



HDC Pānui

Consumer seminars

The Commissioner will be convening regional consumer seminars during October and November 2006. The seminars will be held in Whangarei, Auckland, Wellington, Blenheim and Dunedin. Each seminar will have a particular theme, including Māori, youth, Pacific, mental health, intellectual impairment and older people. These are half-day seminars and will cater for up to 50 participants at each seminar.

HDC is keen to get feedback from consumers on their recent experiences in using health or disability services. We want to know about the good and the not so good to find out what service providers should be doing more of and where there could be improvements. We are also keen to receive feedback on what consumers think our office should be doing differently to better meet their needs.

Information about the seminars will be available on our website, and we will alert our various networks. If you would like more information, contact Penny Bell 09 373 1025 or 0800 11 22 33 ext 5025.



HDC Compendium of Case Notes 2000–2004

In an exciting first for our office, we have recently published a selection of case notes based on HDC's decisions from 2000 to 2004. The notes cover a wide range of services, and illustrate the application of the Code of Health and Disability Services Consumers' Rights (the Code) in situations where consumers complain that their rights were infringed. The compendium is a representative sample of the Commissioner's investigative work, and is intended to be used to educate consumers, providers, and the public about the scope and meaning of the rights affirmed in the Code. Copies of the Compendium may be ordered via the HDC website at a cost of \$29.75 each (including packaging and postage).

Case Study: Internal and External Investigations

The HDC complaints resolution process enables independent appraisal of actions taken by a provider in response to a complaint. An internal investigation may take a narrow focus on individual actions. An external investigation provides the opportunity to widen the lens. Have all relevant issues been explored? Was it a failure of the system, an individual, of teamwork or other constraints? Has a key issue been overlooked? Inadequacies in an "independent" investigation, identified by a subsequent HDC investigation, are discussed in the following case study.

Background

Mrs A was the resident of a rest home and private hospital facility owned by a large provider of residential care for the elderly. Mrs A was receiving treatment for congestive heart failure for which she had been admitted to hospital in August 2004. She had been discharged back to the rest home with a letter outlining the warning signs of heart failure. These included increasing weight, shortness of breath and increased swelling of the legs. She had also had a previous hospital admission due to cellulitis of her legs.

Mrs A's deterioration

Mrs A's condition began to deteriorate early in the month of May 2005 with evidence of congestive heart failure and cellulitis in her left leg. The care manager's plan for Mrs A included thrice-weekly monitoring for blood pressure and weight. But by 16 May, she had not had her blood pressure recorded for eight weeks, nor her weight for six weeks, despite her legs becoming increasingly swollen. She had a skin tear on her left leg that oozed with serous fluid to the extent that bath towels were used to mop up the fluid.

No recordings were taken by nursing staff in response to Mrs A's condition despite reports of her wound discharge having a "slight odour" and her legs becoming "swollen, red and sore". Mrs A was described as being "wheezy", "dizzy", "pale and tired".

Unrecognised need for hospital care

Ms B, a junior nurse, and Ms C, Mrs A's allocated nurse, were on duty on 16 May as Mrs A's condition further deteriorated. Ms C did not read Mrs A's notes at the beginning of the shift, and neither nurse took any observations. During the early afternoon, nursing staff were approached by family members very concerned by Mrs A's condition, observing that she was shaking, and that her leg was grossly swollen and inflamed. They requested that Mrs A be transferred to the public hospital by ambulance for immediate medical assessment, but nursing staff were unwilling to arrange admission to hospital until a doctor made a referral. At the family's insistence Mrs A's GP was called by nursing staff, and was due to attend in the afternoon but, as the family were unwilling to wait for the doctor to arrive, they took Mrs A to hospital in their own car. On admission, Mrs A was treated for congestive cardiac failure and cellulitis of her left leg. Despite treatment, she continued to deteriorate and subsequently died.

Internal investigation

Following the family's complaint to the rest home, an "independent" investigation was conducted by a senior manager from another facility owned by the same group. It made recommendations on existing systems, among them "wound management protocols to be followed", "registered nurses to be responsible for their allocated patients", "clinical meetings to be held each week to discuss challenging clinical issues within the facility with progress reviewed", and "protocol to be developed regarding which registered nurse takes responsibility for the shift". A letter was written from the central office of the provider, apologising for the incident and stating some of the practices in place to prevent such an incident in future. What was missing from the report was any recommendation related to the failure of staff to perform any clinical observations. And none of what had been done was revealed to the family.

HDC investigation

Not satisfied with the investigation conducted by the rest home, Mrs A's family made a complaint to HDC. Independent expert nursing advice obtained during the HDC investigation exposed the ongoing inadequate assessments undertaken to evaluate Mrs A's condition. In essence, Mrs A had deteriorated with the registered staff seemingly oblivious, with her clinical observations not even being recorded on 16 May, as her condition worsened. In the absence of any evidence of her changing condition, the urgent need for staff to arrange for medical assessment had eluded them.

The HDC investigation revealed that Ms B and Ms C did not work together collaboratively, each deflecting responsibility for Mrs A's care to the other. When the family insisted on a hospital transfer by ambulance, both nurses thought that a referral from a GP was required. The care manager's plan for Mrs A's care was inadequate, contradictory and "did not demonstrate an appropriate level

of skill or knowledge". Although it instructed that regular weights and blood pressures be taken, this was not followed through by any staff. The care manager later admitted that she should have checked that her plan was being carried out rather than assuming that everything was satisfactory.

Rigour and disclosure

In addition to system and policy issues, the HDC report identified individual failings of Ms B, Ms C and the care manager. All three nurses were referred to the Nursing Council of New Zealand to be considered for competence review.

The Commissioner commented that to be transparently independent, the rest home's investigation should have been undertaken by a fully independent professional, rather than an employee of the same organisation. He also commented adversely on the failure of the initial investigation to identify, and report to the family, the failure of the individual nurses to demonstrate appropriate levels of care when nursing Mrs A. Providers owe families a "duty of candour" in such circumstances.

If the management and staff of the organisation had not had to face the scrutiny of an independent external investigation, they may have missed crucial insights into issues of teamwork and staff competence. Improvements were needed to the quality of care for all the residents, in team and individual practice.

Recent DP Cases

During June, July and August, there have been seven successful prosecutions of registered health providers before the Health Practitioners Disciplinary Tribunal ("the Tribunal"). Five general practitioners have been found guilty of professional misconduct, one in relation to two different complainants. The Tribunal also upheld a charge against a registered nurse as a result of her conduct in a rest home. The full decisions can be found on the Tribunal's website: www.hpdt.org.nz/Default.aspx?tabid=65.

Failed vasectomy cases

The two prosecutions of Dr Johannes Wilson received some publicity. One couple had a further child after an unsuccessful vasectomy, while the other couple conceived twice after two unsuccessful vasectomies. Dr Wilson admitted that he did not provide adequate information to his patients about the need for a negative sperm test to confirm whether the vasectomy had been successful. Further, instead of cutting a small part of the vas and sending the specimen to a laboratory for analysis, he simply severed the vas and then left the ends without tying them off or cauterising them, leading to an increased chance of the vas ends reconnecting.

One patient did not ever have his sperm tested after the vasectomy. Dr Wilson admitted that he should have facilitated

follow-up of the patient's care and sperm testing. When the other patient later returned a high sperm count, Dr Wilson should have told him that it was likely the vasectomy had failed, but instead sent him off for three more tests. Each returned a result showing that the vasectomy had definitely failed, and yet Dr Wilson failed to explain this to his patient. The same thing occurred after the second vasectomy.

The Tribunal upheld charges of professional misconduct. Bearing in mind the desire to ensure that the settlement reached with one couple was not jeopardised by financial constraints, the monetary penalty imposed by the Tribunal was not high, but it made an order that for three years, Dr Wilson must not perform any vasectomies.

Inadequate assessments

The Tribunal also upheld charges in relation to three general practitioners who failed to undertake adequate assessments or make referrals. One case involved an undetected ovarian cyst weighing 14.7kg, another an undetected bowel tumour, while the third related to management and follow-up of a breast lump. Sadly, in each of the last two cases the patient died of cancer.

While by no means identical, the similarities in all three cases were that there was no criticism of an actual failure to diagnose. It was accepted that ovarian cysts are often very difficult to detect, but the Tribunal made it clear that general practitioners must discharge their responsibilities to perform physical examinations, arrange referrals (sometimes in order to exclude a diagnosis) and, in certain circumstances, impress upon the patient the need to have further tests.

PEG feeding

At the beginning of July, the Tribunal found Nurse E guilty of professional misconduct for reducing an elderly resident's PEG feeding regime without consulting a dietician or medical practitioner. Further, she failed to put in place any systems for monitor and review of the resident's weight.

Over a period of 18 months, from September 2000, the elderly man lost 19.7kg and, by the time he was admitted to hospital in March 2002, he had developed significant bedsores, the effective management of which would have required adequate nutrition. Blood tests showed that he was anaemic, his albumin (protein) level was low, and that he was also septic. He died a few days later.

A penalty has not yet been imposed, and the nurse has appealed.

Sexual relationship

At the beginning of September, Dr Patel, an Auckland GP, admitted a charge that he had had a sexual relationship with his patient, who was suffering from depression. The Tribunal suspended him for two years. Should he wish to

return to practice, he will need to satisfy the Medical Council Sexual Misconduct Assessment Team that he is rehabilitated. Dr Patel was ordered to pay a fine of \$10,000, plus 50% of the costs of the hearing.

Upcoming hearings

Details of upcoming hearings can be found on the Tribunal website at <http://www.hpdt.org.nz/Default.aspx?tabid=60> and in the Proceedings section of the HDC website: www.hdc.org.nz/proceedings/proceedings-upcoming. Case notes and other information about the Proceedings Team can also be found on the HDC website. Unless there is a note saying that the hearing is private, all hearings are open to the public.

Far-flung places

The Nationwide Advocacy Service covers the whole country. This means that advocates need to be available to assist consumers in remote regions, and to make sure they are informed about their rights and the role of advocates and HDC.

Visits to remote locations in Northland, the East Coast and other parts of the North Island, and to Stewart Island, the West Coast, Mackenzie country and other heartland areas of the South Island are carried out on a regular basis to maintain a profile and links with these communities.

A key part of gaining the confidence of remote communities as an outsider coming in is to develop relationships, deal with communication challenges, and build trust. Regular networking is key to establishing and maintaining good relationships, but distance and time is always a challenge. Nationwide coverage is enhanced by having part-time advocates around the country. This impacts on how often visits can be made to remote areas. It is important for advocates to identify the key people and organisations in each community, including community centres, local schools, Māori or iwi organisations and local social service agencies.

There is often a sole practitioner or medical centre providing a health or disability service. Managing relationships in a positive way is important given the need for ongoing contact between consumers and their local service. Consumers may be reluctant to complain owing to worry that the service could be withdrawn.

People living in these areas (including the advocates) have ongoing challenges with communication, cellphone coverage, internet access, and limited TV options. Distribution of information, organising education sessions, and communicating with people in these areas often works better through the postal service, local papers and regular visits, rather than relying on new technology. Advocates may find roads closed by snow or flooding, limited access, and long distances to travel.

Janet MacManus, our advocate in Invercargill, is responsible for Stewart Island. Janet has met with local women to discuss issues unique to their isolation and limited medical services. With a population of just over 600, and 100-plus visitors at any time, Stewart Island doesn't have a resident doctor, chemist, birthing unit, or facilities for older people, but it does have a Nursing Team qualified in emergency response and basic patient care. This team is on call 24/7 and has direct telephone contact with a group of Invercargill GPs who advise on the appropriate treatment for a wide range of health issues. Because of the isolation and severe weather challenges that islanders face, transportation to the mainland is not always a viable option for accident victims or in acute medical emergencies. Mothers-to-be leave the island about three weeks prior to their due date so their babies can be born at Southland's base hospital. Unfortunately, older people have to leave the island when they can no longer be cared for in the community. This often means going into residential care on the mainland, leaving their partner on the island.

Advocate Vicki Martin-Noakes is based in Napier. The Chatham Islands are part of her region. They consist of a group of ten islands, only two of which are inhabited, with a total population of 750 people. No babies are born on the Islands as women are sent to Christchurch, Wellington or Hawke's Bay well before the baby is due. There is also no midwife or Plunket service available. Older people stay in their own homes or move in with family.

Vicki and Advocacy Manager Lewis Ratapu visited the Chathams earlier this year. They met with local people and dedicated health providers. Barbie Joyce from the Māori Community Health Service took Vicki to meet consumers at the fishing settlement of Kaingaroa and at Te One. They visited several local childcare centres to speak with mothers and listen to their experiences. Vicki was also able to carry out presentations to four health providers, network with several local community groups, manage several enquiries, and assist with the resolution of a complaint.

Our advocates have an important role to play in providing support in far-flung places.