A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 02HDC05825)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer's mother
Mr B	Consumer
Mrs B	Consumer's wife
Medical and nursing staff at the public hospital	Providers
Dr C	Consultant general surgeon
Dr D	Director, Critical Care, at the public hospital
Dr E	Orthopaedic registrar
Mr F	Acting Service Manager, Clinical Services, at the public hospital
Dr G	Locum orthopaedic surgeon
Dr H	On-call orthopaedic surgeon
Dr I	Cardiothoracic surgeon
Ms J	Registered nurse

Complaint

On 1 May 2002 the Commissioner received a complaint from Mrs A, the mother of Mr B (then aged 26), regarding the circumstances in which he had been transferred from a regional hospital's Intensive Care Unit to a public hospital. The complaint was summarised as follows:

On 19 March 2002, the public hospital did not provide services of an appropriate standard to Mr B. In particular:

- *the public hospital did not directly admit Mr B to the Intensive Care Unit (ICU) following his transfer from the regional hospital.*
- *Mr B was left for several hours in the public hospital's Emergency Department, before being admitted to the High Dependency Unit. During this time, he was left unattended by medical staff, without pain relief, and was not made comfortable.*

An investigation was commenced on 26 September 2002.

Information reviewed

- Mr B's clinical records from the regional hospital
- Mr B's clinical records from the public hospital
- Letter from Dr C, consultant general surgeon at the regional hospital

- The regional hospital's Emergency Department guidelines and "Policy on Transport and Accommodation Assistance (1996)"
- Responses from the public hospital staff including Dr D (Director, Critical Care), Dr E (orthopaedic registrar), the Clinical Director of the Emergency Department and Mr F (Acting Service Manager, Clinical Services)
- Various guidelines and policies for inter-hospital transfers of the public hospital.

Independent expert advice was obtained from Dr Mary Seddon, Head of Quality, Medicine, Middlemore Hospital.

Overview

On 15 March 2002, Mr B suffered severe multiple injuries as a result of an accident. He was initially treated in the Intensive Care Unit ("ICU") at the regional hospital. Due to the nature of his injuries, the regional hospital decided that Mr B should be transferred to the public hospital for further management, particularly in relation to his fractured shoulder. On 19 March 2002 (coincidentally, his birthday), Mr B was transferred from the regional hospital to the public hospital by an ambulance service. Mr B's treating physicians at the regional hospital expected that he would be transferred directly to the public hospital's ICU and advised Mr B and his family to that effect. However, Mr B was in fact transferred to the public hospital's Emergency Department ("ED"), where he stayed for approximately four hours before being admitted to the High Dependency Unit ("HDU") under the care of the orthopaedic team.

Information gathered during investigation

On Friday 15 March 2002, Mr B sustained severe injuries when the digger he was operating rolled on a slope and he became trapped by his chest, upside down in the crushed cab. Immediately after the accident, when the engine of the digger was still running, a hydraulic pipe ruptured and hot hydraulic fluid ran over Mr B's right hand and fingers. Fire brigade officers freed Mr B and he was airlifted to the regional hospital.

Condition and treatment at the regional hospital

On admission at the regional hospital, Mr B was complaining of pain in his chest between the shoulder blades, in his right shoulder and down his right arm. His face had become bluish as a result of lack of oxygen, with bleeding under the skin, and there was bleeding into the mucous membranes of his eyes. On examination he was found to have burns over the back of his right hand and on his fingers, smaller areas of burns over the right side of his chest, a crush injury to his right arm, a bad fracture of his right shoulder blade, multiple fractured ribs and a fractured sternum. A subsequent CT scan revealed that Mr B's right

lung had collapsed. This was treated with drainage tubes. Mr B was transferred to ICU, where general surgeon Dr C was responsible for his care.

Dr C advised me that in ICU, the main problem with Mr B's management was his pain, particularly from his shoulder. A thoracic epidural was inserted on the day of admission to manage the pain, but this later had to be removed. On Sunday 17 March, a chest X-ray revealed probable fluid on the left side of Mr B's chest. His haemoglobin had fallen to 73 (normal range for an adult male is 140–170). A repeat CT scan showed a large amount of blood within the left lung. Tubes inserted into Mr B's chest drained a total of 850ml from the right side, and 1500ml from the left. On the Sunday night, four units of blood were transfused, which raised Mr B's haemoglobin to 102.

Mr B's pain management became less problematic after the insertion of a patient controlled analgesia ("PCA") pump to administer morphine. He also received droperidol and diazepam.

Decision to transfer and pre-transfer discussions between providers
Dr C advised me that Mr B's severe shoulder injury could not be managed at the regional hospital and, because of his associated chest injuries and burns, it was considered appropriate to transfer him to the public hospital for further management.

It is evident from the clinical notes that on Monday 18 March 2002, the regional hospital's locum orthopaedic surgeon, Dr G, spoke to Dr H, the on-call orthopaedic surgeon at the public hospital. Dr G recorded:

> "[Dr H] would agree to see [Mr B] in consultation for [right] glenoid neck fracture. Told [Dr H] patient had burns on right hand, abrasions on shoulder, significant shoulder girdle swelling and probable axillary nervous system injury. He agrees to see patient if patient transferred in stable condition with trauma team and in care of general or thoracic surgeon. Agrees surgery non-urgent until patient medically stable. Did not request CT scan of shoulder to be done here first. Spoke with physiotherapist re options of getting patient up. May use pillows, slings for comfort. Will continue to follow."

I have been advised that Dr G is overseas and I was unable to contact her during my investigation.

At 8.30pm on 18 March 2002, Dr C wrote in the clinical notes that he had discussed Mr B's transfer with Dr I, cardiothoracic surgeon, a plastic surgeon, and an ICU consultant, all of the public hospital. He recorded:

> "If possible transfer could be tomorrow but dependent on bed availability. [Dr D] intensivist on call tomorrow. Message will be passed on."

Dr C cannot now recall the name of the ICU consultant he spoke to, and advised me that he did not record it, either because he did not know it at the time, or because he felt that noting Dr D was the on-call intensivist the next day was sufficient. Dr C understood that his conversation with the ICU consultant would be relayed to Dr D, that the public hospital's

orthopaedic team would accept management of Mr B, and that he would be admitted to ICU if there was a bed available. Dr C explained that the possibility of transfer to HDU was not discussed.

I have reviewed Mr B's public hospital notes. Dr I recorded his conversation with Dr C, albeit retrospectively, on 20 March as follows:

> "I had a phone call from [Dr C] general surgeon at [the regional hospital] regarding [Mr B] on 18.3.02. History was that of a RTA with crush injury to chest, shoulder and burns to hand. Was told that [chest X-ray] reveals bilateral haemothorax and fractured ribs, fractured sternum with crushed scapula and shoulder. 2mg has drained from chest and post drainage chest x-ray has shown expansion of lungs and CT scan did not show any mediastinal injury. He had spoken to [Dr H] orthopaedic surgeon who suggested operative treatment to shoulder. He has also consulted with plastic team for the burn injuries. As chest injury care was the minor part of his injuries I asked him to contact ICU for transfer."

I do not see any entries in Mr B's public hospital notes by either the plastic surgeon or the on-call ICU consultant recording their conversations with Dr C.

The regional hospital transfer summaries
Dr C prepared a detailed Transfer Summary for the public hospital staff, dated 19 March 2002. In addition a registered nurse, Ms J, completed a set of "the regional hospital Nursing Transfer Notes" in which she recorded the following:

"Date of transfer:	19.3.02
From Ward/Dept:	ICU
Destination:	[The public hospital]
Ward/Dept:	ICU orthopaedic surgeon
Reason for transfer:	Specialist input for Right shoulder – orthopaedic. Right hand burn – ? plastic input.
Level of dependency:	Full assistance required due to pain on movement with fractured shoulder and ribs."

On the front page of the transfer notes, Ms J also recorded details of Mr B's current medical problems, nursing interventions and medications including that a PCA pump of "morphine 60mg/60ml" and left and right chest drains were in situ. She also noted that Mr B was "anxious at times, but this is lessening with pain more well controlled".

Ms J's final entry in the regional hospital's notes confirms "patient retrieved by [the ambulance service] [sic] at 1430hrs to go to [the public hospital's] ICU under orthopaedic surgeon with plastic specialist input also … Forms faxed."

Ms J advised me that the nurse who completes the Nursing Transfer notes may not necessarily be the nurse who actually made the transfer arrangements, but that usually nursing staff would become involved once a consultant at the receiving hospital had

accepted the patient. The consultant at the receiving hospital would inform the registrar, who would advise the relevant ward to expect the patient.

Transfer to the public hospital
The public hospital's ICU Transport Team was not available to carry out Mr B's transfer. Instead, the transfer was made by the ambulance service. Dr C initially informed me that he could not recall whether he was present in the regional hospital's ICU when the ambulance service's Transfer Team arrived. He advised that "it is not essential for all members of the Team looking after a patient to be present at the time of transfer and for obvious reasons this is not always possible anyway. If the Consultants in charge of the patients who are being transferred are not present when Retrieval Teams arrive and there are any questions that arise, the Nursing staff in ICU know to bleep the relevant specialist."

In a subsequent conversation with one of my investigation staff, Dr C recalled having spent what he described as "a long time" time talking to a person from the air ambulance team. This person was dressed in "a green boiler suit" and Dr C assumed that he was from the public hospital. Dr C now realises that the person he spoke to was more likely to have been a staff member from the ambulance service

Since these events occurred, the ambulance service has gone into receivership and I have been unable to locate members of the company's transport team involved in Mr B's transfer. However, included in Mr B's medical records there is the ambulance service's "Patient Record Sheet" which records:

"Referring Hospital Ward/Dr:	[The regional hospital]
Receiving Hospital Ward/Dr:	[The public hospital's] HDU
History (state chief complaint first):	Chest injury and burn 15/3/02 (crushed in cab) – Rib fractures, scapular fracture – Bilateral haemopneumothorax

… Transferred for management of shoulder fracture.
Uneventful transfer.

Depart [the regional hospital]:	15.40
Take off:	16.10
Landed:	17.15
Arrived [the public hospital]:	17.40"

For the reasons set out above I have not been able to confirm when this form was completed, or by whom.

Emergency Department of the public hospital
A "Patient Assessment/Emergency Department" form at the front of Mr B's the public hospital medical records notes that he was received into that Department at 18.00 (6pm), by a triage nurse who has signed her name only as "…". The "triage assessment" section of the form has been completed and notes that Mr B had "bilateral haemopneumothorax, burns to right hand (third degree) and chest, fractured right scapula. On PCA pump 5mg morphine

hourly." At the top right corner of the form is a section headed "Triage Code". This is blank.

Mrs A complained that on arrival at the public hospital's ED, a nurse pushed Mr B into a cubicle, then left and never returned. Mrs A also complained that Mr B was "transferred on to a skinny hard bed". In responding to these points, Mr F, the Acting Service Manager, Clinical Services, advised me that "this nurse would have been the triage nurse whose role is to triage the patients and place them in a cubicle for the allocated nurse to take over management. The triage nurse has no further role to play in the patient's care." The public hospital's ED had only eight ordinary hospital beds in the Observation Unit and all other beds were "specific ED beds" with thin mattresses. "As the length of stay is increasing for patients in ED we are looking to purchase more comfortable mattresses. Currently ED has no reasonable alternative to the use of these thin mattresses."

It is evident from the "Patient Assessment/Emergency Department" form that Mr B was seen by a second nurse at 18.30. Under the heading "Primary Nurse Assessment", a primary nurse has noted "patient complaining of being uncomfortable on ED trolley. Wanting to know how long he will be in department for. Chest drains swinging."

Mr F advised me that the two ED nurses who attended Mr B have since left the public hospital and are overseas. They could not be located during my investigation.

Another aspect of Mrs A's complaint was that Mr B was seen in the ED by "various doctors who never returned". The clinical notes confirm this. Mr F informed me that "it is hospital procedure for patients that present to the emergency department to be assessed and a plan of care decided upon before admitting to a ward/unit", and that "as Mr B presented with a number of injuries he was seen by three different speciality doctors, Orthopaedics, Plastics and Cardiothoracic. I appreciate that it is frustrating to be examined multiple times and have to answer similar questions but unfortunately this was necessary so that all Mr B's injuries could be adequately assessed and a decision made on future treatment and care."

At 18.15, Mr B was seen by the orthopaedic registrar, Dr E, who noted:

> "… from [the regional hospital].
> 'Digger' fell on him 4 days ago.
>
> Right shoulder/bilateral chest injuries.
>
> Right shoulder: deep grazes on right deltoid. N/V [neurovascular status] intact. On arm sling.
> X-Ray: fracture dislocation right G H Jt [glenohumeral joint] with glenoid fracture.
>
> Ortho plan: patient should be under cardiothoracic surgery.
> Ortho plan for CT right shoulder (electively).
> Pain control while waiting for CT.
> Review after CT scan."

Dr E advised me that the orthopaedic condition of Mr B's right shoulder was "thoroughly assessed". He said:

> "It was also found that the patient had bilateral chest drains and also had a burn over his right hand. The x-ray shows a fracture dislocation of the right glenohumeral joint with relocation of the humeral head. There was an obvious fracture at the glenoid fossa. Orthopaedic comment at that time was that the patient should be thoroughly assessed or possibly taken over by cardiothoracic surgery as the chest injury would be potentially a more serious injury compared with the shoulder injury. The orthopaedic plan at that time would be for elective CT scanning of the right shoulder and have adequate pain control and stay in an arm sling while the patient is waiting for scan and subsequent treatment. However, after cardiothoracic assessment the patient was finally referred back to orthopaedics as the cardiothoracic condition was stable at that time and did not need acute intervention so the patient was subsequently admitted to high dependency unit under the orthopaedic team. The patient received close observation in high dependency unit because of the cardiothoracic condition."

The next entry in Mr B's notes, after that of Dr E, is that of a doctor from the plastic surgery team. Neither the name of the clinician making the assessment, nor the time when it was carried out, has been recorded. The entry includes the following:

> "On Examination: patient comfortable, moving fingers …
>
> Plan: 1. continue SSD dressing, 2. splint, 3. debride blister, 4. review by team and may need skin graft."

At 19.00, a cardiothoracic surgery registrar assessed Mr B. The notes state:

> "Transfer from [the regional hospital] …
> Patient treated in ICU in [the regional hospital]
> Had CT chest on 16/3, no mediastinal injury.
> Multiple rib fractures on both sides.
> Right shoulder injury.
> Right hand burn by hydraulic fluid.
> Patient was haemodynamically stable from accident. Had initial right chest tube and left chest drain on 17/3 … big haemothorax.
>
> On examination: Comfortable, Affable, Pulse 100, BP 159/90 …
> Plan: Discuss with [Dr I]: aware of this patient
> Admit under orthopaedic to fix shoulder injury
> We will review his chest tomorrow …
> PCA pain relief.
> Chest physio."

Subsequently, Mr B was seen by the orthopaedic house surgeon, who decided to admit him to Dr H's orthopaedic team. The entry in the notes recording this assessment does not state

what time this occurred or the name of the house surgeon. However, it is clear that a full history and observations were taken before the following plan was made:

"Plan: 1. Admit ortho – [Dr H's] Team,
2. CT shoulder [tomorrow] – team to arrange,
3. Team review,
4. PCA"

The next entry in the notes is as follows: "admitted to HDU at 22.00. Very anxious about not being in ICU. Accompanied by wife … morphine infusion completed. 23.30 – PCA commenced – patient aware of how to use."

General comments: Transfer acceptance and anticipated ward destination
The regional and the public hospital staff clearly had different perceptions of Mr B's transfer requirements, particularly with respect to the ward into which Mr B was to be admitted.

Dr C speculated that the message he had left for Dr D, the public hospital's Director of Critical Care, could not have been passed on, and advised:

> "I was very sorry when [Mr B's] mother mentioned there were delays at [the public hospital] as I felt I had discussed his transfer with the specialists who would be involved in his care at [the public hospital] with the exception of the orthopaedic surgeon whom I knew [Dr G] had spoken to."

Mr F said:

> "In this case [the public hospital] ICU were only contacted as the transport service but as the transport team were unavailable they were unable to do the transport. It was therefore carried out by [the ambulance service]."

In a subsequent letter to me, Mr F went on to say:

> "[Mr B] was never accepted by the Intensive Care Unit … There is nothing recorded in [the public hospital's] or [the regional hospital's] clinical notes to support such an arranged acceptance.
>
> Patients requiring admission to ICU usually have severe, life threatening organ dysfunction. These patients often need some form of life support such as mechanical ventilation, cardiac drugs for blood pressure or/and renal dialysis ….
>
> [Mr B] was admitted to our High Dependency Unit, which is a step down from our ICU but a step up from the general ward. The High Dependency Unit was the most appropriate place for [Mr B]. Patients are not accepted into HDU until a specialty team has taken responsibility for their care following assessment.
>
> [The public hospital's] ICU is quite different to the ICU at [the regional hospital] in terms of the patients cared for. It would be fair to say the ICU at [the regional hospital] is more like our HDU. Therefore simply because [Mr B] was transferred from [the

regional hospital's] ICU does not mean he would be admitted to the ICU at [the public hospital]. It appears to be clear, however, that the family were under a misunderstanding about the transfer and that this has caused a considerable amount of stress and anxiety.

… I have reviewed the bed status report for 19 March and at 5pm there were ten patients in the ICU. ICU is a fourteen bed unit. Therefore there were beds available, though [Mr B] was not an ICU patient."

Dr D informed me:

"This patient was NEVER accepted by me. He was NEVER for ICU admission. We were approached by [the regional hospital] as the transport service – he was referred to the orthopaedic team. As it turned out, we were unable to do the transport, which was in the end done by [the ambulance service]. We therefore were never involved in his care at all. I suggested that they contact [the ambulance service], and I also made sure that an HDU bed was available in case he needed HDU care. There is no confusion as to who was responsible for the patient. This patient was accepted by the orthopaedic team on-call and they were phoned personally by me to be told that he was on his way.

The history given to us was that this patient had rib and scapular fractures and was in pain, needing IV morphine, but that he was completely stable from a cardiovascular and respiratory point of view. There was therefore no definite indication for HDU admission and he may have been suitable for ward admission with a PCA and Pain Team input. It is appropriate therefore that he should have been assessed in ED by the team that he was referred to, in order to decide on the severity of his injuries and the most suitable place for him to be admitted to (like any other hospital admission)."

Inter-hospital transfer policies

The regional hospital
The regional hospital provided me with copies of its policies and procedures relating to inter-hospital patient transfers. I was advised that as at 5 May 2003 several of these policies were under review. The regional hospital's transfer procedure dated September 1999 includes the following:

"Purpose: To transfer patients safely to health care providers off [the regional hospital] site.

Indications: Patients requiring specialised treatment; investigations or procedures that are not available through [the regional hospital].

Action: Medical Officer to discuss with other hospital medical officer the patient care and treatment.

Rationale: The receiving hospital is aware of patient and we can find out what ward he/she will be admitted to"

Another document headed "Transfer of patients from [ward] – Medical team Responsibilities" states that the medical team (Consultant or House Surgeon) is required to contact the receiving hospital or department, decide on the method of transport, decide which hospital will be doing the transfer, decide who will be accompanying the patient, arrange or write the referral letter and make arrangements for copies of notes, X-rays and documents to be sent. This document is undated. A flowchart dated February 2002 confirms that the consultant or house surgeon responsible for the patient's care is required to arrange the acceptance of the transfer, and discuss the transfer requirements with the nursing staff.

The public hospital
The Chief Executive of the public hospital provided me with copies of the policies, guidelines and procedures for inter-hospital transfers involving the public hospital. Extracts from documents relevant to my investigation include the following:

- "*High Dependency Unit Admission and Patient Management Policy*" (January 1999). "[HDU] is designed to offer intensive nursing care on a short term basis" for surgical or emergency patients, or intensive care patients when ICU is full. In addition, for medical patients where major ICU medical input is not required but the patient nevertheless needs to be in a high dependency area, "admission to the HDU is reasonable. In this circumstance, the patient is cared for by the parent medical team primarily (as for surgical patients). Increased input from ICU medical staff will be by arrangement between the teams or where emergencies or other problems occur."

- "*Guidelines for the Safe Transfer of Patients – working draft for six months*" (May 1999). (The Chief Executive advised me that this policy was "rolled over".) Under the heading "Clinical Guidelines for Transfer" this document includes:

  "Patient Status: Status 2
  Condition Serious
  Stability Unstable
  Potential to deteriorate Probable

  Does this patient need to be retrieved by a specialist team [of the public hospital]?
  A: Consult [the public hospital's] ICU Department. They will make arrangements for a specialist medical retrieval team if required. In the case of Status 2 patients, if decision made not to retrieve, go to B.

  B: Arrange appropriately skilled doctor and/or nurse to accompany patient. Phone Regional Ambulance Operations Centre. Request urgent transfer by local ambulance. Advise any special equipment/care needed. Negotiate pick up time. Advise patient, family and nurse of time. Ensure documentation ready."

- "*Inter-Hospital Transfers via the Emergency Department: Memorandum* (8 June 1999). This records that [the public hospital's] Clinical Services managers had agreed to "reduce inappropriate admission to the Emergency Department by inter-hospital transfers". It states:

"**Guidelines for accepting inter-hospital transfers at [the public hospital]:**

1. All inter-hospital transfers accepted for transfer (admission) will immediately be notified to the CNL/nurse co-ordinator by the accepting medical officers ward/unit.

2. It is the responsibility of the referring hospital to contact the duty manager at [the public hospital] (24 hours) to identify ward/unit transfer of their patient. This information will then be communicated by the referring hospital to the transport vehicle and personnel accompanying the patient.

3. The duty manager then informs the respective ward of the transfer with an expected arrival time.

Please note: Direct Admission Exceptions

1. Any patient whose condition has been notified (via ambulance control) as being unstable will require Emergency Department admission for stabilisation.

2. No direct inter-hospital transfers to the High Dependency Unit or Intensive Care Unit unless accompanied by the [public hospital's] Transport team."

This memorandum was copied to the public hospital's Health Duty Managers, St John's Ambulance Service, and NZ Ambulance Service. It does not appear to have been copied to the regional hospital managers.

- "*Explanation of [the public hospital's] ICU Transport Team Activities*" (September 2000). "Any request for transport by our team should be referred by the ICU Registrar consulted to the consultant on-duty for ICU-2, or out of hours the consultant on-call for the Unit." When suitable transport or staff is unavailable, "the obligation rests with the doctor and hospital who is requesting the transfer to continue caring for and if necessary, accompany the patient themselves. In all cases … the referring hospital staff remain responsible for the patient's care. This responsibility is transferred during patient assessment after our team has arrived, but may continue to involve referring hospital staff until the Transport Team leaves that hospital." In addition, it is stated: "In every case of transfer, we must ensure that an accepting team has been arranged, whether the patient is coming to our [Intensive Care] Unit, hospital or another hospital."

A handwritten note at the bottom of this document states that it was sent to all referring regional hospital doctors who had requested transports on record prior to September 2002.

- "*Admission Policy ICU*" (December 2001). "Patients transported by Intensive Care from other hospitals must have a team arranged prior to transfer to [the public hospital]. It is the responsibility of the referring hospital to ensure that the patient has been accepted by a named team within [the public hospital] as well as the Intensive Care Specialist on call, prior to the transfer. On arrival in intensive care, the primary team must be informed of the admission."

Mr F advised me that the procedure followed by the ICU is "for the referring hospital to contact the ICU consultant designated on the day and request a transfer to the unit. A decision [whether to accept the patient as an ICU admission] is made by the consultant based upon the medical information provided."

Independent advice to Commissioner

The following expert advice was obtained from Dr Mary Seddon MBChB, MPH, FAFPHM, FRACP, Head of Quality, Medicine, at Middlemore Hospital:

> "I was asked to review this case from a 'systems' point of view. A system can be defined as a series of processes that produce an outcome. In this case there are 2 main systems that I have reviewed:
>
> 1. The system of inter-hospital transfer: from [the regional hospital] to [the public hospital]
> 2. The system of managing inter-hospital transfer patients in the Emergency Department of [the public hospital].
>
> **Inter Hospital transfer**
>
> After reading the complaint, the clinical notes and the clinician's letters, it would appear as though there was a variance between the [regional hospital] surgeon and family's expectations and the actuality of [Mr B's] transfer into [the public hospital]. Most of the problems appear to have arisen from a series of communication failures compounded by the fact that [Mr B] required in put from three separate surgical services [of the public hospital]: orthopaedic, plastic and cardiothoracic. [Dr C] (General surgeon [at the regional hospital]) notes that he spent a considerable period of time ringing [the public hospital] and talking with the various doctors. He spoke with an ICU consultant on the night before the transfer and was left with the impression that this would be an ICU-ICU transfer. However, the ICU consultant who was on call on the actual day of the transfer does not appear to have been privy to this information. Furthermore, as he states, the [regional hospital's] ICU had stabilised [Mr B's] condition and he would not necessarily have reached the threshold for admittance to the [the public hospital's] ICU.
>
> [The regional hospital] has a comprehensive policy on inter hospital airborne transfer. In this (dated 9/99) it is stated under Action:
>
> 'Medical Officer to discuss with other hospital medical officer the patient care and treatment'
>
> The Rationale for this:

'The receiving hospital is aware of the patient and we can find out what ward he/she will be admitted to.'

In the above case it would appear that the [regional hospital's] medical officer did his level best to discuss with all those concerned at [the public hospital].

[The public hospital] also has a guideline for the safe transfer of patients, dated as a working draft in 1999. I have no evidence that this has been reviewed or up-dated. In this it states that patients admitted to the ICU from other hospitals must have a clinical team arranged prior to transfer to [it]. 'It is the responsibility of the referring hospital to ensure that the patient has been accepted by a named team within [its] hospital as well as the Intensive Care Specialist on call, prior to transfer.' It would appear that [the regional hospital] was not aware of this draft policy and although the case was discussed with three surgical consultants, a 'named team' was not decided on.

There is also [the public hospital's] Emergency Department Memorandum dated June 1999, on inter hospital transfers via the Emergency Department. One of its aims is to 'Reduce inappropriate admission to the Emergency Department by inter-hospital transfers.' This memorandum appears to support direct admittance to wards (bypassing ED), except for the High Dependency Unit (HDU) and ICU and then only when 'accompanied by the [public hospital's] Transport team'. Again there is no evidence that this has been formalised into a policy, and it is clear that this advice (no direct ICU transfers) was not made clear to the referring surgeon [at the regional hospital].

Systemic problems with the transfer:

1. [The public hospital's] inter-hospital policies and memoranda not known to [the regional hospital]. Had the [regional hospital's] surgeon known these, then it is unlikely that he would've told the complainant and his family that he would be directly admitted to the ICU.
2. No central person for transferring doctor to speak with, and therefore much time taken. No evidence of co-ordination in the destination after transfer.
3. No one [public hospital] clinician or group appeared to take ownership of the transfer.

Care in [the public hospital's] ED

Although we have only the complainant's account, reading through the complaint and notes I am struck by how little compassion and common decency was shown to [Mr B] and his heavily pregnant wife. The process appears disjointed and unnecessarily protracted. The documentation in the ED notes is poor which makes it difficult to know exactly how long [Mr B] waited and what he was told.

According to the [the ambulance service's] record, he arrived at [the public hospital] at 17.45 hrs. The triage nurse saw him, though the time is not noted. He was not given a triage code – such a code is designed to prioritise patients and give an indication of acceptable waiting times. The nurse noted that he was 'complaining of being

uncomfortable on the ED trolley and wanting to know how long he will be in the department for'. Whilst it is normal practice for a triage nurse to do the first assessment of the patient and then to hand over that care, this process was not explained to [Mr B] and his wife and they obviously thought that they had been forgotten when the nurse failed to return.

The orthopaedic registrar next saw him at 18.15 hours, and decided that the patient should be under the care of the cardiothoracic surgeons and referred [Mr B] to them. The plastic surgery registrar then saw [Mr B], but no time is noted. At 19.00 hours the cardiothoracic registrar reviewed the patient and suggested that the patient should be under the care of the orthopaedic surgeons. He was then formally admitted by the orthopaedic house surgeon (no time documented) and arrived up in the HDU at 22.00 hours – a total of just over 4 hours after arriving in ED.

It appears that throughout this process [Mr B] and his wife were left alone for long periods and were not involved in the decision-making process. [Mr B] had been in the [regional hospital's] ICU with close nursing and monitoring, so it would have caused considerable anxiety to feel that he was being left to his own devices in ED. This anxiety would not have helped his perception of pain. Better communication, from the triage nurse and the registrars may have alleviated this anxiety. Although both the plastics and cardiothoracic registrars note that he appeared 'comfortable', there is no attempt to quantify his pain on a pain scale and this appears to be a rather cursory examination of the issue. His PCA pump does not appear to be charted in the ED medication chart and it appears to have run out on admission to the HDU (though my photocopy of the notes is poor). During the night his pain score was 8/10 before the basal rate was reset.

Furthermore his wife was 36 weeks pregnant, though little appears to have been done to support her after an exhausting day.

Systematic problems with management in ED:

1. No triage time or code written
2. Poor communication with [Mr B] and his wife.
3. Multiple examinations by different surgical registrars, and until they had decided which subspecialty would be the prime carer, [Mr B] was left in limbo.

There appears to be room for improvement both in the process of arranging inter-hospital transfers, and in how such patients are managed when they arrive in the Emergency Department."

Response to Provisional Opinion

In a detailed response to my provisional opinion regarding Mr B's admission to the public hospital, Dr D, Director of Critical Care, advised me as follows:

> "In summary:
>
> 1. We dispute that anyone in ICU would have given [Dr C] the impression that [Mr B] would be admitted to ICU.
>
> 2. We would certainly have discussed this in detail with the Intensive Care specialist in [the regional hospital] the following day, prior to [Mr B's] transfer. We would have informed him/her that the patient would not be admitted to ICU at [the public hospital] and should be taken to the ED for assessment.
>
> 3. We were unable to offer a transport service and therefore asked [the regional hospital] to make other arrangements. The Intensive Care transport team had no further involvement in the transfer.
>
> 4. The ICU consultant at the regional hospital and the orthopaedic team at [the public hospital] were responsible for the transfer. They both knew the destination of the patient at [the public hospital]. There does not appear to have been any problem at all with the transfer which appears to have been well co-ordinated and to have taken place without a hitch."

Dr D provided me with a copy of the Transport Service card to which he referred in his response. Included on this card is the following information:

> "**Responsibility**
> It is important to realise that the request for ICU transport goes to the ICU Medical Staff, who then decide the appropriate course of action. Discussion may have (and usually should have) taken place with other staff who accept the patient under their care. They may contact ICU staff as well, but eventually, there will need to be contact between referring doctor and ICU medical staff to ensure adequate preparation, communication and eventual transfer of medical and legal responsibility at the point where referring staff 'hand over' to the transport team at the referring hospital."

In another detailed response to my provisional opinion regarding Mr B's time spent in ED, the Clinical Director of the public hospital's Emergency Department, advised as follows:

> "… [I]t must be emphasised that although ED space was utilised for [Mr B's] assessment, ED medical staff were not responsible for his care.
>
> It should also be noted that in terms of the operative guidelines at that time, it was the responsibility of the referring hospital to contact the duty manager at [the public hospital] 24 hours prior to the transfer to identify the ward/unit that the patient was to be transferred to. It was also up to the referring hospital to communicate the relevant

information to the transport vehicle and personnel accompanying the patient. In this instance [the regional hospital] staff did follow this process and the message was not received by ED. The first ED knew of the transfer was when [Mr B] arrived in ED via [the ambulance service]. It was very busy in ED when he arrived.

…

According to the central electronic record for patients on 19 March 2002, Mr B was in fact given a triage score of 2. The triage score relates to the allocation of a recommended waiting time and corresponds with how soon a critical assessment or intervention is needed. This score would have been written on the ED manual 'White Board' which was used for patient tracking at the time. ED did not have a live patient tracking system at the time. All data was recorded on a Data Sheet and retrospectively entered into the computer system (when staff had time to do that). Given that [Mr B] was in fact a 'stable' transfer, he should really have been triaged as a 3, which equates with a recommended waiting time for assessment of 30 minutes. A doctor first saw [Mr B] 15 minutes after triage. He was in fact therefore seen within an appropriate time span.

[Mr B's] history and vital signs were taken and recorded during triage assessment. The triage nurse has signed the notes in the appropriate place. While the triage score is not recorded in [Mr B's] clinical record it was recorded centrally in ED as stated above. I believe that this omission would have been caused, at least in part, by the demands of a very busy shift.

[Mr B's] prolonged stay in ED was not due to ED staff but to the need for all three specialties to assess [Mr B] and decide on the most appropriate specialty. The ED nurses were unable to advise [Mr B] how long he would be in ED until the registrars had made that decision.

While I acknowledge [Mr B's] complaint of the uncomfortable thin mattresses on the ED beds, that was all we had available at the time. We are presently increasing the numbers of special pressure care mattresses available in ED."

I am pleased to note that following receipt of my provisional opinion, the public hospital has updated its policies for inter-hospital transfers and admissions and has distributed them to all hospitals that transfer patients to it.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …

Other Relevant Standards

The policies of the regional and the public hospitals regarding inter-hospital transfers are guidelines or standards for such transfers. Accordingly they are relevant to a consideration of whether Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) is complied with. The policies most relevant to this case are as follows:

The regional hospital

"Action: Medical Officer to discuss with other hospital medical officer the patient care and treatment.

Rationale: The receiving hospital is aware of patient and we can find out what ward he/she will be admitted to." (September 1999)

"The Consultant or House Surgeon responsible for the patient's care is required to arrange the acceptance of the transfer, and discuss the transfer requirements with the nursing staff." (Flowchart, February 2002)

The public hospital

- *"High Dependency Unit Admission and Patient Management Policy"* (January 1999). "If the patient does not need major ICU medical input but nevertheless needs to be in a high dependency area, admission to the HDU is reasonable. In this circumstance, the patient is cared for by the parent medical team primarily (as for surgical patients)."

- *"Inter-Hospital Transfers via the Emergency Department": Memorandum* (8 June 1999).

  "**Direct Admission Exceptions**
  …

  2. No direct inter-hospital transfers to the High Dependency Unit or Intensive Care Unit unless accompanied by the [public hospital's] Transport team."

- *"Explanation of [the public hospital's] ICU Transport Team Activities"* (September 2000). "Any request for transport by our team should be referred by the ICU Registrar consulted to the consultant on-duty for ICU-2, or out of hours the consultant on-call for the Unit."

Opinion: Breach

Acceptance of Mr B's transfer to the public hospital

The first part of Mrs A's complaint was that the public hospital did not directly admit Mr B to ICU following his transfer from the regional hospital. The relevant Code provisions are Right 4(2) and Right 4(5).

Right 4(2) of the Code gives every patient the right to have services provided that comply with relevant standards. The policies I have quoted above constitute some of the relevant standards that should have been adhered to when Mr B was transferred.

Right 4(5) of the Code gives every patient the right to co-operation among providers to ensure quality and continuity of care. In my view there can be few occasions when co-operation between providers is more important than when a patient with severe multiple injuries is being transferred between two hospitals. In this case, it seems that there was a significant misunderstanding between providers at the regional and the public hospitals, which appears to have arisen partly as a result of the public hospital's inter-hospital transfer policies and the way in which communications between providers took place and were recorded.

According to my expert advice and the clinical information available, the regional hospital's ICU staff had stabilised Mr B's condition to the extent that he did not necessarily reach the threshold for admission to the public hospital's ICU. In the circumstances, I accept that Mr B's ultimate admission to the public hospital's HDU, under the care of the orthopaedic team, was appropriate in terms of the applicable standards set out in its "*High Dependency Unit Admission and Patient Management Policy*". There is therefore no breach of Right 4(2) of the Code in this respect.

Because the ambulance service– not the public hospital's ICU transport team – transferred Mr B, the "direct admission exception" set out in the public hospital's Memorandum of 8 June 1999 applied to Mr B's transfer. This policy required that Mr B be assessed by the appropriate specialist team in ED. The fact that this was done was also in keeping with Right 4(2) of the Code. The manner and period of time within which it was done is an issue that I will deal with shortly.

In terms of Right 4(5), it is clear that on 18 March 2002, steps were taken by the regional hospital staff to arrange Mr B's transfer to the public hospital in a co-ordinated manner. The overriding reason for the transfer request was that the regional hospital staff did not consider that they were able to adequately manage Mr B's shoulder injury. Dr G, the locum orthopaedic surgeon, first called Dr H, the public hospital's orthopaedic surgeon. Next, Dr C spoke to Dr I (cardiothoracic surgeon) and the plastic surgeon at the public hospital. Although this was time-consuming, Mr B's injuries required the clinical input of three specialist teams, and it was a helpful way to ensure that upon transfer to the public hospital, continuity of care for Mr B could be maintained. It is important to note Dr I's comment in the notes that "as chest injury care was the minor part of [Mr B's] injuries I asked [Dr C] to contact ICU for transfer".

Dr C then did so. As a result of his conversation with the public hospital's ICU consultant, Dr C's understanding was that Mr B would be admitted to ICU if there was a bed available. He considered that his patient required ongoing ICU care, to be provided primarily under the auspices of Dr H's orthopaedic team. In my opinion this was not an unreasonable expectation, particularly given the content of the conversation between Dr G and Dr H (clearly recorded in the regional hospital's medical notes), and Dr C's own discussion with Dr I. However, I am mindful of the comment of Mr F that "[the public hospital's] ICU is quite different to the ICU at [the regional hospital] in terms of the patients cared for. It would be fair to say the ICU at [the regional hospital] is more like [the public hospital's] HDU."

I consider that it was reasonable for Dr C to expect that the message he had left with the unnamed public hospital's ICU consultant on the evening of 18 March 2002 would be passed on to Dr D the following day. It appears to me that this did not happen or, if it did, Dr C's expectation and understanding that Mr B had been accepted by the orthopaedic team, and was likely to be admitted to ICU, was not expressly conveyed to Dr D.

As director of ICU, Dr D considered on 19 March that ICU care was not necessary for Mr B and that the public hospital's orthopaedic team should assess and admit Mr B either to HDU, if necessary, or directly to the orthopaedic ward if appropriate. I accept that Dr D

discussed Mr B's transfer with someone at the regional hospital, even though the identity of that person has not been confirmed. In his response to my provisional opinion, Dr D stated: "I would … have told [that person] that from the history, [Mr B] was not a candidate for our ICU and that he should be transferred to our Emergency Department for assessment." This particularly important piece of information appears not to have been relayed back to Dr C or his staff by the original recipient. The crux of the matter, therefore, is that because Dr C and Dr D did not speak to *each other*, their divergence of views as to Mr B's transfer destination was not discussed or resolved.

Dr D has asserted that there was "no confusion as to who was responsible for the patient". I cannot accept this. Although I accept Dr D's statements that he *personally* never accepted Mr B's transfer to the public hospital's ICU, and that as far as he was concerned the orthopaedic team had accepted the patient, there was clearly confusion within its orthopaedic team, and between the regional and the public hospitals' ICU staff, regarding the ward to which Mr B would be transferred and the specialist team that had accepted him.

I am satisfied that the public hospital's managers had previously taken steps to inform staff at the regional hospital about its inter-hospital transfer procedures. What is not clear is whether the "direct admission exceptions" policy set out in the memorandum of 8 June 1999 was one of the matters that had been conveyed. Regardless of whether Dr C and his colleagues in ICU were aware of this policy, my view is that because several people from both hospitals were involved in the pre-transfer discussions, confusion inevitably ensued.

I acknowledge that the regional hospital's notes do not specifically record all of the conversations that took place in the course of arranging Mr B's transfer. This is regrettable. The staff involved had a responsibility to adhere to the regional hospital's policies for arranging patient transfers (as set out above) and in my opinion this included formally recording in the medical notes the transfer acceptance and the ward or team into which they expected Mr B to be admitted. Ms J's nursing transfer notes record that Mr B's transfer destination was "ICU orthopaedic surgeon", but there is no record of how this was decided and with or by whom. The public hospital's notes are similarly incomplete in terms of recording Mr B's transfer acceptance. In my opinion, it is significant that Dr H, the public hospital's orthopaedic surgeon, and – to a lesser degree – Dr D and the unnamed ICU consultant with whom Dr C spoke on 18 March, did not make a record of their conversations with the regional hospital's staff, and their actions thereafter.

I accept that Dr D would have seen no need to make any record of a conversation about a patient whom he did not admit and whom he did not consider needed ICU care. It was appropriate for Dr D to inform Dr H's team that Mr B was being transferred to them. However, given the circumstances and severity of Mr B's injuries, the fact that he had been in the regional hospital's ICU for 4 days, and the reasons for the request for his transfer, I find it unusual that Dr H did not make a note of his conversations with Dr G and Dr D at the time, or retrospectively. In this regard, I am mindful of the fact that Dr I, the cardiothoracic surgeon, took time on 20 March to make a very detailed note of his conversations with Dr C two days earlier, even though Mr B had not been admitted under his team's care.

I am satisfied that Dr D made sure that there was an HDU bed available for Mr B and personally informed the orthopaedic team that the patient was in transit and would be taken to ED for assessment. These actions comply with the requirements in the "*Explanation of [the public hospital's] ICU Transport Team Activities*" and "*High Dependency Unit Admission and Patient Management Policy*". However, I cannot be certain that Dr H conveyed to his own staff, and those in ED, the fact that Mr B would shortly be arriving in ED and should be admitted – more likely than not to HDU – as an orthopaedic transfer patient. In this regard, a written note attached to the "Patient Assessment/Emergency Department" form would have been prudent and could certainly have gone a long way towards eliminating the delay and cross-team referrals that occurred in the ED following Mr B's arrival. In short, in my opinion, since the orthopaedic team at the public hospital had accepted Mr B's transfer, he should have been admitted to HDU as soon as he had been assessed by Dr E at 6.15pm.

In forming my opinion, I am mindful of the fact that not all of the clinical and nursing staff or transport team members involved in Mr B's transfer have been spoken to, and that complete documents from the ambulance have not been available. However, I am guided by my expert's conclusions that the main systemic problems with this particular inter-hospital transfer were that there was no central person at the public hospital for Dr C or other transferring doctors to speak with, no evidence of co-ordination in the destination after transfer, and no one public hospital clinician or group that appeared to take ownership of the transfer. I accept those conclusions, and do not consider that the gaps in the evidence detract from them.

In my view the public hospital did not breach Right 4(2) but did breach Right 4(5) of the Code, when accepting Mr B's transfer. For the reasons set out above, I am concerned that in March 2002, the public hospital's inter-hospital transfer policies, guidelines for accepting ownership of transfers, and systems for recording communications and transfer decisions between providers, were not as clear as they should have been, and regrettably their observance led to a breakdown in the continuity of care for Mr B.

Emergency Department

The second part of Mrs A's complaint relates to the events that occurred after Mr B's arrival at the public hospital's ED. Specifically, Mrs A complained that her son was in ED for several hours, during which time he was left unattended by medical staff, without pain relief, and was not made comfortable. I will deal with each of these issues separately. The relevant provisions of the Code are Right 4(3) and Right 6(1).

Duration of stay in ED and attendance by hospital staff

Mr B's public hospital medical records show that he arrived in ED at 18.00 hours and was first seen by an ED triage nurse at a time that is unrecorded. He was next seen by Dr E, the orthopaedic registrar, at 18.15, and by the primary nurse at 18.30. Shortly thereafter, at a time that is unrecorded, Mr B was seen by a doctor from the plastic surgery team, and at 19.00 he was assessed by the cardiothoracic surgery registrar. A form headed "[the public hospital's] Emergency Department 8 Hour Tabular Trend" contains a number of computerised entries showing that at regular intervals between 18.16 and 21.00,

observations such as Mr B's heart rate and oxygen level were made. It is evident therefore that Mr B was attended by at least five medical or nursing staff members within the first hour of his arrival at the public hospital's ED.

Although no triage score is recorded in the hard copy documents that have been provided to me, in response to my provisional opinion, the Clinical Director of ED advised that Mr B was given a triage score of 2, which would have been recorded on the white board. Notwithstanding the absence of further evidence to corroborate the triage score given to Mr B, I am satisfied that he was seen by the orthopaedic registrar within 15 minutes of his arrival in ED, which was appropriate. There was no breach of Right 4(3) of the Code in this respect.

However, I am concerned that Dr E referred Mr B to another specialist team. His plan to do so, documented in the medical notes, appears to be at odds with the information that had already been conveyed to Dr H and the orthopaedic team by Dr G and Dr D, and also with Dr C's understanding of who had accepted the transfer. I am mindful of Dr G's note that Dr H had agreed to see Mr B if he was "transferred in stable condition with trauma team and in care of general or thoracic surgeon". However, Dr I, the cardiothoracic surgeon, had subsequently advised that Mr B's chest injury care was "minor" compared to his orthopaedic injuries, and as Dr D had personally told the orthopaedic team that Mr B was in transit and would be taken to ED for assessment, I would have expected Dr E's assessment of Mr B to be followed immediately by admission to HDU. Instead, Dr E's decision to refer Mr B to the cardiothoracic team, though made in good faith, was the first key event that led to the inordinate delay in Mr B's admission to HDU.

The Clinical Director says that Mr B's prolonged stay in ED was due to the need for three specialties to assess Mr B and decide on the most appropriate admitting speciality and, further, that ED medical staff were not responsible for Mr B's care whilst this decision was being made. I cannot accept those assertions. In my opinion, the public hospital breached Right 4(3) of the Code in a number of respects. First, assessment by representatives from three surgical teams in the ED did not amount to the provision of services in a manner consistent with Mr B's needs. His needs, primarily management of a severe shoulder fracture and adequate pain control, had been identified at the regional hospital and clearly conveyed to senior members of the public hospital's clinical staff, who agree that Mr B had been accepted as an orthopaedic team transfer.

Secondly, even though the cardiothoracic surgery registrar assessed him at 7pm and documented "admit under orthopaedic to fix shoulder injury", Mr B was then left in ED for another three hours. No satisfactory explanation has been given for why this happened. I accept that ED was particularly busy on the afternoon and evening of 19 March 2002, but this does not excuse Mr B's prolonged stay in ED after 7pm on that day.

Thirdly, it appears that from 7pm until 10pm when Mr B was admitted to HDU, he was left unattended for long periods of time. The tabular trend record shows that observations were taken at half-hourly intervals between 7pm and 9pm. This record ends at 9pm. With the exception of the orthopaedic house surgeon's admission note (which is not timed), there are no other entries in the medical notes or on the "Patient Assessment/Emergency

Department" chart confirming that medical or nursing staff from any department attended Mr B. This is evidence of inadequate record-keeping or that Mr B was not attended to in a manner consistent with his needs. Given that a "direct admission exceptions" policy was in force, and Mr B had just been transferred from the regional hospital's ICU, ED had a responsibility to Mr B to ensure that regardless of the amount of time he spent in ED he was seen regularly, his questions were answered, his pain control monitored if necessary, and appropriate notes were made. Certainly, if Mr B and his wife were anxious and asking questions about what was happening to them, ED staff should at the very least have read the medical notes, and made an effort to contact the orthopaedic house surgeon or registrar at 7pm in order to facilitate a transfer to HDU in less than three hours.

Pain relief and comfort

Mr B arrived at the public hospital's ED with a PCA pump in situ. He had been encouraged to use this by staff at the regional hospital. Included in the regional hospital's notes is an "Acute Pain Program Description" prepared for Mr B which shows that on 18 March, the PCA was set up to administer a 2mg dose of morphine on each use of the pump, with "lockout" at 10 minutes, and an hourly dose limit of 10mg. The clinical notes for that day record that Mr B had pain well controlled with 60mg administered over 8 hours.

A sheet headed "Details of Syringe Contents" records that at 5am on 19 March, 60mg of morphine in 58ml of normal saline was prepared for Mr B. I cannot be certain from the records when this preparation was commenced in Mr B's PCA. However, Ms J, the transfer nurse at the regional hospital, has recorded that PCA was "in progress" at 14.00, and the ambulance service staff recorded that Mr B used the pump during his transfer, administering 27mg between 15.30 and 18.00.

The public hospital's triage nurse and primary nurse both recorded the presence of the PCA pump on the "Patient Assessment/Emergency Department" form but neither they nor any other ED staff member completed the Emergency Department drug chart on the reverse of that form, to show the rate at which Mr B was using it. The notes of Dr E and the plastics registrar fail to note the presence of PCA at all. The cardiothoracic surgery registrar also did not mention it, although an amended entry in different handwriting on that page of the records includes "PCA pain relief" as part of the treatment plan. The orthopaedic house surgeon, when deciding to admit Mr B, noted that PCA was part of the treatment plan but did not record the amount of infusion left in the pump at that time. Notes made after Mr B's admission to HDU at 22.00 record that the morphine infusion had been completed.

I can only assume from the above information that Mr B had some degree of pain relief available to him whilst in ED, in the form of the PCA pump. I cannot be certain how much pain relief he administered, when he did so, or when the infusion ran out. I agree with Dr Seddon that Mr B's anxiety at being in ED for a prolonged period of time would not have helped his perception of pain, and that "although both the plastics and cardiothoracic registrars note that he appeared 'comfortable', there is no attempt to quantify his pain on a pain scale and this appears to be a rather cursory examination of the issue". In my view, noting only that Mr B was "comfortable" was inconsistent with his needs. In the circumstances of a patient who had been in ICU at the regional hospital, who had just been

transferred by air ambulance, and who had experienced previous difficulty in managing his pain, it was incumbent upon the public hospital staff to know whether Mr B was using his PCA appropriately and whether it was providing him with appropriate pain relief, and to record this on the drug charts and/or clinical notes.

Additionally, both assessments that Mr B was "comfortable" were made in the first hour of his stay in ED. No assessment was made of this in the following three hours. In my opinion, the failure of the public hospital staff to record information about Mr B's pain management inevitably led to the morphine PCA infusion being completed before he arrived in HDU, and this was entirely unacceptable.

Finally, leaving aside the issue of comfort from pain, I note Mrs A's remaining concern that her son spent four hours in ED on a "hard skinny bed" and was not made physically comfortable. The public hospital's response to the complaint acknowledged this issue, stating that the majority of ED beds were "specific ED beds with thin mattresses". In my opinion it was inappropriate for Mr B to spend four hours on a "specific ED bed" given the severity of his injuries. I am reassured that the public hospital is taking steps to remedy this situation for future patients.

For the above reasons, in relation to Mr B's pain management and comfort in the Emergency Department, I find that the public hospital staff breached Right 4(3) of the Code.

Information provided to Mr B

In response to my provisional opinion that Right 6(1) of the Code had been breached, the public hospital's solicitor submitted that there were mitigating circumstances in that "ED staff did not know that [Mr B] was being transferred, as [the regional hospital] never informed them of the matter. The first ED knew of [Mr B's] transfer was when he arrived unexpectedly in ED via [the ambulance service]. While ED staff acknowledge that [Mr B] may have gained the impression that he was left unattended in ED, this was due in part to his arrival at a particularly busy time. It should also be noted that ED staff expected that [Mr B's] initial assessment would be concluded earlier than it was and that his stay in ED would be brief."

I consider this explanation insufficient to excuse the failure of the public hospital's staff members to provide Mr B with basic information about what was happening to him.

Dr D had told the orthopaedic team that Mr B was en route to ED. As already noted, it would therefore have been prudent for the orthopaedic team to have related this to ED staff, and in particular to the triage nurses. I accept that the triage nurse, "…", would not necessarily have known that Mr B was expecting immediate and direct transfer to ICU. Her role was a limited one in that it is normal practice for a triage nurse to do the first assessment of a patient and then hand over care to other providers. However, this process appears not to have been explained to the patient.

Within 15 minutes of arrival in ED, Mr B had been seen by Dr E. It is not clear whether Dr E was aware that Dr D and Dr C understood that Mr B had been accepted as an

orthopaedic transfer. In any event, since Dr E decided to refer Mr B to the cardiothoracic team, the minimum information he should have received by 6.30pm was that he would have to wait for a further assessment. At the very least, in accordance with Right 6(1)(c) Mr B was entitled to be told the estimated time within which that further assessment would happen. Each time he was assessed thereafter, the same information should have been provided along with an explanation of what was happening and when he might be admitted to HDU. I have not been provided with any information that shows that this occurred. In these circumstances I do not accept that an expectation by ED staff that Mr B's initial assessment would be concluded "earlier" and that his stay in ED would be "brief" can be mitigating factors.

I agree with Dr Seddon that it would have caused considerable anxiety for Mr B to feel that he was being left to his own devices in ED and that he was not appropriately involved in the decision-making process, particularly as he had just come out of ICU in the regional hospital. Better communication and information from the public hospital staff – from the triage nurse and ED nurses through to the specialty registrars and house surgeons – may have alleviated this anxiety. The fact that a provider is particularly busy does not lessen the obligation to comply with the Code in this respect.

Accordingly, I remain of the opinion that the public hospital breached Right 6(1) of the Code.

Actions taken

In response to my provisional opinion, the public hospital advised in December 2003 that it had updated its policies for inter-hospital transfers and admissions and had distributed them to all hospitals that transfer patients to the public hospital. I have reviewed these policies and I commend the changes that have been made. The most significant terms of the new policy insofar as they relate to my opinion on this case are:

- "All transfers into [the public hospital] shall be notified to the Duty Manager who will confirm a bed prior to the patient leaving their current location."

- "All transfers to [the public hospital] shall be transferred directly from the ambulance to the designated bed unless:
  - there has been a clinical deterioration in transit …
  - there has been negotiation with the ED Co-ordinator and ED has agreed to have the patient transfer to ED for assessment prior to moving to the designated bed."

- "Transported patients shall be handed over to the receiving provider in a manner which:
  - ensures the patient's clinical safety
  - ensures continuity of effective healthcare
  - ensures a verbal and written hand-over has occurred."

Actions recommended

I recommend that the public hospital take the following further actions:

- Apologise to Mr B, his wife, Mrs B, and his mother, Mrs A, for the breaches of the Code by its staff, and acknowledge the distress the family experienced as a result of shortcomings in its systems for patient transfer and management in the Emergency Department. This apology is to be sent to the Commissioner and will be forwarded to the family.

- Further review and update its policies for inter-hospital transfers and admissions to HDU and ICU. Particular consideration should be given to the issues of "ownership" of transfers and the documentation of pre-transfer discussions.

- Continue to distribute its updated policies to all hospitals that transfer patients to it, as well as the non-hospital transport teams that carry out the transfers.

- Review its practices for the management of transfer patients in ED and, in particular, the information that is provided to patients by ED and specialist staff during the assessment process.

- Review and monitor the record-keeping practices of all staff who carry out triage and clinical assessments in ED and who care for patients in ED for extended periods of time. In particular, attention should be paid to the documentation of triage times, triage codes, patients' pain levels, pain control and medication.

Further actions

- A copy of this report will be sent to the regional hospital with a recommendation that its policies and procedures relating to inter-hospital patient transfers be reviewed in light of this case.

- A copy of this report, with details identifying the parties removed, will be sent to the Chief Medical Advisors of all District Health Boards, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.