

# **Auckland District Health Board**

## **A Report by the Deputy Health and Disability Commissioner**

**(Case 17HDC01195)**



Health and Disability Commissioner  
*Te Tuhou Hauora, Hauātanga*



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## Executive summary

1. On 26 Month1<sup>1</sup> 2017, Mr A was admitted to a public hospital following two days of abdominal pain and having not passed a bowel motion. Mr A had a history of cognitive impairment, Parkinson's disease, hypertension,<sup>2</sup> and prostatism.<sup>3</sup> Mr A was taking cilazapril and doxazosin — two drugs that are known to cause hypotension.<sup>4</sup>
2. On 27 Month1, Mr A underwent surgery for a closed loop small bowel obstruction. That day, a falls risk assessment was completed and Mr A was assessed as having a low risk of falling. Subsequent falls risk assessments on 31 Month1 and 1 Month2 assessed Mr A as a medium risk for falls.
3. On 6 Month2, a day after Mr A experienced delirium and hallucinations and removed his urinary catheter, he was started on quetiapine (which also can cause hypotension).
4. Mr A was discharged on 9 Month2. The medical notes record that Mr A's wife was educated in managing a urinary catheter at home. However, there was no clear documentation of what was discussed with Mr A and his family about the District Nursing Service, or what the family was told about assisting Mr A at home.
5. On 12 Month2, Mr A returned to the hospital's Emergency Department and was admitted to the Urology Ward with leakage around his urinary catheter, haematuria,<sup>5</sup> and lower abdominal discomfort. A falls risk assessment completed that day recorded Mr A as being a high risk for falls.
6. At 4.54pm, Mr A fainted while he was in the bathroom. Later that evening, Mr A was given several medications, all of which can cause hypotension. No medicine reconciliation was carried out.
7. On 13 Month2 at around 1.30am, Mr A was found to be hypotensive. Soon afterwards, Mr A had an unwitnessed fall. The fall resulted in forehead lacerations and an unstable cervical spine fracture. Mr A later developed a retropharyngeal haematoma,<sup>6</sup> and he died a short time later.

## Findings

8. In the Deputy Commissioner's view, by failing to ensure that Mr A's falls risk was assessed appropriately and actions taken to prevent a fall, and for failing to ensure that Mr A was receiving appropriate medication for his needs, ADHB failed to provide Mr A with the

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<sup>1</sup> Relevant months are referred to as Months 1–2 to protect privacy.

<sup>2</sup> High blood pressure.

<sup>3</sup> A disorder resulting from obstruction of the bladder neck by an enlarged prostate gland.

<sup>4</sup> Low blood pressure.

<sup>5</sup> Blood in his urine.

<sup>6</sup> Occurs in some cases following a fall, when blood collects in a specific deep space of the neck; it is rare but can be a potentially fatal cause of airway obstruction.

services required to minimise the potential harm to him, and, as a result, ADHB breached Right 4(4) of the Code of Health and Disability Services Consumers' Rights.<sup>7</sup>

9. The Deputy Commissioner also considered that information about the referral to the District Nursing Service prior to discharge and in relation to catheter education needed to be communicated more effectively to Mr A and his family.

### **Recommendations**

10. It was recommended that ADHB provide HDC with an update in relation to the effectiveness of the changes made following these events; carry out an audit of medicines reconciliation to show when it occurs following a patient's admission; and provide a letter of apology for Mr A's family.
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### **Complaint and investigation**

11. The Health and Disability Commissioner (HDC) received a complaint about the services provided to Mr A by Auckland District Health Board (ADHB). The following issue was identified for investigation:

- *Whether Auckland District Health Board provided Mr A an appropriate standard of care between Month1 and Month2 2017.*

12. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

13. The parties directly involved in the investigation were:

Complainant/consumer's son	
Auckland District Health Board	Provider

14. Independent expert advice was obtained from a consultant physician, Professor Tim Wilkinson (Appendix A), and a registered nurse (RN), Kaye Milligan (Appendix B).
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<sup>7</sup> Right 4(4) states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

## Information gathered during investigation

### Background

15. Mr A , aged 84 years, had some cognitive impairment (thought to be partly Alzheimer’s disease), Parkinson’s disease, hypertension,<sup>8</sup> for which he was taking cilazapril, and prostatism,<sup>9</sup> for which he was taking doxazosin (both drugs are known to cause hypotension<sup>10</sup>). At home, he took the cilazapril in the morning and the doxazosin in the evening, to reduce the likelihood of a double hypotensive effect. He lived independently at home with his wife.

### First admission to hospital

16. On 26 Month1, Mr A was admitted to the public hospital following two days of not passing a bowel motion and experiencing abdominal pain. On admission, staff documented his ongoing medical issues, including the Parkinson’s disease and cognitive impairment. His history of hypertension and prostatism was also documented. On 27 Month1, he underwent a laparoscopy<sup>11</sup> and adhesiolysis<sup>12</sup> for a closed loop small bowel obstruction. A falls risk assessment was completed that day, and he was noted to have a low risk of falling.
17. On 31 Month1, a further falls risk assessment was completed, and Mr A was identified as being at medium risk.
18. On 1 Month2, Mr A was transferred to another ward for rehabilitation. A falls risk assessment that day scored him at medium risk, and a plan was put in place that included physiotherapy and occupational therapy reviews, and the measurement of lying and standing blood pressures to minimise his risk of falls. It was documented that Mr A had experienced a fall within the previous year.
19. On 5 Month2, Mr A experienced delirium and hallucinations, and removed his urinary catheter, causing trauma. The catheter was reinserted successfully. A plan was formulated on the ward round for: (i) the nursing staff to educate Mr A’s wife on how to care for a urinary catheter, (ii) a referral to be made to the district nurses to change the catheter every six weeks, and (iii) a referral to be made to the Urology Clinic on Mr A’s discharge from hospital.
20. On 6 Month2, Mr A was started on quetiapine (which also can cause hypotension) to treat his delirium and poor sleep.
21. Also on 6 Month2, the medical notes refer to the need for catheter education for Mr A’s wife, and the nursing notes acknowledge this need on both 7 and 8 Month2. However,

<sup>8</sup> High blood pressure.

<sup>9</sup> A disorder resulting from obstruction of the bladder neck by an enlarged prostate gland.

<sup>10</sup> Low blood pressure.

<sup>11</sup> Examination of the organs inside the abdomen.

<sup>12</sup> Removal or division of internal scar tissue to relieve symptoms.

there is no documentation of whether such education was provided around this time. A referral was made to the District Nursing Service on 8 Month<sup>2</sup>, and it is noted that a district nurse was to contact Mr A, and that Mr A would require assistance. The referral was allocated a non-urgent status, which ADHB told HDC meant that Mr A would be contacted on 12 Month<sup>2</sup>.

22. On 9 Month<sup>2</sup>, catheter urine samples were sent for culture because of sediment concerns; this later showed increased white cells in the urine and a culture for *E. Coli*. Later on 9 Month<sup>2</sup>, Mr A was discharged home. A referral was made on this day for the Urology Team to follow up on Mr A. Mr A's family told HDC that they are concerned that Mr A was discharged on this date without antibiotics, as they understood that he had a urinary tract infection.
23. The final medical entry for this admission states that Mr A's catheter had been changed, and that his wife had been educated in the management of a urinary catheter at home. Both the medical notes and the occupational therapist notes mention that education was provided. ADHB told HDC that the nurses were under the impression that Mr A's wife felt able to assist with catheter care, and that she understood the instructions.
24. However, there is no clear documentation in Mr A's medical notes of what was discussed with Mr A and his family about the District Nursing Service prior to discharge, or what was communicated to the family about assisting Mr A at home. Mr A's family told HDC that they were not aware of a referral having been made to the District Nursing Service.
25. ADHB acknowledged that there are deficiencies in the documentation relating to the education about catheter care provided by the nursing staff to Mr A and his wife. ADHB said that all referrals to the District Nursing Service are now followed up by telephone to check details and confirm dates for visits/assessments with the patient/family. Furthermore, all correspondence in relation to referrals is now documented into a main clinical system, providing a clear record of all interactions with the patient or the patient's whānau.

### **Second admission**

26. On 12 Month<sup>2</sup> at 7.36am, Mr A returned to the Emergency Department (ED) and was readmitted for leakage around his urinary catheter, haematuria,<sup>13</sup> and lower abdominal discomfort. He was given antibiotics in case of infection, and his catheter was irrigated. He was transferred to the Urology Ward under the care of a urology consultant. A registered nurse completed a falls risk assessment on transfer to the ward, and Mr A was scored as being a high risk (80/120). The second page of the falls risk assessment and care plan was not completed (contrary to ADHB's Falls Prevention in Adults policy, 2014), and there is no evidence of any further planning around falls prevention.
27. At around 4.54pm, Mr A fainted while he was in the bathroom.

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<sup>13</sup> Blood in his urine.



28. Mr A's falls assessment was updated following the faint, and his falls risk score was increased to 105/120. However, the falls documentation was incomplete, and again no falls care plan was added or measures put in place to prevent falls. The name of the assessor was not documented, and nor was date or time completed. ADHB told HDC that this did not meet its expected standard of documentation.
29. At 8pm, Mr A was given his usual medications — cilazapril and doxazosin. At 9pm, he was given quetiapine, and that night he was also given oxybutynin (no time recorded). All four medications can cause hypotension (particularly cilazapril). No medicine reconciliation was carried out to determine what medication Mr A had been taking at home and what he was prescribed in hospital.
30. On 13 Month2 at around 1.30am, Mr A was found to be hypotensive. A Code Red<sup>14</sup> alert was made. His systolic blood pressure was found to be 78mmHg; it fell further to 75mmHg, and eventually rose to 85mmHg. His indwelling catheter was found to be blocked, and after 40 minutes of manual bladder irrigation he was settled back into bed. The clinical notes record that the side bed rails were down. There was no documentation from the Code Team.
31. Soon afterwards, Mr A had an unwitnessed fall. The DCCM<sup>15</sup> and medical registrars attended. The fall resulted in forehead lacerations and an unstable cervical spine fracture. No new neurological deficits were detected. Following orthopaedic review, Mr A was treated with an ASPEN collar (a neck brace). His urinary catheter had been pulled out again, and could not be reinserted following two attempts, so Mr A underwent a cystoscopy<sup>16</sup> and insertion of a 3-way catheter. During the cystoscopy, a bulbourethral<sup>17</sup> injury was noted, likely as a result of the pulled catheter.
32. Mr A developed a retropharyngeal haematoma,<sup>18</sup> which was attributed to the cervical spine fracture. The haematoma threatened his airway, and he was intubated. Sadly, Mr A deteriorated and died.

### Other information

#### *Falls*

33. ADHB's expectation at the time of Mr A's admission was for a falls assessment to be completed within six hours of admission, or on transfer to another unit in the hospital. In addition, ADHB required the falls care plan to be re-evaluated every shift to determine whether it was still appropriate for the patient.

<sup>14</sup> An emergency call within the hospital to advise staff that a patient is having a medical emergency.

<sup>15</sup> Department of Critical Care Medicine.

<sup>16</sup> Where a thin tube with a camera and light on the end is inserted through the urethra (the tube that carries urine out of the bladder) and into the bladder so that the inside of the bladder can be visualised.

<sup>17</sup> A gland in the reproductive system.

<sup>18</sup> Occurs in some cases following a fall. A haematoma forms when blood collects in a specific deep space of the neck; it is rare but can be a potentially fatal cause of airway obstruction.

34. ADHB had a Nursing Familiarisation book with a section on patient safety and risk assessment (including falls), which focused on individualised interventions to prevent falls. ADHB told HDC that during regular nursing observations, nursing staff are expected to assess patients to ensure that the recommended care plan has been implemented, and that the care being provided is ensuring the desired outcome for the patient, and that the patient is safe.
35. ADHB also said that in the event of a fall, the expectation was that ward nurses were responsible for completing documentation around the fall in the patient's notes. ADHB acknowledged, however, that "[t]here was no clear expectation or guideline around required documentation by the team".
36. ADHB also told HDC that the ratio of nurses to patients during overnight shifts on the ward where the fall occurred was found to be inadequate, and that it has since increased the number of nurses on the ward.
37. ADHB stated that the importance of clear documentation has since been reinforced in its nursing education. Staff are now expected to document triage activity in the patient's electronic record, and the District Nursing Service's standard operating procedure is being reviewed to provide clear expectations regarding documentation.
38. ADHB acknowledged the importance of robust falls assessment and care planning, and that this is essential for patient safety. It said that at the time of events it had multiple forms for falls assessment and care planning, and it has since refined and adapted these into one document, in line with Health Quality & Safety Commission (HQSC) guidance. The documents are monitored via monthly organisation audits, and the results are reported to HQSC.
39. ADHB has now implemented a Patient at Risk (PaR) team, which responds to emergency code alerts and is expected to complete an electronic documentation template to record the event that led to the emergency code alert.
40. Regular audits are conducted regarding patient falls and the documentation around them.

#### *Medicines reconciliation*

41. ADHB's Clinical Procedure #104 Medicines Reconciliation, May 2016 details the expected actions of the pharmacists/intern pharmacists throughout the process of medicines reconciliation — Collection, Compare, Communicate, and Reconcile.
42. ADHB said that expected practice was for pharmacists to be involved in the medicines reconciliation process as soon as possible after a patient's admission, ideally within the first 24 hours of hospital admission.
43. ADHB told HDC that it has no policy or procedure defining or outlining its expectations in relation to medicines review following a fall. However, nursing or medical staff will at times request pharmacist input in these circumstances, and an individual pharmacist may

provide review and recommendations within the pharmacist's professional scope of practice.

### Root Cause Analysis

44. ADHB investigated this event and completed a Root Cause Analysis Report (RCAR) in February 2018. The report identified the following issues:
- Contrary to ADHB's policy, no falls care plan was completed on Mr A's second hospital admission, despite him being scored as a high falls risk.
  - ADHB's policy "Better Brain Care Pathway" had not been implemented on the Urology Ward at the time of events.
  - There was no documentation from the "code team" following Mr A's first fall on 12 Month2.
  - There was no resuscitation record.
  - There was no review of medications post fall. Multiple medications were prescribed with similar side effects of lowering blood pressure and causing sedation or confusion.
  - Oxybutynin was given to Mr A with no clear documentation as to why.
  - The falls assessment was updated and Mr A's falls risk increased following his first fall, yet no falls care plan was made.
  - There was no documentation from the "code team" following Mr A's second, more serious fall (although documentation was added retrospectively).
  - There was no standard documented process on how to lift a patient with a potential cervical fracture following a fall.

### RCAR recommendations

45. The following recommendations from the RCAR have now been completed:
- A falls module was implemented to assist with ensuring that falls risk assessments and care plans are completed. Training is now completed within one month of employment for new staff, and every 12–24 months.
  - The Better Brain Care Pathway of behaviours of concern is now in place and is followed. Staff have been educated on the policy.
  - The Standard Operating Procedure has been updated to ensure that there is medical review of patients after a Code Red call is communicated. This is now the responsibility of the registrar on the Code Team.
  - The Pharmacy has reviewed its procedures with a view to standardising the time at which a medicines reconciliation report is generated, so that it arrives before 8am each day. The Pharmacy has also worked on raising awareness that all members of the multi-disciplinary team can refer a patient directly to a clinical pharmacist for review.

It is hoped that this will assist with ensuring that medicines reconciliation is undertaken in a timely manner.

- The RCAR was used as a case study to ensure that the care of older persons in an acute surgical environment (such as those with multiple medications, and other issues that heighten their risk of falls) is more clearly understood.
- Further training and education was implemented in relation to lifting patients who may have experienced a cervical fracture.

### **Responses to provisional opinion**

46. The parties were all given the opportunity to respond to relevant sections of my provisional opinion.
  47. ADHB had no further comment to make.
  48. Mr A's family noted that if a district nurse had been made available to assist and follow up during the weekend following Mr A's discharge after his first admission, they may not have experienced the problems that led to him needing to be readmitted.
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### **Opinion: ADHB — breach**

49. This case illustrates the challenging circumstances DHB clinicians must accommodate and manage appropriately when treating patients such as Mr A — who had complex health and disability conditions — within a mainstream secondary or tertiary service environment.

### **Falls risk assessment and care plans**

50. At the time of these events, falls risk assessment and care planning at ADHB required the completion of multiple forms. Professor Wilkinson advised: "I found the documentation relating to falls risk not easy to follow and many of the observations were not dated. This, in itself, is a problem."
51. I am critical that there was no clear guideline outlining what documentation was required in relation to falls, and that falls and care planning required multiple forms. It is pleasing to see that ADHB has since refined and adapted its falls assessment and care planning into one document.
52. I am also concerned that there was inadequate planning around Mr A's falls risk to minimise any potential harm presented by that risk.
53. In relation to Mr A's second admission to hospital, although there are two documented falls risk scores indicating high risk, no plan was made to minimise the risk. Again, it is not clear from the notes when the scores were given. There is no evidence in the clinical notes

of any actions taken as a consequence of the high risk score, and there is no evidence that Mr A had been examined by a doctor at that time.

54. I further note that ADHB's RCAR identified that following Mr A's falls, no documentation was made by the Code Team at the time.
55. Accurate care planning is one of the foundations of clinical decision-making. ADHB is responsible for ensuring that its staff provide appropriate assessments and care planning to minimise the risk of harm to patients. I acknowledge the advice of my expert nursing advisor, RN Kaye Mulligan, that individual aspects of the nursing care were adequate. However, I agree with Professor Wilkinson that overall, "the documentation of falls risk and the actions taken to prevent a fall were not adequate and that these are a **major departure** from accepted practice that would incur moderate–severe disapproval of other peers".
56. I consider that failures by ADHB at an organisational level contributed to the deficiencies in this case. A DHB is responsible for ensuring that it has in place robust systems that are both understood and followed by all its clinicians, to ensure that appropriate services are provided to its patients.

### Medicines reconciliation

57. Over his two admissions, Mr A was taking several medications known to lower blood pressure (doxazosin, cilazapril, quetiapine, and oxybutynin) and potentially cause faintness. Mr A did experience hypotension, a faint, and a fall. Professor Wilkinson advised:
- "Had medicine reconciliation taken place it is likely that these issues would have been recognised. The failure to undertake medicine reconciliation, in my opinion, would therefore represent a moderate departure from expected practice."
58. I am concerned that Mr A was given several medications known to cause hypotension, and that these medications continued to be given despite him having experienced hypotension and falls. None of the staff at ADHB appear to have queried Mr A's medicines or ensured that medicines reconciliation was carried out prior to continuing to administer his medications.
59. Expected practice is for pharmacists to be involved in the medicines reconciliation process as soon as possible after a patient's admission. However, at the time of Mr A's admission to hospital, ADHB's practice was that medicines reconciliation would occur within the first 24 hours of hospital admission. In my view, this is not soon enough, and the delay could result in harm to patients. I am also critical that ADHB had no policy or procedure defining or outlining the steps required in relation to medicines review following a fall. More definitive direction and guidance is required by way of process and guidelines. I am very critical that medicines reconciliation was not undertaken close to admission, when Mr A

was discovered to be hypotensive, or at any time during his admission. In particular, there should have been a review of his medications following his falls.

### **Conclusion**

60. By failing to ensure that Mr A's falls risk was assessed appropriately and actions taken to prevent a fall, and for failing to ensure that Mr A was receiving appropriate medication for his needs, ADHB failed to provide Mr A with the services required to minimise the potential harm to him, and, as a result, ADHB breached Right 4(4) of the Code of Health and Disability Services Consumers' Rights.

### **Adequacy of discharge following first admission — adverse comment**

61. Mr A's family were concerned that Mr A was discharged on 9 Month2 without antibiotics, as they understood that he had a urinary tract infection. My expert advisor, consultant physician Professor Tim Wilkinson, advised that antibiotics were not needed. He noted:

“In my experience, bacteria are always present in the urine when someone has an indwelling urinary catheter, but the presence of bacteria is not the same as an infection. It would actually have been bad practice to prescribe antibiotics in these circumstances where there was no evidence of infection.”

62. Mr A's family also told HDC that they were not given any education around catheter care or told that a referral had been made in relation to catheter care.
63. I note that it is documented that referrals were made to both the District Nursing Service and the Urology Service in relation to following up on catheter care when Mr A was discharged from hospital. Professor Wilkinson advised that “these discharge planning arrangements were consistent with good practice”.
64. I further note that Mr A's final medical entry for the admission states that Mr A's family had been educated around managing a urinary catheter at home. Both the medical notes and the occupational therapist notes mention that education was provided. However, there is no documentation regarding any communication with Mr A and his family about a referral to the District Nursing Service prior to discharge or in relation to the catheter education. Professor Wilkinson advised: “[I]f the follow-up information has not been received by Mr A's wife, then the communication was not effective.”
65. I accept from the evidence noted above that referrals were made, and that education was provided. However, clearly the information needed to be communicated more effectively to Mr A and his family. There is always the potential for families to have a different understanding and interpretation of the information provided to them during a busy and stressful time, and accordingly it is important for the information to be documented.
66. It is pleasing that ADHB's staff are now expected to document triage activity in the patient's electronic record, and that the District Nursing Service standard operating procedure regarding documentation is being reviewed and that clear expectations are being formulated.

## Recommendations

67. I recommend that ADHB:
- a) Provide HDC with an update in relation to the effectiveness of the changes made following these events. As part of this, ADHB is to provide this Office with the last audit undertaken in relation to patient falls and staff documentation around the falls. The information is to be provided to HDC within three months of the date of this report.
  - b) Carry out an audit of medicines reconciliation to show when it occurs following a patient's admission. The audit should cover a period of one week (seven days), and the information is to be provided to HDC within three months of the date of this report.
  - c) Provide a letter of apology for Mr A's family. The apology is to be provided to HDC within three weeks of the date of this report.
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## Follow-up actions

68. A copy of this report with details identifying the parties removed, except Auckland DHB and the experts who advised on this case, will be sent to HQSC and placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.

## Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Professor Tim Wilkinson:

“I have been asked to provide an opinion to the Commissioner on [the public hospital] (Auckland District Health Board) and [Mr A] (dec), ref C17HDC01195. I have read and agreed to follow the Commissioner’s Guidelines for Independent Advisors.

My qualifications are: Bachelor of Medicine and Bachelor of Surgery from the University of Otago, Fellowship of the Royal Australasian College of Physicians, Fellowship of the Royal College of Physicians (London), Master of Clinical Education from the University of New South Wales, Doctor of Philosophy from the University of Otago and Doctor of Medicine from the University of Otago. I have worked as a Consultant Physician in Geriatric Medicine at The Princess Margaret and Burwood Hospitals in Christchurch, New Zealand, since 1994 and I am also a Professor in Medicine at the University of Otago, Christchurch. In my clinical work, I deal with common problems faced by older people, particularly those that threaten their independence. I see older people in their homes, in Outpatient Clinics and in Inpatient Wards.

The instructions from the Commissioner are as follows:

‘Please review the enclosed documentation and advise whether you consider the care provided to [Mr A] at [the public hospital] was reasonable in the circumstances, and why. In particular, please comment on:

1. The adequacy of [Mr A’s] discharge planning, including communication with [Mr A’s] wife.
2. The reasonableness of [Mr A’s] discharge without antibiotics.
3. The adequacy of [Mr A’s] falls risk assessment and the procedures in place to ensure he had an effective falls care plan in place.
4. The care provided to [Mr A] following his fall.
5. The quality of documentation, especially in relation to falls.
6. Any other matters in this case that you consider warrant comment.’

I have available to me copies of

1. Letter of complaint dated [...]
2. Clinical records
3. Response letter from Auckland District Health Board (ADHB), dated 14 August 2017

My summary of the timeline of key events is as follows:

26 [Month1] [Mr A] was admitted to [the public hospital] following two days of not passing a bowel motion and abdominal pain. Other relevant



- active problems included Parkinson's disease and cognitive impairment.
- 27 [Month1] He underwent a laparoscopy and adhesiolysis for closed loop small bowel obstruction. A trial removal of urinary catheter was unsuccessful.
- 29 [Month1] His Parkinson's disease was reviewed by the Movement Disorders service who noted no falls and recommended review by physiotherapy.
- 1 [Month2] Transferred to [the] ward for rehabilitation. Falls risk assessment that day scored 25/125 (indicating medium risk) and a plan was put in place that included physiotherapy and occupational therapy reviews and measurement of lying and standing blood pressures. A fall in the previous year was noted.
- 5 [Month2] At a time of experiencing delirium and hallucinations, [Mr A] removed his own urinary catheter causing some trauma, but this was reinserted successfully.
- 8 [Month2] Catheter urine sample sent for culture because of sediment concern; this later showed increased white cells in the urine and a culture for E. Coli.
- 9 [Month2] Discharged home.
- 12 [Month2] Readmitted to [the public hospital] for leakage around urinary catheter, haematuria and lower abdominal discomfort. He was given antibiotics and irrigation of the catheter.
- 13 [Month2] It is not clear to me the exact order of events on this day, particularly when the urological intervention occurred in relation to the other events, but knowing this is not essential to my forming an opinion. The following all seemed to occur on this day: Unwitnessed fall at around 1.30am resulting in forehead lacerations and an unstable cervical spine fracture (C5 spinous process fracture with C5 anterior-inferior endplate fracture, fracture of the right C5 lamina extending into the spinous process, fracture of the spinous process of C4). No neurological deficits were detected. Following orthopaedic review, this was treated with an ASPEN collar. The urinary catheter was again pulled out but could not be reinserted following two attempts so he underwent a cystoscopy and insertion of 3-way catheter. At the time of cystoscopy, a bulbourethral injury was noted, likely as a result of the pulled catheter. He developed a retropharyngeal haematoma,

attributed to the cervical spine injury, that threatened his airway. He was intubated until 15 [Month2].

17 [Month2] Deteriorated and died.

**1. The adequacy of [Mr A's] discharge planning, including communication with [Mr A's] wife.**

The clinical notes record clearly the discussions held with the family in the days leading up to [Mr A's] death. The rationales for decisions at that time are also well documented. From this, I conclude that communication around time of death seems very well documented and consistent with good practice.

The complaint letter states that 'Catheter education was given to [Mr A's wife] on discharge'. This also seems supported by the documentation I read in the clinical notes. From this I conclude that the communication around catheter care was consistent with good practice.

There is disagreement around the shared understanding of the follow-up arranged for [Mr A] regarding catheter care after discharge. It is documented that referrals were made to both the District Nurse and to Urology in relation to following up on the catheter. I note that [Mr A] was to be contacted by the District Nurse on Monday 12 [Month2] but his readmission would have pre-empted that. From this, I conclude that these discharge planning arrangements were consistent with good practice.

It is hard to form an opinion on the adequacy of communication here except to note that if the follow-up information has not been received by [Mr A's] wife, then the communication was not effective. The ADHB shares this view as the response letter states 'there was no clear documentation in the patient's record of interaction between the District Nursing Service Triage Nurse and [Mr A] and his family prior to discharge. Following this investigation, staff are now expected to document triage activity in the patient's electronic record. The District Nursing standard operating procedure regarding documentation is being reviewed and clear expectations in regards to documentation are being formulated.'

**2. The reasonableness of [Mr A's] discharge without antibiotics.**

I concur with the views stated by ADHB that antibiotics were not needed. In my experience, bacteria are always present in the urine when someone has an indwelling urinary catheter, but the presence of bacteria is not the same as an infection. It would actually have been bad practice to prescribe antibiotics in these circumstances where there was no evidence of infection. One could argue that the catheter urine should never have been sent for culture as it only caused concern but knowing the bacteria that are present, should symptoms of an infection arise, can help in deciding the choice of initial antibiotic should that be required. In summary, it is my opinion that good practice was followed here.

**3. The adequacy of [Mr A's] falls risk assessment and the procedures in place to ensure he had an effective falls care plan in place.**

On [the first admission] a second falls risk score was completed on 31 [Month1] and was 35/120 (medium risk) and seemed to be accompanied by appropriate preventative interventions. The first falls risk score was 15/120 (low risk) but this is not dated. I presume this was completed during the same admission but before the second assessment (that is, some time between 26 [Month1] and 31 [Month1]). For this admission, I conclude that the risk assessments were adequate apart from the documentation around dates.

During [Mr A's] stay in [the rehabilitation ward], I noted that on 1 [Month2] the clinical notes recorded that he had one prior fall that year which was attributed to getting up too fast in the garage when his leg was 'asleep'. I see that also on 1 [Month2] a falls risk score was 25/125, indicating medium risk and that there was an associated plan to minimise the risk of falls. On 2 [Month2], it was documented that there was no drop in his blood pressure on standing and the physiotherapy assessment noted he was steady with a frame. There was some drop in blood pressure on standing noted on 6 [Month2] of 20mmHg and again on 8 [Month2] from 140 mmHg to 118 mmHg. On 7 [Month2], the physiotherapist noted good balance (Berg balance 54/56) and that [Mr A] was safe to mobilise independently. It is my opinion that all these actions were consistent with good practice.

However, over all admissions he remained on Doxazosin, despite also having a urinary catheter. Doxazosin is normally prescribed to people with urinary outlet obstruction, such as caused by prostatic enlargement and is used to make it easier to pass urine. One of its side effects is a drop in blood pressure on standing which can cause symptoms of faintness. Faintness can be a cause of falls. While a person has a urinary catheter in place, there is no additional benefit of the drug although it can be of benefit when trialling a person without the catheter. There was no evidence up to this point that [Mr A] was at risk of falling due to low blood pressure. Nevertheless, it would have been good practice to stop the Doxazosin in circumstances when (a) it was not causing a benefit (as there was a catheter in place and when there were no immediate plans to trial without it) and (b) where there was some evidence of harm — a drop in blood pressure noted on at least one occasion. I accept that knowing exactly when he might be trialled without a catheter may not have been determined, so remaining on the Doxazosin, in the absence of it causing harm, was not unreasonable. On balance, it is my opinion that while what was done was not necessarily best practice, I do not consider it a significant departure from accepted practice. Furthermore, the more important assessments and interventions around falls prevention taken over that time were consistent with standard practice.

In contrast, following his readmission on 12 [Month2], I found the documentation relating to falls risk not easy to follow and many of the observations were not dated. This, in itself, is a problem. The most relevant observation is that there is a falls risk

score of 105/125 indicating high risk. While this score is not dated, the patient label indicated it related to the admission on 12 [Month2] and the sequence in which the notes are ordered suggested it probably occurred on that day. I formed this view because it would be hard to conclude that the falls risk score was undertaken after that date, given the ensuing events. The date on the patient label showing his admission date of 12 [Month2] suggests it would be hard to conclude it occurred before that date, that is, before he was readmitted. Regardless of the actual date it occurred, I could find no evidence of any actions taken as a consequence of that score. I could also not find evidence that [Mr A] had been examined by a doctor at that time, although it is possible the relevant part has been misfiled or not included in the records supplied to me and I would therefore be pleased to be reassured on this point. It is possible his examination in the emergency department sufficed for the record on this aspect. I also note, as stated above, that he remained on Doxazosin and there is a suggestion in the notes that faintness may have contributed to this fall.

Putting aside these difficulties in evaluating the evidence, it is my opinion that the documentation of falls risk and the actions taken to prevent a fall were not adequate and that these are a major departure from accepted practice that would incur moderate–severe disapproval of other peers.

There are two possible mitigating factors: (1) falls risk was assessed thoroughly at [the rehabilitation ward] and judged to be low at the time of discharge, (2) there were many things happening at the same time of readmission on 12 [Month2] so there may simply not have been enough time. However, I also note that times of transition (admission, discharge or transfer) are high risk periods for falls at the best of times. These mitigating factors do not alter my opinion.

#### **4. The care provided to [Mr A] following his fall.**

I interpret this as relating to his orthopaedic assessment, the urological intervention, the management of his airway and the decision-making leading up to his death. Apart from the end of life decision making issues, these are areas not directly within my expertise. Nevertheless, I note the clear documentation in the clinical notes, the clear record of discussions with family, the clear outlining of rationales for decisions and that appropriate expert advice was obtained. As such, my opinion is that the care appeared to be of high quality.

#### **5. The quality of documentation, especially in relation to falls.**

This is covered under question 3. My conclusion is that this was a major departure from accepted practice that would incur moderate–severe disapproval of other peers.

#### **6. Any other matters in this case that you consider warrant comment.**

I wonder if the falls risk chart could be altered to make it easier to understand the dates and times when these assessments are undertaken?

The outcome of the ADHB Root Cause Analysis investigation as a 'Severity Assessment Code (SAC) 1' will be important.

Yours sincerely

**Professor Tim Wilkinson**  
**MBChB, MClined, PhD, MD, FRACP, FRCP"**

On 11 July 2018, Professor Wilkinson added:

"I think that RCA is comprehensive and appropriate. It doesn't change my views but does reassure me that appropriate actions are being taken. I don't think there are individuals there who should be specifically criticised — if anything it seems many individuals were working to mitigate things."

On 13 August 2019, Professor Wilkinson added:

"In considering the medications [Mr A] was taking I note that in addition to the doxazosin, which was not a necessary treatment at the time of the fall, he was also taking other medications that either lower blood pressure or can have low blood pressure as a side effect, specifically cilazapril, quetiapine and oxybutynin. Had medicine reconciliation taken place it is likely that these issues would have been recognised. The failure to undertake medicine reconciliation, in my opinion, would therefore represent a moderate departure from expected practice."

## Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from RN Kaye Milligan:

**“[Mr A] and [the public hospital] (Auckland DHB)**

I have been asked to provide advice to the Commissioner on case number C17HDC01195.

I have read and agree to follow the guidelines ‘Guidelines for Independent Advisors’.

**My qualifications** are Registered Nurse, PhD, Master of Arts (Hons), Bachelor of Arts (Nursing), and Diploma of Teaching (Tertiary). I have worked as a registered nurse for approximately 40 years in clinical practice and in nursing education. My teaching experiences include undergraduate nursing students (including teaching in older persons’ health), registered nurses and postgraduate students. My clinical practice as a registered nurse includes surgical services and also Assessment, Treatment and Rehabilitation of Older Adults. My PhD thesis was a case study of the clinical decisions that Registered Nurses in Residential Aged Care in NZ make.

**The aim of this report** is to provide the Commissioner with advice about the care provided by [the public hospital] to [Mr A]. In particular I will provide advice, as requested, on:

- The adequacy of [Mr A’s] discharge planning, including communication with [Mr A’s] wife
- The adequacy of [Mr A’s] falls risk assessment and the procedures in place to ensure he had an effective falls care plan in place
- The care provided to [Mr A] following his fall
- The quality of documentation, especially in relation to falls
- Any other matters that I consider warrant comment

**List of documents and records reviewed:**

- Letter of complaint dated [...]
- Auckland DHB’s response dated 14 August 2017
- Clinical records from Auckland DHB covering the periods of 26 [Month1] to 7 [Month2] and 12 [Month2] to 17 [Month2].

**List of resources referred to:**

Health and Disability Commissioner. (1996). Code of Health and Disability Services Consumers’ Rights. Retrieved from <http://www.hdc.org.nz/the-act--code/the-code-of-rights>

Health Quality & Safety Commission New Zealand. (2017). Ask, assess, act. Retrieved from <https://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/projects/ask-assess-act/>

Health Quality & Safety Commission New Zealand. (2017). DHB assessment tools and care plans. Retrieved from <https://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/projects/dhb-assessment-tools-and-care-plans/>

Health Quality & Safety Commission New Zealand. (2013). Falls risk assessment tools and care plans in New Zealand district health board hospitals: A review and discussed document. Retrieved from <https://www.hqsc.govt.nz/assets/Falls/10-Topics/topic3-risk-assessment-tools-care-plans-Sep-2013.pdf>

Ministry of Health. (2008). Standards New Zealand Health and Disability Services (Core) Standards. Wellington, New Zealand. Retrieved from <https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf>

Nursing Council of New Zealand. (2007). Competencies for Registered Nurses. Retrieved from <http://www.nursingcouncil.org.nz/Nurses>

### **1: The adequacy of [Mr A's] discharge planning, including communication with [Mr A's] wife**

The documentation indicates that once [Mr A] was considered surgically fit for discharge he was transferred to Older Person's Health for multidisciplinary team input. His discharge from Older Person's Health on 9 [Month2] was planned in an ongoing way by appropriate health professionals ie medical staff, physiotherapist and occupational therapist reassessed him and considered him ready for discharge. Nursing staff also documented the plan for his discharge.

- The physiotherapist documented discharge on 9 [Month2].
- The occupational therapist appears to have made an error regarding the date of final documentation. An initial assessment was dated 2 [Month2] at 1215hrs and a subsequent assessment was also dated 2 [Month2] at 0915hrs. The second assessment and review (dated 2 [Month2] at 0915hrs) was in the context of [Mr A's] discharge and stated he was ready for discharge from the NZROT's perspective. The occupational therapist specifically documented 'Patient and patient's wife reported they feel confident with the catheter management and have received education from the nursing staff'.
- On 6 [Month2] medical staff documented in the clinical notes that 'Nurses to pls [please] educate wife re catheter cares' and on 7 [Month2] 'Catheter care education for wife'. On 9 [Month2] medical staff documented 'Pt [patient] family have been educated re catheter cares ...'. The discharge summary was dated 9 [Month2] and amended 12 [Month2] and referred [Mr A] to his GP if he had any problems with his catheter or to see the GP within 2 weeks of discharge if there were no problems.
- The request by medical staff on 6 [Month2] for nurses to educate [Mr A's] wife re catheter is followed up by nurses who reiterated this plan on 6 [Month2] at 1430 and 2100hrs; on 7 [Month2] at 0550, 1300 and 2100hrs; 8 [Month2] at 0530, 1430 and 2130hrs. However despite the plan being repeatedly reiterated the nurses



have not documented that they provided education, nor when this occurred. They also did not document an evaluation of the education ie level of competence and confidence by [Mr A's] wife with the catheter cares. There is also no nursing entry after 0420hrs on the day of discharge.

A referral was made on 8 [Month2] by the registered nurse to the Adult Community Services for continence services (supply of continence bags) and district nursing services (catheter replacement 6/52). The referral to the District Nurse on 8 [Month2] was for 'IDC bag support and DN r/v after 6 weeks'. This does not indicate the need for a home visit over the weekend (the day of discharge was Friday) and there is no specific indication that a weekend visit was required. Nor does it request the first visit to occur on a particular date. It does state that [Mr A's] wife would 'assist with emptying the bag as well as attaching/detaching of nocte bag'.

Comments:

- Registered nurses are required to be competent in their documentation (Competency 2.3 of the Competencies for registered nurses). The lack of documentation by nurses about the education provided to [Mr A's] wife and also about [Mr A's] discharge on 9 [Month2] are both omissions in documentation.
- It appears most probable that education about the catheter was provided as the medical staff and occupational therapist both reported specifically on this.
- While education may be provided there is always the potential for different knowledge, understanding and interpretation by the patient and family and so it would be more beneficial for the registered nurses to document an evaluation of the education ie what [Mr A's] wife knew and was able to do following education.

**Summary:** In my professional opinion, the discharge planning overall was adequate and appropriate. I consider that the education about the catheter was most likely provided but not documented by the registered nurses. The lack of documentation by the registered nurses is an omission that I consider to be a minor departure from acceptable standards.

**2: The adequacy of [Mr A's] falls risk assessment and the procedures in place to ensure he had an effective falls care plan in place**

Admission 1: The documentation related to [Mr A's] admission for surgery and immediate postoperative cares indicates:

- 27 [Month1] MORSE falls risk assessment was completed but no 'care plan' (score 15 which leads to core interventions for all patients); 31 [Month1] MORSE falls risk assessment was completed (score 35 which leads to medium level of interventions) with interventions stated to assist/supervise transfers and mobilisation and to orientate patient at each contact; 1 [Month2] MORSE falls risk assessment was completed (score 25 which leads to medium level of interventions) with



interventions stated to assist/supervise transfers and mobilisation and to orientate patient at each contact as well as to refer to physio.

- Medical notes: 29 [Month1] requested a physiotherapy assessment for mobility; 1 [Month2] documented one previous fall earlier in the year after getting up too fast; 7 [Month2] 'advised techniques for getting out of bed to minimise postural symptoms' (for postural drop).
- Nursing notes from 30 [Month1] to 6 [Month2] documented that [Mr A] had decreased mobility and at times was unsteady on his feet. Also that he was supervised when mobilising independently (ie he walked unaided or with a walking frame but had nurse supervision for potential unsteadiness). On 5 [Month2] (overnight) [Mr A] was found walking in the corridor past the nurses station.
- Combined occupational therapy and physiotherapy entry on 1 [Month2] stated orange band was given and supervision was required for mobility, bed mobility and bed to chair transfer.
- Physiotherapist assessed [Mr A's] mobility on 30 [Month1] 'red socks and supervision band provided' and requested nurse supervision for mobility; 2 [Month2] mobility assessment was completed and specific exercises were to be promoted; 7 [Month2] reassessment was completed using Berg Balance Scale and [Mr A] was considered safe to mobilise unaided independently and was ready for discharge from the inpatient physio perspective. On 8 [Month2] [Mr A] did not attend falls education and he declined with no reason given.
- Occupational therapist documentation: Document 1 was dated 2 [Month2] and stated falls prevention information had been provided; reduced balance, endurance and strength following surgery as well as previous medical conditions, and also exercises were provided and falls prevention information and education was provided regarding home environment safe set up. Document 2 was dated 2 [Month2], however this appears to be relevant for 8 [Month2] stating [Mr A] was ready for discharge with discharge ? following day.
- A Modified Elderly Mobility Scale was completed on 2 [Month2] and again on 7 [Month2] showing improved overall functional mobility.

#### Comments:

- A multifactorial assessment was completed using a standardised tool which covered many risk factors (eg a history of falling, problems with mobilising, taking medication that could increase the risk of falling, impaired cognitive state, problems with continence, problems related to underlying conditions and risks associated with hospitalisation, Health Quality & Safety Commission New Zealand, 2013).
- Appropriate interventions were identified on the clinical notes and were implemented.

- As this hospitalisation covered the time of surgery and recovery from surgery, [Mr A] experienced reduced mobility that improved during this stay.

Admission 2: The documentation related to [Mr A's] re-admission due to issues regarding his catheter indicates:

- 12 [Month2] MORSE falls risk assessment was completed (score of 105 which indicated a high score) but no falls care plan was completed.
- 12 [Month2] at 0848hrs 'Assessment to Discharge Part A' plan was completed and a previous fall in past 12 months was recorded with the AED action being to keep call bell within reach. Also documented was that there were 'no concerns' regarding [Mr A's] behaviours.
- 12 [Month2] 'Assessment to Discharge Part B' plan documented a falls risk assessment was completed and a Behaviour of Concern form was not required. 'Current function' indicated supervision was required for all mobility.
- 12 [Month2] at 2110hrs on the Clinical Notes the registered nurse documented [Mr A's] transfer to the ward at 1600hrs. Also documented was that [Mr A] had low blood pressure and a vaso-vagal episode requiring the emergency team to attend. He was immediately assisted to bed. He remained on the bed following this episode. He was to have all Activities of Daily Living supervised (this includes mobility). Some other details were also documented.
- 12 [Month2] Adult Observation Chart showed vital sign recordings were taken at 1700, 1730, 1805, 2100hrs and (13 [Month2]) 0020, 0130, 01(?)35, 0150, 0200, 0205, 0300 and 0415hrs.
- 13 [Month2] at 0130hrs medical staff documented another emergency team callout was made as [Mr A] was found with reduced level of consciousness and low blood pressure. This resolved spontaneously and was considered another vaso-vagal episode. An unwitnessed fall was subsequently documented when the RN left the room for approximately 2 minutes to clear equipment and the impression was syncope from likely low blood pressure on standing. A 'watch' was requested.
- 13 [Month2] at 0800hrs registered nurse documented the events of the night shift (2300hrs 12 [Month2] to 0700hrs 13 [Month2]). Documentation includes reference to: low blood pressure and code red; patient agitated and aggressive; catheter washout was performed due to pain which resolved following the washout; [Mr A] subsequently settled; after 5 minutes patient appeared to be sleeping and nurse left the room leaving side rails down; [Mr A] had unwitnessed fall within next 2 minutes and was found face down on the floor. A 'watch' was present after the fall.
- 13 [Month2] Behaviour of Concern Pathway form was completed stating [Mr A] was confused, high falls risk (interference with treatment, lack of co-operation, falls risk, unable to follow instructions, disorientated/confused) and that increased observation was required for constant visual observation with patient in sight at all

times (Category B) requiring additional staffing for increased observations by Health Care Assistant. This form is dated 13 [Month2] but no time is included.

- An attender completed documentation at 0700, 0730, 0800, 0835, 0900 and 0950hrs on 14 [Month2].

Comments:

- Information was recorded on the 'MORSE falls risk assessment' and the 'Assessment to Discharge Part A' form regarding [Mr A's] earlier fall (ie prior to both admissions). This information was not transferred to the 'Adult observation chart' dated 12 [Month2]. However a prior fall is only one risk factor among many and the falls risk assessment showed a high level of risk.
- There were four forms completed on the day of admission which all addressed the falls risk in varying detail ('Morse Falls Risk Assessment and Care Plan', 'Assessment to Discharge Part A', 'Assessment to Discharge Part B' and the 'Adult observation chart'). There is the potential for information to be lost between forms. It is also likely that the ward nurses will pay attention to the form that is most relevant to their ward area and most recently completed.
- The intervention to prevent falls ie of supervision of mobility, was clearly ticked on the 'Assessment to Discharge Part B' plan dated 12 [Month2] but not on the Care Plan section (page 2) of the 'Falls Risk Assessment and Care Plan' dated 12 [Month2].
- The procedures to ensure an effective falls care plan include the completion of multiple forms and this may detract from the handover of key information.
- The procedures to ensure an effective falls care plan appear to have been mainly carried out, and in spite of this [Mr A] did suffer a major fall.

**Summary:** In my professional opinion, appropriate falls risk assessments were completed adequately, though not thoroughly, on relevant forms for both admissions. On the second admission the appropriate intervention was identified on one assessment form and in the clinical notes ie supervision of mobility. The intervention appears to have been carried out. The procedures to ensure an effective falls care plan appear to be adequate.

### **3: The care provided to [Mr A] following his fall**

Appropriate nursing care appears to have been provided to [Mr A] following his fall. This took place in the Urology Ward and in the Department of Critical Care (DCC).

**Summary:** In my professional opinion, the nursing care provided following [Mr A's] fall was appropriate.

### **4: The quality of documentation, especially in relation to falls**

The documentation related to both admissions appears to be standard documentation. While it has not all been fully completed it adequately documents the

assessments completed and cares provided to [Mr A]. It would be very unusual to have all forms fully completed for any patient. However, the documentation provides sufficient detail, as well as the overall picture and gives an appropriate account of the events that occurred.

**Summary:** In my professional opinion, the quality of documentation is satisfactory.

**5: Any other matters I consider warrant comment**

Forms for documentation are used in every hospital setting and they do vary. In my professional opinion there are aspects that work well for some patients and not for others, depending on the particular problem/s the patient experiences. It is more challenging to complete documentation for patients with complex needs. A review of the forms used in order to further streamline them may be useful.

I note the Auckland DHB is undertaking a root cause analysis.”