had seen the file and known that she had been holding her head to relieve her neck pain, because this gesture was indicative of a possible fracture of the cervical spine. Dr C said that he examined Mrs A's range of neck movements by observing her moving about the lounge and he palpated her neck, feeling for spasm of the muscles.

My expert, Dr Tessa Turnbull, advised that Dr C should have examined Mrs A's clinical record. However, if the record was unavailable, he should have elicited a better history, questioning the registered nurse more closely about Mrs A's history before conducting his examination. Dr Turnbull stated that it is possible, because of the intermittent nature of Mrs A's neck symptoms, that when Dr C examined Mrs A her neck pain was less apparent. Some signs of neck injury were likely to have been apparent and an X-ray of the neck should have been taken at the same time as the hip X-ray. Dr Turnbull was initially critical of Dr C's examination and advised that "an adequate clinical examination would have elicited some loss of movement or pain with movement of the neck". She stated that, in light of Mrs A's preceding history of neck problems, Dr C's advice to the rest home staff should have been to monitor her condition, especially when his examination did not indicate any significant abnormality of her neck.

In response to the provisional opinion, Dr C produced evidence of his examination of Mrs A on 23 March 2005. Contrary to his recollection without the notes to aid his memory, this record showed that Dr C examined Mrs A's neck for tenderness and range of movement. He instructed staff to observe Mrs A for any alteration to her range of neck movement and provide pain relief as charted. Dr C had mistakenly recorded the details of his assessment in another resident's chart with the incorrect date of 23 May, and these errors were not picked up by the nursing staff.

Dr Turnbull reviewed this additional information. She noted that Mrs A's neck pain had been intermittent and it appeared that Dr C examined Mrs A at a time when the pain was less apparent. He could have performed an X-ray of the neck, but his examination reassured him sufficiently. Dr Turnbull advised that Dr C's examination of Mrs A and his instructions to the nursing staff was adequate.

Hip injury

It appears that Mrs A was reluctant to lie down to be examined when reviewed by Dr C on 23 March 2005. Dr C said that he assessed Mrs A's range of hip movement by observing her moving about the lounge, and examined her while she was sitting in a chair. He did not comment on whether there was any shortening or rotation of her leg, but made a provisional diagnosis of undisplaced fracture of the neck of her left femur. (In the event of an undisplaced hip fracture, the diagnostic signs of shortening and internal rotation are usually not evident.) Dr C ordered pain relief and an X-ray of Mrs A's left hip. The X-ray showed that there was no hip fracture.

Dr Turnbull considered that Dr C's examination of Mrs A's hip was not really adequate because the examination was conducted while she was sitting in the chair, but the absence of a formal record makes judgement difficult.

In response to the provisional opinion, Dr C stated that hip and pelvic fractures are not always obvious and clinical examinations can be unreliable, so he has a "low index of scepticism for X-raying hips especially in demented people". His record of

the examination shows that he found Mrs A "uncooperative", with a bruise of her left hip; she was unable to stand but had "no shortening" of the affected leg.

Dr Turnbull reviewed Dr C's response and advised:

> "The late finding of the clinical record in the wrong file had changed the picture dramatically. Although, [Mrs A] sustained a significant neck fracture which was diagnosed later than ideal, [Dr C] cannot be held to blame for the delayed diagnosis."

I am satisfied that, although Dr C documented his assessment in the wrong file, and dated the record incorrectly, this did not have any bearing on the delayed diagnosis. In my opinion, overall, Dr C provided Mrs A with an adequate standard of care and therefore did not breach Rights 4(1) and 4(2) of the Code.

Opinion: No Breach — Ms D

Mrs A was also entitled to have nursing services provided with reasonable care and skill, in compliance with relevant standards. My nursing advisor, Jan Featherston, commented that pain levels in the elderly are very difficult to assess. Mrs A was unable to tell the staff where her pain was located and how severe it was. Ms Featherston suggested that if the nursing staff had used the rest home group's "Pain Assessment Record Initial Assessment" they might have been able to gauge the severity of Mrs A's pain more accurately

Registered nurse Ms D was on the morning shift on 20 March 2005 when the night staff reported to her that during the night Mrs A had complained of intermittent neck pain and had been seen frequently supporting her head with her hand. Mrs A was provided with heat packs and regular Panadol for her pain. Mrs A was also noted to be more unsteady than usual.

At 9am Ms D noted that Mrs A was unable to move her head without a jerking movement and seemed to be more confused than usual. She was unable to accurately report her symptoms because of her dementia. At 9.30am Ms D left a message with the on-call doctor, Dr F. At 10.15am Ms D left a second message for Dr F. Ms D noted that Mrs A was in severe pain. At 10.25am Dr F telephoned and, following discussions about Mrs A's symptoms, instructed Ms D to provide Mrs A with analgesics, monitor her condition and contact her again if Mrs A did not respond. Mrs A responded well to the Panadol. She was given two further doses over the next 24 hours and was comforted by the heat packs staff applied.

My expert advised that Ms D undertook an assessment of Mrs A when she presented with a significant problem, and when she found no obvious cause for the symptoms referred her to the on-call medical officer. The doctor's orders regarding observation

and treatment were implemented. Ms Featherston stated that, although Ms D did not document a care plan for this incident, her care was of an appropriate standard. It is common practice to use the clinical notes to guide caregiving staff in the provision of treatment.

Mrs A continued to complain intermittently of neck pain. The clinical records indicate that the interventions suggested by Dr F relieved Mrs A's pain, but the relief was not consistent and she continued to exhibit signs of distress. Although the staff at the rest home had the documentation available to assess and chart Mrs A's pain, this was not done. Dr F gave orders for twice-daily blood pressure and pulse observations. It appears that a chart was not set up for staff to record these observations and there is no record in the nursing notes that this recording was undertaken.

On the morning of 23 March Ms D documented the concerns the night staff reported to her about Mrs A — that she had bruising to her left hip and arm and was still experiencing neck and head pain on movement. Ms D examined Mrs A and took her recordings, which were all normal.

During the morning Mrs A was noted to suddenly be unable to weight-bear on her left leg. Ms D contacted the on-call general practitioner, Dr C. Dr C visited, assessed Mrs A and ordered an X-ray of her hip. The X-ray found no obvious sign of injury. Dr C gave the nursing staff instructions to provide Mrs A with the charted pain relief and observe her for any abnormality of neck movement.

On 24 March, Mrs A continued to complain of neck pain intermittently and was seen holding her head in her hand. Staff continued to provide pain relief, and to observe and report her condition.

At 7am on 25 March, Ms D noted that although Mrs A denied any pain, she appeared to be experiencing spasms of neck pain. Ms D notified Dr F. Dr F visited and examined Mrs A and noted that, although there was no history of a fall that could have caused a neck injury, it was likely that Mrs A had a neck fracture. Dr F organised an X-ray of Mrs A's neck, which confirmed that she had a cervical spine odontoid peg fracture. Mrs A was admitted to hospital.

Ms Featherston stated that Ms D could have made a more thorough documentation of her assessment of Mrs A, and the required observations and treatment plan, but this omission would be viewed "very mildly by peers working in aged care". I agree with Ms Featherston's opinion. On the two occasions that Mrs A's condition departed significantly from normal, Ms D noted the change, informed the family and consulted with a doctor. It could be argued that Ms D noted Mrs A to be in pain over a three-day period without pursuing the cause of the pain more vigorously. However, I note my expert's comments that it is very difficult to accurately assess pain levels in a demented patient. Additionally, Mrs A's pain was intermittent and responded to mild analgesia. In my opinion the care provided to Mrs A by Ms D was appropriate and therefore she did not breach Rights 4(1) and 4(2) of the Code.

Opinion: No Breach — Ms E

On 21 March 2005 registered nurse Ms E noted that staff on the previous night reported that Mrs A had been unsettled, wandering about holding her head and neck. Ms E assessed Mrs A and gave her Panadol to some effect. Ms E recorded this information in Mrs A's clinical notes and that Mrs A's daughter had visited, was concerned about her mother, and requested a medical assessment.

There is no evidence that Ms E actioned Mrs A's daughter's request for a medical review of her mother. However, shortly after being given the Panadol Mrs A was well enough to go on an outing to a concert. On her return to the rest home she ate a good lunch. Ms E's clinical notes are brief and there is no evidence of ongoing assessment of Mrs A. Ms Featherston stated that Ms E did not appear to be concerned about Mrs A on 20 March and assumed that was because Mrs A attended the concert.

Ms Featherston advised that a full physical assessment should be done of a patient who presents consistently with specific complaints. As previously mentioned, assessment of pain in a demented patient is not simple, and the implementation of a pain chart is the most effective method of accurately assessing the pain suffered.

However, Ms Featherston advised that Ms E's lack of thorough assessment would be viewed very mildly by her peers, and the clinical records are typical of what one would commonly find in an aged-care facility.

I accept Ms Featherston's advice about Ms E's practice. In my view, the action Ms E took in relation to her observation and assessment of Mrs A on 21 March was understandable in the circumstances. Mrs A did have an episode of severe pain, but this appeared to settle with a mild analgesic and she was able to attend an outing. Ms E could have been more proactive in her documentation, but given that Mrs A was unable to give a clear description of her pain owing to her dementia, her complaints of neck pain were intermittent and there was no evidence of injury, I find it reasonable that she took a "wait and see" approach at that time. Accordingly, in my opinion Ms E did not breach Rights 4(1) and 4(2) of the Code.

Opinion: No Breach — The Rest Home

The rest home provided staff with policies and procedures to guide them in assessing unwell residents, planning cares, pain assessment and management, and incident/accident assessment.

Although Ms E and Ms D did not use the rest home group's pain assessment form used at the rest home to assess and monitor Mrs A's pain, there is evidence in the clinical records that the registered nurses assessed and monitored her and directed staff to observe and report her condition. When Ms E and Ms D were concerned about Mrs A they appropriately reported their concerns to the medical officers.

My expert advised that the clinical notes were adequate and to the level expected in an aged-care facility. However, the general nursing care plans were out of date. It is expected that care plans are evaluated and updated on a regular basis.

Ms Featherston noted that the demented elderly present pain in very different ways. They are not able to express what they are feeling and staff should be alert to any changes in behaviour that could be an indication that something is amiss. Mrs A's complaints of neck pain were treated with regular Panadol and heat packs, which relieved the pain to a degree, but this was not consistent and Mrs A continued to complain of pain. Ms Featherston advised that a full physical assessment should be done when a patient presents with specific complaints. She stated that the documentation in Mrs A's clinical notes was adequate, but it is common for staff not to read back more than a day or two, so a nursing care plan that clearly documents the issues would be a better way of ensuring that records of care and daily evaluation are visible for all staff to see.

Ms Featherston stated that more attention to documentation could have ensured that the X-ray of Mrs A's neck was taken sooner. However, overall, the care provided to Mrs A was of an adequate standard. Ms Featherston advised that the areas she commented on that could have been improved and which may have led to an earlier diagnosis would be viewed by peers with very mild disapproval.

I am satisfied that, although the standard of documentation could be improved, Mrs A was provided with an adequate standard of care. Accordingly, in my opinion, the rest home did not breach Rights 4(1) and 4(2) of the Code.

I note that the rest home has audited all residents' clinical records and care plans, and reviewed care assessment and planning, pain management training, and documentation in light of this case.

Recommendation

I recommend that Dr C:

- apologise to Mrs A's family for his breach of the Code.
- review his standard of documentation in light of this report.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, the Nursing Council of New Zealand, and the Royal New Zealand College of General Practitioners.
- A copy of this report, with identifying features removed, will be sent to Residential Care New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.