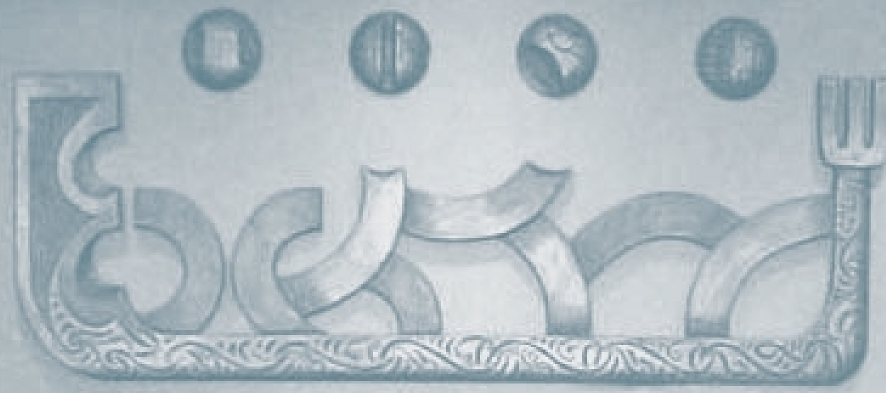

Bulletin from the
Health and Disability Commissioner
and Advocacy Services

No 12, September 2007

HDC Pānui

Accountability of providers of health services to the elderly

One of the most vulnerable groups in society is the elderly, often highly dependent on others to have their medical and everyday needs met. Many instances of neglect and abuse go undetected, or unreported, or have been hard to substantiate. It can be very difficult to prove poor care when the recipient may be unable to communicate.

However, providers of health services to the elderly can and have been held accountable. The Director of Proceedings(1) has issued proceedings against a number of providers who have been referred by the Commissioner after investigation. About half of the disciplinary charges laid against registered nurses have involved negligent or disrespectful care of the elderly.

The cases summarised below illustrate deficiencies in care that have resulted in successful prosecutions of the providers concerned.

Care planning and documentation

One theme that emerges is a failure on the part of registered nurses to plan, document and monitor care. These shortcomings have become apparent when there have been later adverse events.

The HPDT(2) upheld a charge of professional misconduct against a registered nurse(3) who was also Director and Manager of a nursing agency that provided full-time private care for an elderly patient in her own home for over a year. The patient developed ischaemic ulcers on her feet and significant pressure sores on her torso, from which she later died. The Tribunal found that there was an inadequate nursing plan in relation to pressure areas, nutritional status, weight and pain; that there was a failure to ensure the use of appropriate wound care products or equipment; and inadequate training of staff and involvement of a registered nurse. The Tribunal said:

"*Mr Henry, and others in his circumstances, must appreciate that when they accept the responsibility for caring for elderly, vulnerable patients there are minimum standards that must always be adhered to. The plight of the patient in this case, and the overall inadequacy of her care has been a source of considerable concern and distress to the Tribunal.*"

In another case where inadequate care led to significant pressure areas, proceedings were issued in the HRRT(4) against not only the registered psychiatric nurse, but also the licensees and manager of the rest home, who had failed to comply with requirements under the National Contract and other relevant legislation. By consent, declarations were made that the resident's rights had been breached.(5)

Caregiver's failure to report fall

In August 2007 the HRRT issued its finding that a caregiver, who dropped a resident during transfer, but failed to report the incident, was in breach of the Code. This was the first case brought by the DP against a caregiver. The resident, who was immobile and unable to communicate, was found with bruising on her shoulder, which an X-ray proved to be the result of a fractured humerus. The rest home conducted an investigation, with the assistance of Aged Care and the Police. Having denied any knowledge of the possible cause of the fracture, the caregiver eventually acknowledged, some three weeks later, that the patient had fallen during a transfer. While her decision to transfer the patient without assistance was criticised, the more serious aspect was not reporting the incident to anyone so that the resident could receive the examination, assessment and care she deserved.

Conclusion

There are many other examples of cases involving neglectful, disrespectful or abusive conduct. While it is acknowledged that there will inevitably be matters that do not come to the attention of HDC, potential breaches of the Code are viewed very seriously. Where appropriate, proceedings are issued in order that standards are maintained, the public is protected, and providers are held accountable.

The public–private interface for surgery

Any consumer receiving a health service has a right to information about the options for receiving that service, and the costs of each option, so that he or she can make an informed choice about accessing his or her care. In New Zealand, where one episode of care may span both public and private sectors, a patient's right to be fully informed is paramount. A recent HDC case (05HDC12122) highlights the responsibility this places on the clinician.

Assessment for cataract surgery

Mrs B (who was 82 years old) attended a private ophthalmologist, Dr C (who also worked in the public system) for her first specialist assessment (FSA) for cataract surgery. Her assessment qualified her for treatment in the public system, and as she could not afford the expense of private surgery, she requested transfer directly to the public hospital waiting list. From this point on, Mrs B assumed that any further treatment she received in relation to her cataract surgery would be free. Mrs B was unaware that she remained Dr C's private patient, and this was not explained to her by Dr C.

Consultations in private rooms

Three months later, Mrs B was assessed at the hospital ophthalmology department, and her priority was confirmed. Dr C performed a preoperative assessment for Mrs B at his rooms. After her surgery, the ophthalmology department provided information about a follow-up appointment with Dr C, who subsequently saw Mrs B for two postoperative appointments at his rooms. Mrs B paid a fee for each of these consultations. She thought that since she had scored enough points to qualify for publicly funded cataract surgery and had elected to receive treatment through the public system, all the costs associated with her surgery would be covered. She received no explanation from Dr C about why he was still charging her and felt "indignant" about the charges. She was confused as to why Dr B was not conducting the pre- and postoperative appointments at the hospital as part of the general outpatients system, since her surgery was being done publicly. However, she did not feel comfortable about raising the issue with Dr C. A complaint was made to HDC.

Dr C's response

Dr C stated his view that "the average person realises" that private consultations in a surgeon's private rooms would incur a fee. But the Commissioner stated that the test is not what the "average person" would realise. It was not reasonable to expect 82-year-old Mrs B to understand that although she qualified for, and had asked for, public care, and had received surgical care from Dr C at the public hospital, the location of her pre- and postoperative appointments at his rooms in effect changed her status to that of a private patient for those visits. Dr C had not provided Mrs B with adequate information about the public and private components of her care — treatment options and likely costs — and so breached Right 6(1)(b) of the Code of Health and Disability Services Consumers' Rights.

Ethical standards and exploitation

There is a potential conflict of interest if a surgeon has responsibility for a patient's surgery in the public system but also has a personal interest in any income from private consultations. Dr C was in a position of trust, and needed to ensure he did not abuse this position by charging Mrs B. The Commissioner found that Dr C's conduct had the effect of exploiting Mrs B, and that he failed to comply with ethical standards in this regard, breaching Rights 2 and 4(2) of the Code.

Funding arrangements

The Commissioner's expert advisor, Dr Peter Haddad, noted that public hospitals are funded to provide the complete package for public cataract surgery — the free service would include a preoperative consultation, the surgery, and postoperative follow-up visits. As a public patient, it was inappropriate for Mrs B to pay for pre- and postoperative visits. Any departure from standard practice would need to be specifically explained to the patient.

Due to an administrative oversight, the hospital was unaware that Mrs B was a public patient. When it was alerted to the fact that Dr C had been charging public patients for services that the DHB was already paid to provide, Dr C was advised to discontinue the practice.

Public/private partnership

Dr Ray Naden, Clinical Director, Elective Services, Ministry of Health, advised that it is customary in New Zealand for "specialists to work both the public and private sectors and it is not uncommon for a specialist to treat the same patient for the same episode of care at times in a private capacity and at other times in a public capacity". Specialists may put private patients on public hospital waiting lists. While this favours patients who are able and willing to pay for a private service, it also benefits others by decreasing the numbers having to be seen at public outpatient clinics and reducing the waiting times. The public/private model may not be inherently unethical or inappropriate as long as the patient is fully informed about both the publicly and privately funded options, all patients have similar access to publicly funded options (no discrimination), and there are no pressures brought to bear on the patient to choose the private option (no coercion).

To safeguard all patients' rights to choose, and equitable access to services, guidelines may be helpful. As a result of this case, the Commissioner has recommended that the National Ethics Advisory Committee be asked to advise the Minister of Health on the ethical issues raised by the current

mix of public and private treatment options in relation to elective services, and whether any guidelines are needed to clarify the limits of ethically acceptable practice.

Systems failures results in damage to eye

A recent HDC case (06HDC00096) about the services provided by a plastic surgeon and a private hospital highlights an adverse event arising from a number of systems failures.

Eyelid surgery

Mrs A was referred to Dr B, a plastic surgeon, for cosmetic eyelid surgery, known as blepharoplasty, where excess tissue around both upper and lower lids is removed, making the eyes appear wider open, and the face rejuvenated. The eyes themselves are protected from inadvertent damage during surgery by eye shields. At the hospital where Mrs A underwent surgery, usual practice was to disinfect the shields by soaking them in an alcohol and chlorhexidine solution in a preparation area, then for the nurse to rinse off the solution prior to use and place the shields on the sterile trolley ready for the operation. Rinsing is important because chlorhexidine is known to be an irritant to the cornea and causes extraordinary discomfort.

During Mrs A's surgery, the circulating nurse delivered the eye shields to the scrub nurse at the sterile trolley and went to get some sterile water to rinse them. In the interim, Dr B, who was unaware that the items were not ready for use, placed the eye shields in Mrs A's eyes. When the scrub nurse alerted him to the problem, Dr B took them out, examined Mrs A's cornea and conjunctiva (which appeared normal), rinsed her eyes with saline, and then replaced the rinsed shields before continuing the surgery. Dr B thought that the solution consisted of a dilution of chlorhexidine in water, and was familiar with its use to disinfect skin. He was not aware of the alcohol in the soaking solution, or the toxicity of chlorhexideine to the cornea. The incident was not recorded in either the nursing notes or the operation record, and Mrs A was not informed.

Mrs A experienced a burning and persistent pain inside her eyes (rather than at the surgery site) and two days later was referred to an ophthalmologist, who diagnosed corneal burns. Despite treatment, Mrs A continued to have pain and visual disturbances for six weeks, causing distress and affecting her ability to cope, and she eventually resigned her job. The adverse event came to light only when Mrs A complained to the hospital seeking an explanation for her eye problems, and an investigation was carried out.

Complaint to HDC

Mrs A was dissatisfied with the outcome of her complaint to the private hospital, and made a complaint to HDC. The Commissioner found that both the hospital and Dr B failed to provide services of an appropriate standard to Mrs A and, in addition, Dr B did not provide appropriate information to Mrs A about what went wrong. Dr Mary Seddon, the Commissioner's independent expert advisor, identified several systems factors that contributed to this adverse event.

Potentially harmful sterilising system

The hospital was using eye shields that could not be high-heat sterilised, and there was no low temperature autoclave available. Staff were using an alcohol and chlorhexidine sterilising technique, which required the shields to be rinsed before use — this process should have happened in the preparation room. Instead, equipment that was not patient ready was placed on the sterile trolley — an accident waiting to happen.

Lack of communication in theatre

There was poor communication within the operating theatre regarding the eye shields and their sterilisation. Dr B was unaware of the potential harm posed by the sterilising solution. All staff involved in the surgery should have been informed that the solution was harmful and that the shields needed rinsing before use.

Lack of adequate orientation

Dr B took the eye shields directly from the trolley rather than having them passed to him by the scrub nurse who was responsible for items in the sterile surgical field. The hospital had an appropriate policy in place for the management of theatre equipment, but Dr B did not follow standard practice. Dr Seddon queried whether Dr B had known of the protocol and had been required to attend an orientation to familiarise himself with the hospital's standard practices. She noted that having different orientation programmes and requirements for attendance for employed and visiting staff is likely to lead to misunderstandings.

Lack of incident reporting

Dr B was not aware that chlorhexidine can be toxic to the cornea without the addition of alcohol, and alcohol at the concentration present will also damage the cornea. The severity of the mistake with the eye shields was not fully appreciated by the surgeon or other staff present, and it was not documented in Mrs A's notes. As a result, the incident was not communicated to the recovery staff, Mrs A's postoperative pain was not appropriately managed, and Dr B was not alerted to the situation and consequently did not attend Mrs A before her discharge. The nurse who wrote the discharge summary did not know of the mistake, and it was not communicated to Mrs A or her general practitioner.

Lessons learned

As often happens, the adverse event experienced by Mrs A resulted from a series of interlinking failures by a number of

people. To ensure such accidents do not recur, all systems deficiencies must be addressed. As a result of Mrs A's complaint, the hospital has identified opportunities for quality improvement. It has discontinued chlorhexidine/alcohol soaks for eye shields, adopting the Sterad sterilising process, and has made changes to its policies for the orientation, communication and practice expectations of visiting practitioners.

New Naming Policy

On 1 July 2007 HDC introduced a new policy that will lead to more providers found to have breached the Code of Health and Disability Services Consumers' Rights being publicly identified in final reports. The reasons for this change are set out below.

Policy context

Despite being one of the first countries to move to a system of co-regulation (ie, by professional registration authorities and an independent Commissioner), New Zealand has adopted a more secretive approach to complaints and discipline than other countries using systems of traditional professional self-regulation.

Secrecy is undermining public confidence in the health professions and disciplinary procedures. The public has been "kept in the dark" about information that may influence a person's choice of practitioner or facility, and there is an increasing public desire for openness. The veil of secrecy is all the more remarkable given the absence in New Zealand of the major alternative forum for public hearings about the quality of health care — the civil courts (as a result of the statutory accident compensation regime).

More than a decade after the public disquiet that led to the overhaul of the complaints and medical disciplinary system, HDC has decided that the time is now right to identify providers in appropriate cases — which may actually lead to less sensationalism in the media.

The policy will apply only to healthcare providers who have been found in breach of the Code after an investigation, and have been given an opportunity to comment on the proposed identification.

Group providers

HDC will name group providers (district health boards, rest homes, private hospitals, pharmacies and medical centres) in final reports unless identification would not be in the public interest or would unfairly compromise the privacy interests of an individual. Relevant public interest factors may include:

- whether identification would detract from quality improvement efforts of the provider;
- the nature and circumstances of the breach; and
- the passage of time since the events in question.

Group providers will be offered an opportunity to comment on the decision to name the provider when the provisional opinion is issued.

Individual providers

HDC will continue to anonymise the names of individual providers in the majority of cases. Individual providers have a strong interest in protecting their professional reputation and livelihood, and identification in an HDC opinion may lead to negative media coverage. However, there will be situations where an individual's privacy interest is outweighed by the public interest in making the information available. This may lead to the individual provider being named if one of the three following situations arise:

- public safety concerns — the conduct of the provider demonstrates a flagrant disregard for the rights of the consumer, or a severe departure from an acceptable standard of care; or
- frequent breaches — the provider has been found in breach of the Code in relation to three separate episodes of care within a three- to five-year period; or
- recalcitrant behaviour — the provider has refused to comply with recommendations in the final report.

In determining whether an individual provider should be named, HDC will have regard to other mechanisms that are available to protect the public, such as competence reviews and conditions on practice that can be imposed by registration authorities. However, in the case of unregistered providers who pose a risk of harm to the public, there may be few other options for limiting their practice.

Again, individual providers will be offered an opportunity to comment on the decision to name the provider when the provisional opinion is issued.

HDC seminars for consumers

In the past year, HDC has convened several consumer seminars around the country. The seminars offer health and disability services consumers an opportunity to comment on ideas for improving the safety and quality of health and disability services. It also provides consumers with an opportunity to give feedback to the Commissioner about the services his office provides. Seminars gave voice to perspectives from youth, older people, Māori, people who use disability services, people who use mental health services, and Pacific peoples. On average, 93% of participants found the seminars useful.

Participants at the seminar for young people wanted HDC staff to carry out more school visits, and to make better use of text messaging to inform students, and they wanted information about HDC to be placed in school spaces, such as the nurse's office or common rooms. In Whangarei Māori

consumers suggested that health professionals find ways of sharing with their patients information that is easier to understand, with less technical jargon and fewer medical terms. Participants from the older persons seminar in Blenheim wanted information about HDC to be more accessible, for example, attached to their rates bill or placed at the local Citizens Advice Bureau.

Participants from the Wellington seminar focusing on mental health services were concerned about the consequences of making a complaint, and wanted to feel safe in raising concerns with their health care providers. Participants from the Pacific Islands consumer seminar wanted to be more actively involved in decisions about their care. Participants from the seminar for people with an intellectual impairment suggested a range of ideas for increasing opportunities for making their own decisions and having their choices respected by caregivers working in their homes.

Planning has begun for the next round of regional consumer seminars for the year ahead.

(Footnotes)

1 The Director of Proceedings is a statutory position created under s 15 of the Health and Disability Commissioner Act 1994. For more information about the role and the different types of proceedings, visit: http://www.hdc.org.nz/proceedings.

2 The HPDT is the Health Practitioners Disciplinary Tribunal, which deals with disciplinary charges against registered health practitioners.

3 22/Nur05/07D. Copies of the decisions of the Health Practitioners Disciplinary Tribunal may be found at www.hpdt.org.nz.

4 The Human Rights Review Tribunal may consider breaches of the Code, in relation to any provider, after there has been a breach Opinion by the Commissioner. To see some of the Tribunal's decisions, visit: http://www.nzlii.org/nz/cases/NZHRRT/.

5 *Director of Proceedings v Sisson, Ohope Rest Home and Scott* (unreported, HRRT 22/06, Decision 11/07, 10 August 2007).

We welcome feedback on *HDC Pānui*. Please send any comments about information you would find useful to Elizabeth Finn, Education Manager, at panui@hdc.org.nz. *HDC Pānui* is also available on www.hdc.org.nz.