Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00018)

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Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. HDC received a complaint from Ms B about the care her friend, Mr A, received from a medical centre.

2. Ms B's concerns relate to the care the medical centre and two of its general practitioners (GPs), Dr C and Dr D, provided to Mr A on three occasions between June and September 2020.

3. The following issues were identified for investigation:

- *Whether Dr C provided Mr A with an appropriate standard of care between June 2020 and September 2020 (inclusive).*
- *Whether Dr D provided Mr A with an appropriate standard of care on 27 June 2020.*
- *Whether the medical centre provided Mr A with an appropriate standard of care between June 2020 and September 2020 (inclusive).*

4. This report sets out the Deputy Commissioner's opinion on the quality of the care Mr A received from Dr C, Dr D, and the medical centre.

5. In-house clinical advice about Mr A's care was obtained from Dr David Maplesden, a GP (Appendix A).

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

6. Having carefully considered all relevant information, the Deputy Commissioner found that Dr C breached Right 4(2)[1] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to keep full, accurate patient records that complied with the relevant professional and ethical standards, and failing to inform Mr A of a test result that he could reasonably have expected to receive.

7. The Deputy Commissioner found that Dr D breached Right 4(1)[2] of the Code, in that she failed to communicate all relevant and/or accurate clinical information during a house call, culminating in a failure to provide services to Mr A with reasonable care and skill.

8. The Deputy Commissioner found no breach of the Code by the medical centre.

9. The Deputy Commissioner recommended that Dr C provide an apology to Ms B on behalf of Mr A for the failings identified in this opinion, undertake refresher training on clinical record-keeping, and complete a relevant section of the Royal New Zealand College of General Practitioners (RNZCGP) clinical record-keeping self-audit.

10. The Deputy Commissioner recommended that Dr D provide an apology to Ms B on behalf of Mr A for the failings identified in this opinion and provide a report to HDC about her reflections and the changes made to her practice as a result.

Key events

11. In June 2020, Mr A (aged in his eighties) was receiving palliative care[3] at home for terminal lung cancer. Ms B was Mr A's friend and carer, and his attorney under his Enduring Power of Attorney (EPA). Ms B complained about the GP care Mr A received on the following three occasions between June and August 2020.

3 June 2020 — telephone consultation with Dr C

12. On 3 June, Mr A had a consultation with his usual GP, Dr C. Ms B said that Mr A sought the consultation as he was experiencing worsening fatigue, shortness of breath, and a dry cough in the context of his terminal cancer.

13. Dr C assessed Mr A by telephone due to COVID-19 protocols in place at the time.[4] In addition to his regular medications, Dr C gave Mr A a new prescription for morphine hydrochloride oral solution for pain relief. Dr C's full notes of the telephone consultation state:

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[1] Right 4(2) stipulates: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

[2] Right 4(1) stipulates: 'Every consumer has the right to have services provided with reasonable care and skill.'

[3] Holistic care and support to provide relief from the symptoms and stress of life-limiting illness.

[4] New Zealand was at Alert level 2: https://covid19.govt.nz/about-our-covid-19-response/history-of-the-covid-19-alert-system/#alert-levels. The medical centre stated that the advice of the RNZCGP and the Ministry of Health at the time was that 80% of patient contact should take place by remote means.

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> 'Virtual consultation — COVID pandemic lock-down: response to reduce face to face consultations as College of GPs. Virtual consultation without seeing patient. Verbal patient consent obtained.'

14. Ms B submitted that a telephone consultation was not appropriate despite the COVID-19 protocols. She considered that Dr C should have seen Mr A in person given his cancer history and said that a telephone call was not conducive to effective communication of Mr A's symptoms and concerns.

15. Dr C told HDC that he would have preferred to see Mr A face to face. However, due to his own compromised immunity and the COVID-19 vaccine not being available at that time, Dr C was able to see only patients who were considered well following a telephone triage. The medical centre said that the RNZCGP risk assessment protocols were used to risk assess all its employees. The medical centre stated that as Dr C was identified to be at extreme risk, he was stood down from direct patient contact, and measures were put in place to ensure that his patients' needs were met by 'immunocompetent' staff.

16. Dr C cannot recall whether Mr A was 'markedly' shorter of breath during the telephone consultation. However, he accepted that it would have been better to have referred Mr A to another GP when it became clear that he needed more than a repeat prescription. Dr C stated:

> 'I am not in the habit of prescribing morphine without a face-to-face assessment and a discussion of effects and side effects. In this instance I was motivated by expediency and a desire to help as much as I could in the circumstances.'

17. Dr C concluded that the telephone consultation was 'extraordinary and not indicative of [his] usual care'.

18. In addition, Dr C told HDC that he was usually 'fastidious' in his record-keeping, but his notes of this consultation were 'sub-optimal', for which he apologised. Dr C could not explain the lack of notes but presumed that their brevity was due to work pressure. He said that the transfer of notes to a new computer system in October 2020 also could have compromised them, but he had no evidence of that.

Subsequent events

19. On 11 June, Ms B telephoned the medical centre and advised a nurse that Mr A had been deteriorating. The records show that Ms B queried whether Mr A should be referred to the Care Co-ordination Centre (CCC)[5] or the hospice and requested that Dr C return her call. Dr C later documented that he was unable to reach Ms B or Mr A by telephone. He therefore asked the nurse to refer Mr A to the CCC and explore whether he would consent to a hospice referral.

[5] A needs assessment and service coordination centre that assists individuals with health and disability needs to access appropriate support services and to live as independently as possible.

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20. On 12 June, Ms B spoke to the nurse at the medical centre again and advised that Mr A had been taken to Hospital 1, where he was found to have a large pleural effusion.[6] Mr A's pleural effusion was drained at Hospital 2 later that day. On 24 June, he returned to Hospital 2 to have an indwelling pleural catheter (IPC)[7] inserted to manage recurrent fluid collection.

21. Ms B told HDC that Dr C was 'negligent' by not reviewing Mr A in person on 3 June as pleural effusion is known to be common in cancer patients.

27 June 2020 — house call by Dr D

22. On 27 June, Mr A began reporting pain at his IPC wound site. Ms B said that he also seemed to have a fever and just wanted to sleep, so she contacted the district nursing service. Registered Nurse (RN) E visited Mr A. She documented that his temperature was 38°C and he felt hot and had taken oral morphine twice that day for pain. RN E also noted that Mr A's 'IPC site [was] checked, redness and heat coming from the area, friend says not different from yesterday, dressing intact, no visible leakage'. Ms B told HDC that the district nurse did not inspect the dressing on Mr A's IPC site.

23. At around 6pm, RN E telephoned the medical centre to request a GP house call due to Mr A's pain and temperature. Dr D attended as she was the on-call doctor at the medical centre. Ms B said that Dr D did not bring equipment to take Mr A's temperature or blood pressure. Ms B was also concerned that Dr D did not inspect Mr A's IPC site.

24. Dr D said that she has her own equipment for house calls, but she did not bring it to Mr A's home as she was nearby when she received the request to visit him, she knew that the district nurse was already there, and she did not want to 'lose time unnecessarily' by going home to get her house call bag. Dr D said that she personally used the district nurse's very good quality equipment to take Mr A's vital signs.

25. Dr D documented that Mr A's temperature was 38°C, and he had no rigors, chills or sweats, no increased shortness of breath, and no abdominal pain or pain passing urine. However, he was having episodes of sudden stabbing pain around his pleural drain with certain movements. Dr D recorded Mr A's blood pressure (120/80mmHg) and pulse (109 beats per minute) and noted that he had 'superficial' redness around his IPC site. Dr D's impression was that Mr A had an infection, although the site of the infection was unclear. She prescribed Mr A the broad-spectrum empiric antibiotic cefalexin.[8]

26. Ms B stated that Dr D incorrectly informed her that the after-hours pharmacy was open until 9pm to dispense Mr A's antibiotics. However, when Ms B arrived at the pharmacy at 7pm, she found that it had closed at 6.30pm. The medical centre told HDC that Dr D apologised for having given Ms B incorrect information about the pharmacy's opening hours.

[6] Fluid build-up in the space between the lungs and chest wall, causing shortness of breath and pain.
[7] A small, flexible tube used to remove fluid from around the lungs.
[8] Empiric antibiotics are given for suspected infection before the cause of the infection is known.

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27. Ms B said that she spoke to a telephone health service[9] for assistance and was advised that there were no other pharmacies near her that would still be open to dispense the antibiotics. Eventually, she called an ambulance to take Mr A to Hospital 2, where he received intravenous (IV) antibiotics. Hospital 2 doctors later concluded that Mr A's pain was primarily from tight sutures at his IPC site.

28. Dr D told HDC that she had assumed, rather than confirmed, that Ms B was staying at Mr A's home. Dr D said that had she known that she was not, she would have given more detailed safety instructions and potentially asked Ms B to stay with Mr A. Dr D cannot recall 'formally' discussing the option of hospital admission with Mr A, and her impression was that he did not want to go to hospital. Dr D said that she did not want to stress him or make his death more traumatic, and she hoped the antibiotics would allow Mr A to stay in his home. She acknowledged that she has since become more aware of the need to ask for and document consent, even where the patient would rather not discuss the matter. Dr D also recognised that she did not document any safety-netting instructions at this visit. She said that it was her usual practice to do so, and her documentation and safety-netting was now much more consistent.

29. Dr D stated that she did not inspect Mr A's IPC site as the district nurse had recently dressed it and it did not appear clinically necessary to disturb the dressing (RN E's notes state that she in fact inspected the dressing and found it intact). Dr D said that she saw no redness suggestive of skin infection beyond the edges of the small dressing at the IPC site (she documented 'superficial' redness) and the district nurse did not report any signs of infection. Dr D said that her differential diagnosis was a skin or lung infection, which she decided to treat with a broad-spectrum antibiotic, and inspecting the IPC site would not have made any difference to that decision.

30. The medical centre said that it has an emergency kit for its on-call doctors. In addition, every doctor is expected to have a personal kit for house calls and rest-home visits, with the contents of the kit stipulated and audited by the RNZCGP.

Complaint to medical centre

31. Two days later, on 29 June, Ms B telephoned the medical centre to complain about the outcome and cost of Dr D's house call. A Complaint Record form was completed, and Dr D was made aware of Ms B's concerns. Dr D was unable to reach Ms B by telephone that day but documented having had a 'long discussion' with her about her complaint on 1 July, during which Dr D told her:

> 'I did not discuss end of life options with [Mr A] as such … I did not explain that the option was to stay or to go to hospital, I admitted that the very cheerful ambiance at their home had made me make these decisions by myself and I had known that [Mr A] could become septic but I had thought that his wishes would have been to stay at home if possible and that I had assumed that because we were in a palliative situation. I also

[9] A 24 hours a day, 7 days a week free telephone health service that provides health advice, information, and treatment from professional healthcare providers.

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admitted that, again because of the cheerful tone, I had not realised to what extent [Ms B], as a carer, was stressed and tired.'

32. Dr D documented that she told Ms B that she would explore having the house call charge of $185 credited, and that Dr C had later approved the credit. The medical centre said that subsequently it apologised to Ms B that the credit (a goodwill gesture) was not processed until early August 2020.

33. Ms B told HDC that Dr D listened to her complaint, took full responsibility, and apologised sincerely. Ms B said she felt that Dr D had resolved the concerns she had raised about her house call.

27 August 2020 — face-to-face consultation with Dr C

34. Ms B said that Mr A was seen by a district nurse on 27 August and noted to have worsening bloody pleural effusion, increased weakness, a rapid heart rate, shortness of breath, and pale skin. The district nurse made an appointment for Mr A to see Dr C that afternoon.

35. Dr C told HDC that he saw Mr A for right posterior hip/flank pain, for which Mr A was taking morphine. Dr C's notes of the consultation state that Mr A also had decreased appetite and some constipation, and he was pale, short of breath at rest, and had a dull left base on chest examination (indicative of abnormal lung density). Dr C considered that Mr A was 'deteriorating overall'. Dr C felt that Mr A's pain may have been muscular or from his right kidney, and he ordered a urine test (which ultimately was negative for infection). Dr C also increased Mr A's morphine and laxative doses and recommended that he go to hospital if his pain was not controlled adequately. Dr C noted that Mr A wanted to remain at home.

36. Ms B raised concerns that Dr C did not order blood tests or an X-ray for Mr A at this consultation. She said that Dr C had 'pondered over an x-ray, and also pondered over an iron transfusion for anaemia', but then ordered a urine test only.

Subsequent events

37. On 31 August, Dr C received a fax from a palliative care co-ordinator at the hospice. She said she had visited Mr A the previous day and he wanted to have a blood test to 'gauge where he is at'. Dr C arranged for Mr A to have a blood test on 2 September. Dr C said that when the blood test results became available later that day, he telephoned Mr A with the result but was unable to contact him. The telephone call was not documented.

38. On 7 September, Mr A was admitted to Hospital 2 and diagnosed with MSSA sepsis.[10] Ms B considers that Dr C's failure to order blood tests or an X-ray on 27 August delayed Mr A's sepsis diagnosis. In addition, Ms B contends that if those investigations had been done, they may have prevented Mr A developing sepsis. Ms B was also critical that Dr C did not advise Mr A of his 2 September blood test results. This is not disputed by Dr C.

[10] MSSA is an infection caused by methicillin-susceptible *Staphylococcus aureus* bacteria. Sepsis occurs when the body has an abnormal, extreme response to an infection. The body's own infection-fighting processes turn on the body, causing organs to work poorly and become damaged. Sepsis is a medical emergency.

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39. Dr C told HDC that usually he would try to contact a patient about their test results once or twice himself 'if it was critical', and then task a staff member with making further attempts to contact the patient. There is no record that Dr C tasked another staff member to contact Mr A on his behalf. Dr C said he suspects that he did not pass on the result to a staff member as he wanted to speak to Mr A himself, and he would have delayed documenting the situation until he had done so. Dr C stated that it was an 'omission' and he apologised that he did not persist in contacting Mr A.

40. The medical centre said that it had a policy in place at the time regarding follow-up of test results. The July 2018 policy stated that the person who generates a test request is responsible for ensuring that the results are followed up appropriately. The policy dictates that test results are notified in various ways depending on whether they are urgent, normal, or abnormal, and whether the result was expected. Relevant to Mr A's case, the policy stated:

> '[I]f the patient's test result[s] are abnormal (not urgent but unexpected) the doctor's comments will be conveyed to the patient by the Practice Nurse and appropriate follow-up arranged.'

41. The medical centre also provided evidence that its policy and practice for test result notification had passed an RNZCGP Cornerstone[11] programme assessment for 2016–2019.

Responses to provisional opinion

42. The sections of the provisional opinion that relate to Dr C were sent to him for comment. Dr C advised that he had no further comments.

43. The sections of the provisional opinion that relate to Dr D were sent to her for comment. Dr D replied that she had no further comments.

44. Information material to the provisional opinion was provided to Ms B for comment. Ms B confirmed that Dr D had taken appropriate steps to resolve her complaint about the house call of 27 June 2020. She also clarified details relating to the initial treatment of Mr A's pleural effusion, review of his IPC site at the house call, and the delayed refund of the house call charge. This information has been incorporated into this opinion where appropriate.

Opinion: Dr C — breach

45. Having undertaken a thorough assessment of the information gathered and guided by the in-house clinical advice I received from Dr David Maplesden, I am critical of aspects of Dr C's clinical record-keeping and communication during his care of Mr A. I have set out my opinion on these matters below.

[11] A voluntary quality programme operated by the RNZCGP, which supports general practices across New Zealand to provide safe, equitable, and high-quality health care.

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Consultation of 3 June 2020

46. Ms B submitted that Dr C should have reviewed Mr A in person on 3 June 2020, rather than undertaking a telephone consultation, due to Mr A's cancer history and to aid the communication of his symptoms.

47. It is notable that Dr C told HDC that it would have been better for him to have referred Mr A to another (immunocompetent) GP on 3 June. I accept this submission by Dr C, and recognise his forthright reflection that referral was appropriate once he realised that Mr A needed more than repeat prescriptions. Dr C's notes refer only to the consultation being 'virtual' due to the COVID-19 pandemic and make no mention of the symptoms or treatment he discussed with Mr A. As a result, I could not determine the adequacy of Dr C's assessment of Mr A.

48. Good quality clinical records are crucial to ensuring safe, effective, and timely health care. They reflect a doctor's reasoning and are an important source of information about a patient's current and previous care. The Medical Council of New Zealand (MCNZ) sets out the standards expected of doctors in its *Good Medical Practice*[12] publication and its published statements. The MCNZ's record-keeping standards are detailed in its 'Managing patient records' statement (October 2019):[13]

> '[Doctors] must maintain clear and accurate patient records that note: clinical history including allergies; relevant clinical findings; results of tests and investigations ordered; information given to, and options discussed with, patients (and their family or whānau where appropriate); decisions made and the reasons for them; consent given; requests or concerns discussed during the consultation; the proposed management plan including any follow-up; [and] medication or treatment prescribed including adverse reactions.'

49. Dr Maplesden advised that telephone consultations require the same standard of clinical documentation as face-to-face consultations. This was made clear in the RNZCGP's November 2017 'telehealth' statement, which was available at the time of Mr A's 3 June telephone consultation.[14]

50. Dr C started Mr A on a new prescription for morphine at the 3 June consultation, and Dr Maplesden made a distinction between that situation with a new medication and a routine consultation for a repeat of previously prescribed, regular medication. Dr Maplesden noted:

> '[T]he initiation of morphine … implies a change in [Mr A's] clinical condition requiring a change in management. There is no reference [in the notes] to discussion of the

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[12] MCNZ, *Good Medical Practice*, November 2021, https://www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf

[13] The version valid at the time of Mr A's 3 June 2020 consultation.

[14] RNZCGP, Telehealth and technology-based health services in primary care, November 2017, https://www.rnzcgp.org.nz/gpdocs/New-website/Advocacy/Position-Statements/Telehealth-and-technology-based-health-services-in-primary-care-updated-....pdf.

symptoms requiring initiation of morphine, or how the severity of the symptoms was assessed.'

51. Dr Maplesden considered that this was a moderate departure from the accepted clinical record-keeping standard. I agree. The omissions in Dr C's notes mean that they do not provide an understanding of his care of Mr A on 3 June as they should. I commend Dr C's open acknowledgement of that.

Consultation of 27 August 2020 onwards

52. Ms B raised concerns that Dr C failed to order blood tests or an X-ray at Mr A's consultation on 27 August. She also complained that Dr C then did not inform Mr A of his 2 September blood test results. I accept Dr Maplesden's advice that Dr C's 27 August assessment of Mr A was adequate, and that blood tests were not required at that time. Dr Maplesden stated that with Mr A receiving palliative care and approaching end of life, it was not imperative to investigate his symptoms further with blood tests.

53. On 2 September, Dr C received the results of the blood test Mr A had requested. They showed moderate iron deficiency anaemia,[15] with Mr A's haemoglobin[16] having dropped significantly from his previous result. Dr Maplesden advised that Dr C 'had a responsibility to notify Mr A of any significantly abnormal result in a timely manner'. As Dr C has openly acknowledged, this did not happen. Dr Maplesden considered that this communication failure was a moderate departure from the accepted standard of care.

54. Dr C said that when he cannot reach a patient with their test results, he passes the results on to a staff member to communicate on his behalf. Dr C's normal actions are in line with the medical centre's process for notifying test results, but it is evident that this process was not followed on this occasion. Dr Maplesden advised that while notification of the results 'was not critically urgent', he would expect further efforts to have been made by the end of the week (4 September). I agree. An iron transfusion to treat Mr A's symptomatic iron deficiency anaemia could have been contemplated at that point if further efforts had been made to inform him of his test results.

55. As it is, there is no evidence that Mr A received the results at all. Dr Maplesden considered that Dr C's failure to convey the results did not have an impact on Mr A's subsequent deterioration with sepsis, yet nevertheless it was a failure to provide information that Mr A could reasonably have expected to receive.

Conclusion

56. Dr C accepted that he failed to fully document his consultation with Mr A on 3 June 2020 in line with accepted record-keeping standards. As a result, neither Mr A's presentation on that day nor the adequacy of the consultation could be established by this investigation. Further, Dr C did not inform Mr A of his 2 September blood test results. This communication

[15] Iron deficiency anaemia is a lack of healthy red blood cells to carry oxygen around the body due to insufficient iron.

[16] A protein containing iron that facilitates the transport of oxygen in red blood cells.

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oversight meant that Mr A was not made aware that he was moderately anaemic, and the possibly of an iron infusion to treat his symptoms was not discussed with him.

57. Accordingly, I find that Dr C breached Right 4(2) of the Code by failing to keep full, accurate patient records that complied with the relevant professional and ethical standards, and failing to inform Mr A of blood test results that he could reasonably have expected to receive.

Opinion: Dr D — breach

58. Having undertaken a thorough assessment of the information gathered and guided by the in-house clinical advice I received from Dr David Maplesden, I am critical of aspects of Dr D's communication during her call-out to Mr A's home. I have set out my opinion on these matters below.

House call of 27 June 2020

59. Ms B complained that Dr D arrived at Mr A's home without the equipment to take his temperature or blood pressure and failed to inspect his IPC site.

60. I am not critical of Dr D's decision to attend Mr A's house call without her own equipment. In my view, Dr D made a considered and reasonable decision to do so, after weighing the fact that the district nurse was known to be on site and could be expected to have the necessary equipment, against the time it would take her to retrieve her own equipment from her home. Dr D was able to take Mr A's temperature and blood pressure using the district nurse's equipment as she had anticipated. I have seen nothing to suggest that this visit to Mr A's home without her own equipment represents Dr D's usual approach to house calls.

61. Dr D told HDC that she did not inspect Mr A's IPC insertion site as it was not clinically necessary (it appears that Dr D also understood that the site had been redressed by RN E, who in fact documented that she only inspected the site). Dr Maplesden stated that as Dr D did not inspect the IPC site, best practice would have been for her to have sought information from the district nurse as to whether she had any concerns about the IPC site. I am satisfied that Dr D did that. While she could not recall whether she asked the nurse directly if there were any signs of infection, Dr D noted that RN E (who had herself requested the GP home visit) was present during her assessment of Mr A and would have told her if she had suspected infection. Dr D also documented noting 'superficial' skin redness around the dressing on Mr A's IPC site, and discussing it with Ms B, who told her that the redness had not increased over the previous two days. RN E similarly documented that Ms B (referred to as 'friend' in her notes) told her that Mr A's IPC site appeared no different from the previous day.

62. I accept Dr Maplesden's advice that overall Dr D's assessment of Mr A was satisfactory. Her prescribed treatment with a broad-spectrum empiric oral antibiotic would also have been satisfactory provided Mr A could be monitored by a responsible adult, his antibiotics were

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accessible in a timely manner, and appropriate safety-netting advice was provided. I am critical that Dr D did not ensure that these provisos were in place.

63. Dr D assumed, rather than confirmed, that Ms B would be staying overnight with Mr A. As Ms B was not planning to stay, Mr A would not have been monitored overnight. Dr Maplesden said that Mr A should have been offered the option of hospital admission in that situation. In her record of her telephone call with Ms B, Dr D noted that she did not give Mr A the option of hospital admission as she 'thought his wishes would have been to stay at home if possible and … had assumed that because we were in a palliative situation'. Dr Maplesden considered that Dr D's failure to discuss hospital admission with Mr A represented a mild to moderate departure from the accepted standard of care.

64. As it was, Mr A was admitted to hospital that evening after Ms B was unable to fill his antibiotic prescription as the after-hours pharmacy was closed. Dr D had given Ms B the opening hours of the pharmacy but was unaware that those hours had changed. The medical centre told HDC that Dr D apologised for the inconvenience she had caused by mistakenly giving Ms B incorrect information about the pharmacy's opening hours. While unintentional, this was a shortcoming in Dr D's care. Her treatment plan relied on Ms B being able to obtain Mr A's antibiotics from the after-hours pharmacy that evening.

65. The problem Ms B encountered when trying to fill Mr A's prescription was possibly compounded by a lack of safety-netting advice. Safety-netting ordinarily comprises instructions about the treatment given and advice about actions that should be taken if the patient's condition changes or fails to improve within a certain timeframe or concerns arise in the future. Dr D stated that her usual practice was to provide this information, and she believes she would have done so for Mr A. It has not been possible to confirm that, however, as Dr D's notes of the house call do not mention safety-netting advice. In this respect, Dr D's record-keeping did not meet MCNZ's record-keeping standards.[17]

Conclusion

66. My investigation of Dr D's house call to Mr A highlights the importance of clear, open, and honest communication in the delivery of safe and effective patient care. It is notable that Dr D recognised most of the issues I have identified at the time. Dr D documented:

> '[I was critical] that I did not discuss end of life options with [Mr A] as such, that I did not explain that the option was to stay or go to hospital. I admitted that the very cheerful ambiance at [Mr A's] home had made me make these decisions by myself.'

67. I commend Dr D's frank reflection on this matter.

68. Determining whether Dr D's failures during the house call met the threshold for a breach of the Code was not straightforward. Had Mr A not been particularly vulnerable and at the end of his life, an adverse comment about Dr D's care may have been more appropriate than a breach finding. Given the circumstances at the time, however, I find that Dr D breached

[17] MCNZ, 'Managing patient records' statement (October 2019). This version was valid at the time Dr D attended Mr A's home on 27 June 2020.

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Right 4(1) of the Code, in that she failed to communicate all relevant and/or accurate clinical information, culminating in a failure to provide services to Mr A with reasonable care and skill.

Opinion: Medical centre — no breach

69. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. I have considered whether the medical centre's processes or systems, including those regarding test result notifications and doctors' house call kits, contributed to any of the failings I have identified in the care provided to Mr A.

70. In my view, Dr C's and Dr D's errors were individual failings that do not reflect broader systems issues at the medical centre. Further, the RNZCGP Cornerstone programme assessment for 2016–2019 demonstrates that the medical centre had appropriate processes in place for test result notifications and the provision and maintenance of portable doctors' kits prior to Mr A's care in 2020.

71. I am also satisfied that the medical centre managed Ms B's verbal complaint appropriately. It was documented accurately, and it was fitting that Dr D responded on behalf of the medical centre. Dr D contacted Ms B within two days of receiving her complaint and documented their discussion in Mr A's records. Dr D's detailed notes suggest that the matter was resolved to the extent possible at that time. Ms B advised that she would send a written complaint to the medical centre for a formal response, but there is no indication that she did so. The medical centre refunded the house call fee Ms B paid, albeit late. These were reasonable actions by the medical centre in response to Ms B's concerns.

72. In conclusion, I find that there was no breach of the Code by the medical centre.

Changes made since events

73. Dr C provided HDC with a clinical notes audit he completed in July 2023, focusing on 10 randomly selected telephone consultations he had undertaken.[18] Dr C stated:

> '[A]ll notes were present and accessible, follow up was clear and results were noted. There were some deficiencies in recording family and social history, which I will try to remedy on a case-by-case basis.'

[18] Module 2 of the RNZCGP 'Clinical record review self-audit checklist.'

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Recommendations

74. I recommend that Dr C:

a) Provide a written apology to Ms B (on behalf of Mr A) for the deficiencies identified in this report. The apology should be sent to HDC, for forwarding to Ms B, within three weeks of the date of this report.

b) Undertake refresher training on clinical record-keeping. The training should be in conjunction with, or endorsed by, a relevant professional association or authority. Evidence of completion of the training should be provided to HDC within three months of the date of this report.

c) Repeat the RNZCGP clinical record review self-audit checklist, focusing on Indicator 14 of Module 2 only (relating to test result follow-up actions).[19] A copy of the audit results, and the completed 'Report and Plan template' if necessary, should be provided to HDC within three months of the date of this report.

75. I recommend that Dr D:

a) Provide a written apology to Ms B (on behalf of Mr A) for the deficiencies identified in this report. The apology should be sent to HDC, for forwarding to Ms B, within three weeks of the date of this report.

b) Reflect on the deficiencies in care identified in this case, particularly around communication, including end-of-life discussions, and provide a report about her reflections and the resultant changes she has made to her practice since the events. The report should be sent to HDC within three months of the date of this report.

Follow-up actions

76. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's and Dr D's names in the covering letters.

77. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[19] Based on Dr C's July 2023 results for Indicator 14 of Module 2 of this audit.

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Appendix A: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from Dr David Maplesden, a general practitioner, on 22 July 2021:

'1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a practising general practitioner. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her friend [Mr A] (dec), by staff of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the following information:

- Complaint from [Ms B]
- Response from [Dr C]
- GP notes [the medical centre]
- [The] DHB clinical notes [Hospital 1] and [Hospital 2]

2. Clinical notes show [Mr A] was diagnosed with a non-small cell lung cancer in 2017 and underwent partial lung resection in November of that year. In May 2019 he was investigated for respiratory symptoms and recurrence of the cancer was diagnosed associated with recurrent pleural effusion. The recurrence was not treatable and palliative care was introduced. [Mr A] had co-morbidities of hypertension, atrial fibrillation, previous CVA and lumbar spine issues. [Ms B] was a close friend of [Mr A] and was his primary support person as his illness progressed. [Ms B] raises the following issues in her complaint:

   i. Adequacy and appropriateness of a telephone consultation on 3 June 2020 (Covid level 2) when [Mr A] reported fatigue, cough and shortness of breath and was prescribed morphine for the first time. [Mr A] continued to deteriorate and [Ms B] took him to hospital several days later where he required draining of a large pleural effusion.

   ii. [Mr A] was admitted to [Hospital 2] on 23 June 2020 and discharged on 25 June 2020 following insertion of an indwelling pleural catheter (ICP). On (Saturday) 26 June 2020 [Mr A] was complaining of pain around the ICP site and was drowsy, confused and feverish. A district nurse assessed him later that day and confirmed a fever and advised GP review. When the GP arrived she did not have a thermometer or blood pressure machine and did not review the ICP site. [Ms B] is concerned at these omissions. The GP prescribed oral antibiotics but there was no pharmacy open to collect these and [Ms B] eventually rang an ambulance. [Mr A] was admitted to hospital and required IV antibiotics for a wound infection.

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iii. On 27 August 2020 [Mr A] attended [Dr C] with general deterioration in his condition including weakness, increasing bloody pleural effusion associated with shortness of breath, pallor and rapid pulse. [Dr C] diagnosed bleeding from the kidneys and took a urine sample but no other tests. Hospice recommended a blood test and [Dr C] arranged this on 1 September 2020, stating at this time the urine test was clear. By 7 September 2020 [Mr A's] condition had deteriorated further and blood tests results had not been notified. A visiting district nurse contacted hospice who recommended hospital admission. [Mr A] was admitted and diagnosed with a life-threatening MSSA sepsis. [Ms B] is concerned that the blood tests results were never conveyed to [Mr A] and inadequate follow-up by [Dr C] contributed to the delayed diagnosis of sepsis.

3. On 3 June 2020 [Dr C] states he had a telephone consultation with [Mr A] for repeat of his usual medications and *I also prescribed him a small amount of morphine elixir to help with chest pain and cough … I do not recall whether he seemed markedly more short of breath during [the consultation].* GP notes record the prescriptions provided as per the response including morphine elixir 1mg/ml, 1.25–5ml PRN up to Q4hrly. The actual consultation note reads: *Virtual Consultation — COVID Pandemic lock-down: Response to reduce face to face consultations as per College of GPs. Virtual consultation without seeing patient. Verbal patient consent obtained.* This may be a preformatted entry.

   Comment: The same standards of clinical documentation apply to a telephone consultation as to a face-to-face consultation[20]. The initiation of morphine in this case implies a change in [Mr A's] clinical condition requiring a change in management. There is no reference to discussion of the symptoms requiring initiation of morphine, or how the severity of the symptoms was assessed in terms of determining whether it was appropriate to undertake a tele-consultation in preference to a face-to-face consultation. In the absence of this documentation, I am unable to comment on the adequacy of the assessment and [Mr A's] subsequent deterioration was not necessarily evident at this point i.e. it may have been appropriate to undertake the telephone consultation if the symptoms were deemed to be mild in nature and were an expected part of the progression of [Mr A's] disease.

   However, I am moderately critical at the standard of clinical documentation on this occasion when morphine was initiated and there is no reference to the indications or assessment of the patient in this regard. I would be somewhat less critical if this had been a routine consultation for repeat of previously prescribed regular medications. The use of tele-consultations is accepted practice[21] and frequency of such consultations has increased markedly since the Covid pandemic as directed by the

[20] RNZCGP statement "Telehealth and technology-based health services in primary care" (November 2017). https://www.rnzcgp.org.nz/gpdocs/New-website/Advocacy/Position-Statements/Telehealth-and-technology-based-health-services-in-primary-care-updated-....pdf
[21] Medical Council of New Zealand statement "Telehealth" (October 2020). https://www.mcnz.org.nz/assets/standards/c1a69ec6b5/Statement-on-telehealth.pdf

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Ministry of Health. It is vital from a patient safety and medico-legal perspective that accepted standards of clinical documentation are maintained for these consultations. I recommend [Dr C] perform a clinical notes audit (per module 2 of the RNZCGP audit resource[22]) for ten randomly selected telephone consultations and provide to the Commissioner the results of this audit and any planned improvements.

4. On 11 June 2020 [Ms B] spoke with a [medical centre] practice nurse. This is recorded as: *P/C from carer and noted NOK [Ms B] concerned re [Mr A]. he has lung ca and she has noticed a recent deterioration in his condition over the last 1/12 eg unable to walk around the supermarket, walk to letter box. [Ms B] visits x 3 weekly and phones [Mr A] daily Msge to [Dr C] — ? needs review, referral to CCC* [Care Coordination Centre] *or* [the hospice]. *[Ms B] suggest contacting her — ph number in NOK details as [Mr A] is hard of hearing and often does not pick up the phone. She will discuss with [Mr A] her call to me also suggested making official her ability to speak for [Mr A] etc.* [Dr C] states he attempted to contact both [Mr A] and [Ms B] but was not successful. He tasked the practice nurse with referring [Mr A] to CCC (confirmed in notes) and establishing whether [Mr A] would accept a referral to [hospice] (previously declined by the patient). When the nurse contacted [Ms B] on 12 June 2020, [Mr A] had been admitted to hospital and a decision regarding ongoing support from [the hospice] was deferred until his discharge. Inpatient notes refer to a history of progressive *SOB over weeks to months limited to a few meters … started morphine for a cough productive of white sputum that has been helped by this ….* Hospital notes include a referral letter from [Hospital 1 doctor] dated 11 June 2020 which records history of *3/7 L rib pains and SOB worse on exertion.* [Mr A] was admitted to hospital for drainage of a large left-sided pleural effusion. He was referred to [the hospice] for community assessment following discharge (letter of acceptance received at [the medical centre] 22 June 2020) and insertion of an IPC was scheduled for 24 June 2020.

   Comment: It is apparent [Mr A] had a gradual deterioration in his breathing status over weeks to months prior to his admission with a more abrupt deterioration in the three days prior to admission (i.e. sometime after the telephone consultation of 3 June 2020). [Medical centre] staff made appropriate efforts to contact [Mr A] and [Ms B] following [Ms B's] message on 11 June 2020 but were unsuccessful. [Ms B] evidently sought GP review of [Mr A] at [Hospital 1] A&M later the same day. I would expect [Dr C] to have seen [Mr A] for review on 11 June 2020 if he was provided with the history recorded by [the Hospital 1 doctor] but he was not given the opportunity to do so.

5. As noted in the complaint, [Mr A] had another admission to [Hospital 2] 23–25 June 2020 with re-accumulation of his pleural effusion. This was managed with insertion of an IPC and antihypertensive medications were stopped because of low blood

[22] https://www.rnzcgp.org.nz/gpdocs/New-website/Quality/Draftv1RecordReviewAUGUST2018.pdf

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pressure. There was a palliative care consultation during the admission recorded as: *He was seen by [the palliative care consultant] while an inpatient. We discussed his symptoms, mainly breathlessness and cough. He was advised to take morphine elixir as required for breathless[ness], cough or pain, and to take metoclopramide and laxsol with it to prevent nausea and constipation, and he was agreeable to this plan. We also broached the topic of prognosis — this was estimated at 8 months a year ago by his oncologists, and [Mr A] understands that while it is great he continues to feel well that his cancer is progressing and the role of hospice is to help manage his symptoms on an ongoing basis. Currently he lives alone and gets support from a close friend. He has been referred to community hospice who will link in with him in the coming days to provide equipment etc. as necessary.* District nurses were to assist with the IPC drainage and removal of sutures.

6. On 27 June 2020 the district nurse attending [Mr A] noted he was complaining of pain around the IPC insertion site and had a fever of 38.0. He had no urinary or abdominal symptoms and was otherwise stable. On-call [medical centre] doctor, [Dr D] undertook a home visit. Her notes include: *Saturday evening home visit with DN [RN E]. [Mr A] has* [Temp] *38, says fine, no rigors or chills or sweat, no increased sob, no pain passing urine, no abdo pain, parox stabbing pain around pleural drain, usually when he moves in a certain way it then subsides. Daughter present … says [Mr A] might not actually tell if he is not well. oe in bed, cheerful, colours ok lungs: reduced ae but ae nevertheless L lung\bp 120/80 \p109 superficial skin erythema around dressing (seem to have had reaction to a prior dressing, as per daughter redness not increased over the last 2 days. imp: fever, no focal site of infection found, lung? drain? Plan: cefalexin empiric.* [Dr D] was under the impression the antibiotics prescribed could be obtained from an after-hours pharmacy and apologised this information was incorrect. [Mr A] presented to hospital by ambulance later on 27 June 2020 when the antibiotics could not be obtained. Admission notes refer to no change in [Mr A's] breathing but presence of fever and tachycardia (P 109). CRP was elevated but white cell count normal. IV Augmentin was commenced to cover for *potential skin/pleural infection* but cultures were negative and antibiotics changed to oral. It was felt the IPC insertion site pain was due to constricting sutures rather than infection and some sutures were removed with relief of pain. [Mr A's] fever settled and he was discharged on 30 June 2020 on oral antibiotics following further drainage of his effusion.

   Comment: There is no reference in [Dr C's] response to [Dr D] not having a sphygmomanometer or thermometer on her visit. I note both blood pressure and temperature were recorded as part of the assessment, presumably using the district nurse's equipment or noting recordings taken by the district nurse. Either of these scenarios contributed to what appears to be a satisfactory assessment of [Mr A] by [Dr D] although best practice would be to have viewed the IPC insertion site unless the district nurse had already done this and reported no particular concerns (and there was no suspicion of cellulitis at the insertion site noted during [Mr A's] hospital

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admission). While the RNZCGP specifies equipment a practice should hold[23] there is no longer a particular specification for home visit equipment. Some practices will have a "practice" home visit bag checked and maintained regularly by nursing staff. Other GPs may have their own "visit bag". I would expect a GP performing a home visit to carry the equipment required to perform an adequate assessment of the patient in the home environment. In a patient such as [Mr A], when there was a possibility of sepsis, measuring temperature and blood pressure are an important part of the assessment process and it is practical to carry the equipment for this. These measurements were undertaken and I am unable to fault [Dr D's] assessment. However, had she not recorded blood pressure or temperature I would be critical of the assessment, including the failure to bring appropriate equipment to enable an assessment appropriate to the clinical scenario presented.

[Mr A's] condition was apparently stable with no red flags for sepsis although some amber flags were present.[24] I believe it was reasonable under the circumstances to prescribe a broad spectrum oral antibiotic empirically provided [Mr A] could be monitored by a responsible adult, the antibiotic was accessible in a timely manner, and appropriate safety netting advice was provided. If [Mr A] did not have a responsible adult at home, I believe he should have been given the option of hospital admission and would be mildly to moderately critical if this was not done. [Dr D] was not aware the after-hours pharmacy had changed its hours and prescribed the antibiotic with the expectation it could be accessed the same day. Best practice is to document any safety netting advice provided (not evident in [Dr D's] notes).

7. On 27 August 2020 a district nurse contacted [Dr C] with concerns that [Mr A] had right flank pain, decreased appetite and a general deterioration in his condition. [Dr C's] response includes: *I saw [Mr A] later that day. He had right posterior hip/flank pain. He was using the morphine resulting in some constipation and poor appetite. He wanted to remain at home. On examination he was pale, short of breath at rest. His weight was 62kg, BP 130/80. Pulse 90, oxygen saturations 82%. He had a tender right flank, chest examination revealed a dull left base. My assessment was that the pain may have been from his Rt kidney or may have been muscular. I recommended a urine test which was subsequently normal. I increased his morphine and laxative. I recommended that he consider going to hospital if his pain wasn't adequately controlled. On 1 September 2020 I received a note from [the hospice] asking about his blood count and arranged for a blood test the following day. I tried to call [Mr A] with the result but was unable to connect.* Clinical notes are consistent with the response. MSU was negative for infection. On 1 September 2020 [Dr C] received a fax from the [hospice] palliative care coordinator (dated 31 August 2020) which includes: … *I saw [Mr A] and [Ms B] yesterday at [Ms B's] home. He was in reasonably good spirits having just had a pleural drain — but as you [k]now does get SOB prior to*

[23] https://www.rnzcgp.org.nz/Quality/Foundation/Appendix_1/Quality/Foundation_pages/Appendix_1.aspx?hkey=8c255025-8066-4757-8b79-54fdc919d9ff

[24] https://www.nice.org.uk/guidance/ng51/resources/algorithm-for-managing-suspected-sepsis-in-adults-and-young-people-aged-18-years-and-over-outside-an-acute-hospital-setting-2551485716

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this being done. His back pain has disappeared over the last few days. [Mr A] didn't want to engage in planning for the time when he will deteriorate. He is however interested in having a blood test to gauge where he is at and what his HB [haemoglobin] *is. Would this be something you would consider?* [Dr C] arranged a blood test which was performed on 2 September 2020. Results showed a picture consistent with moderate iron deficiency anaemia (Hb 83 g/L, reference range 130–175, hypochromia, microcytosis, low ferritin) but normal white cell count and differential, borderline elevation in CRP, normal renal function. [Dr C] states he made an attempt to contact [Mr A] with the result but *was unable to connect*. [Mr A] was admitted to hospital on 7 September 2020 having deteriorated in the few days prior to admission (see below).

Comment: I believe [Dr C's] assessment of [Mr A] on 27 August 2020 was adequate although best practice would be to record temperature in a patient with loin pain if infection/pyelonephritis was suspected. If [Mr A] had new onset confusion I would expect this to be documented and considered as a possible red flag for sepsis[5] although other parameters measured were not suspicious for sepsis. With the benefit of hindsight, the blood tests results from 1 September 2020 were also not suspicious for sepsis (normal white cell count and differential, minimally elevated CRP) with results on 7 September 2020 showing an entirely different clinical picture. In the context of a patient receiving palliative care and approaching end of life, I do not believe it was imperative to investigate further by way of blood tests, but best practice might have been to have discussed this option with [Mr A] if anaemia was suspected. Safety netting advice was provided by way of offering hospital admission if [Mr A's] pain symptom worsened. The fax from [the hospice] was relatively reassuring and did not suggest there were major concerns regarding [Mr A's] current condition, with the blood test suggested as a general request from [Mr A]. I do not believe [Dr C] could foresee [Mr A's] apparent rapid deterioration from around 4 September 2020 leading up to his admission to hospital with sepsis.

Once the blood tests were requested, [Dr C] had a responsibility to notify [Mr A] of any significantly abnormal result in a timely manner. It appears an initial attempt to notify was made by [Dr C], but no further attempts had been made by the time [Dr C] became aware of [Mr A's] hospital admission on 7 September 2020. The result showed an iron deficiency anaemia with haemoglobin 83 g/L having dropped significantly from the previous result on file (108 g/L on 23 June 2020 during hospital admission). While notification of the result was not critically urgent, I would expect further attempts to notify the patient to have been undertaken (usually via referral to the practice nurse) before the end of the week (Friday 4 September 2020) and I am moderately critical this was not done. Although [Mr A] was receiving palliative care, the option of an iron infusion to treat symptomatic iron deficiency anaemia was still an option he might have considered and the failure to convey the haemoglobin result before 7 September 2020 (with no apparent plan in place for notification) I believe would be met with moderate disapproval by my peers. However, I do not believe the failure to convey the result impacted on [Mr A's]

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subsequent deterioration with sepsis. The practice should have a policy regarding notification of abnormal results to patients and a copy of this might be requested.

8. [Mr A] was re-admitted to hospital on 7 September 2020 with discharge summary noting history of: *[Man in his eighties] presenting with several days of increasing confusion, lethargy, lack of appetite, shortness of breath and fevers. Also reporting discoloured urine, although no urinary symptoms … Regular IPC drainages performed by DN in the community — recently good drainage volumes, with no chest pain or difficulties with drainage, although over past fortnight, increasingly blood stained pleural fluid. Rapid symptomatic deterioration over the past 3–4 days as above, and febrile with DN during IPC visit triggering presentation to hospital … T38, 118/68, RR32, 88%RA, HR 74-->120. Alert, fluctuating concentration, confusion evident …* haemoglobin had dropped further to 71 g/l, marked neutrophil leukocytosis present. [Mr A] was diagnosed with sepsis secondary to pleural line infection and received IV antibiotics and a blood transfusion. His condition stabilised and he was discharged to a long-term care facility on 16 September 2020 for palliative and end of life care.'

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