Private Hospital / Two Charge Nurses

Report on Opinion - Case 98HDC15375

Complaint

The Commissioner received a complaint about services provided to the complainant's late mother at a private hospital. The complaint is summarised as:

Private Hospital

- *In early March 1998 a nurse tried to give the consumer her medication. The consumer did not want to take the medication. The nurse over-powered the consumer, who sustained an injury to her lip and left hand.*
- *The consumer's son was not advised that his mother had been assaulted by the nurse until after eight days later and then only because the hospital was aware that a relative had contacted him.*
- *At no time was the complainant advised that there were any problems with his mother's food or medication.*
- *In early April 1998 the consumer had a fall in her room and broke her hip in three places. She was not properly assessed following the fall.*
- *The complainant was not advised that his mother had fallen in early April 1998.*
- *During a telephone conversation in mid-April 1998, the complainant was not advised by the hospital that his mother had suffered breathing problems the night before which required her to be attended by a doctor that evening. The consumer died later that day.*
- *The hospital has denied that the consumer's death was connected in any way to her fall in early April 1998.*

First Staff Nurse

- *In early March 1998 a nurse tried to give the consumer her medication. The consumer did not want to take the medication. The nurse over-powered the consumer, who sustained an injury to her lip and left hand.*

Second Staff Nurse

- *In early April 1998 the consumer had a fall in her room and broke her hip in three places. The consumer was not properly assessed following the fall.*

Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Investigation Process

The Commissioner received the complaint on 12 June 1998 and an investigation was commenced on 26 August 1998. Information was obtained from:

Consumer's son, complainant
Consumer's cousin
Consumer's grand niece
Principal Nurse, Private Hospital
Deputy Principal Nurse, Private Hospital
Two staff nurses, Private Hospital
Caregiver, Private Hospital

Clinical records were obtained and reviewed.

Information Gathered During Investigation

In 1994 the consumer was admitted to a private hospital following a stroke. She suffered from right-sided paralysis and an inability to talk. As a result of her stroke she was wheelchair bound and communicated by way of physical expression, for example pointing things out with her left hand.

The admission record stated the consumer's son was her next of kin. The consumer's son lived in another country. He could be contacted by telephone at work or home. The emergency contact person was listed as the consumer's sister, the consumer's cousin and the consumer's grand niece.

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

In early March 1998, during afternoon duty, the staff nurse responsible for giving the consumer her medication reported to the acting charge nurse that the consumer was refusing her medication including codalax syrup (a laxative). The charge nurse offered to administer the medication to the consumer. There was no one else present when she attempted to give the consumer the medication. The consumer sustained a cut to her bottom lip and bruising to her left hand. The charge nurse advised the Commissioner:

> "*As she* [the consumer] *usually took her medications for me I offered to give them to her. When I entered her room* [the consumer] *was quite agitated. I talked to her and asked her to take her medications especially her laxatives as she often had problems with her bowels. She lashed out with her unaffected arm and leg attempting to hit and kick me. I held her hand with mine to try to stop her.*
>
> *As I continued to speak to her she quietened down and appeared to be going to take the medications but as I went to give them to her she reacted in such a way that the spoon connected with her lip causing the injury to it.*
>
> *At no time during the date in question did I attempt to overpower* [the consumer]. *The hand injury occurred when I was attempting to stop her hurting herself and me. The lip injury occurred when the spoon made contact with her lip when she appeared to be going to accept her medications then changed her mind.*"

The charge nurse advised the Commissioner that although the medication signing sheet for 5.30pm that day records the medication as given, it is not her signature. The charge nurse was unable to recall specifically whether she had succeeded in administering the medication to the consumer but said she thought probably not because of the way the consumer reacted: "*I would have stopped. I know I caused the injury to her lip because it appeared she was going to take it, but I would not have forced it*".

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The consumer's caregiver for that afternoon advised the Commissioner that at around 5.00-5.30pm that day the charge nurse came and told her that the consumer was upset because she (the charge nurse) had tried to give the consumer some medication and the consumer was bleeding at the sides of her lips.

The caregiver went to see the consumer straight away and advised the Commissioner:

> "*She* [the consumer] *really was upset, crying and making noises (*[the consumer] *didn't speak, but could make herself understood) which I recognised as the sound she made when she was upset. I could see blood on the side of her mouth and* [the consumer] *pointed to her hand and I could see a bit of bruising starting to come out to the back of her hand. I cleaned the blood from the side of her mouth with clean water which seemed to make her feel better. I sat with her for five or six minutes and talked to her and calmed her down. She didn't want any dinner, but that was not unusual.*"

The caregiver continued with her other duties and checked on the consumer periodically. The caregiver washed, changed, and settled the consumer for bed between 6.30-7.30pm.

At some time during the afternoon duty following the incident, the charge nurse asked the caregiver how the consumer was and told the caregiver what had happened. The caregiver advised the Commissioner that she recalled the charge nurse telling her that the incident had occurred when the charge nurse had tried to give the consumer her medication and the consumer did not want it, and started hitting out and kicking. The charge nurse had said she put her hand on top of the consumer's hand to stop the consumer hitting her (the charge nurse). The caregiver recalled that the charge nurse advised her:

> "*As* [the charge nurse] *put her hand on* [the consumer's] *the chair went back.* [The charge nurse] *kept trying to give* [the consumer] *the medicine, and then the chair came forward and that's how the incident happened.*"

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The caregiver said the charge nurse told her that the chair the consumer was seated in tipped backwards because the consumer had pushed on the floor with her functional leg when the medicine was being held to her mouth. When the consumer stopped pushing with her leg, the chair tipped forward again and her lip was cut on the medicine implement being held to her mouth.

The caregiver suggested to the charge nurse that she should fill out an incident form. At the end of the shift the caregiver recorded in the consumer's notes:

> "*PM: Splits on side of mouth, bruise to lower lip, also on left hand.*"

The charge nurse did not report the incident in the nursing notes or fill out an incident form as required by the hospital's protocols.

The following day the deputy principal nurse was contacted by the consumer's cousin, as she had concerns about the incident the day before. The deputy principal nurse advised the consumer's cousin that a full investigation would be carried out and that the results would be made available to her upon completion.

The principal nurse at the hospital advised the Commissioner that she was made aware of the incident by two staff members on duty at the time: a caregiver who no longer worked at the hospital and the caregiver involved in her care that day. The caregiver telephoned the principal nurse from home the day after the incident to ask if the charge nurse had filled in an incident form. The caregiver then told the principal nurse about the incident. The principal nurse conducted an investigation into the matter. The interview records from her investigation with the staff on duty on the day of the incident are no longer available.

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The principal nurse advised the Commissioner that "[r]*eluctance to take laxatives in any form and constipation was an ongoing problem with* [the consumer]". The principal nurse noted that on the day of the incident the charge nurse did not document the incident in the nursing notes, fill out an incident form, or contact the next of kin or emergency contact persons to advise them of the incident. Two days later the principal nurse completed an incident form for the matter. Comments by the principal nurse on the incident form included:

> "*If* [the consumer] *refuses to take her medication please explain again the effects of missing the dose might have, offer it to her again and if she refuses document it but do not insist on administering the medication.*
>
> *B) Change to policy required*
> *Nil – Policy already in place re medication dispensing*"

The medication administration policy current from October 1996 until October 1998 said:

> "*Should a client be unhappy about taking a certain drug or refuse to take it, the matter should be referred to the doctor who will offer further explanation or reassurance as required.*
>
> *Clients have the right to refuse any drug or treatment but every attempt should be made to ensure that the client is adequately informed so that consent can be given based on correct and appropriate information and consent is not withheld due to ignorance or fear.*"

The principal nurse advised the Commissioner that staff are educated about the policies at the hospital as part of their orientation.

> "*Registered nurses do not administer medications until they have been instructed either verbally, by reading the policy, or both regarding medication administrations. With specific reference to* [the charge nurse], *she was a long time staff member who knew of this policy.*"

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

Approximately one week later the principal nurse completed her investigation into this matter. The result of her investigation was that the charge nurse was provided with a written warning from the hospital about her actions and inaction in relation to this incident. The formal warning to the charge nurse read:

> "*It has been brought to my attention that* [in early March 1998], *your behaviour while giving* [the consumer] *her medication was unacceptable.*
>
> *I am told that* [the consumer] *was refusing to take her medication. It was evident from the 'loud noises' which were heard by other staff and the injury sustained by* [the consumer] *that some degree of force was used in administering medication.*
>
> *I understand that you had* [the consumer's] *interests at heart but the manner in which it was expressed was a direct violation of* [the consumer's] *rights.*
>
> *I have noticed that you have not filled out an Accident / Incident Form thus failing in your duty as Charge Nurse to complete documentation.*
>
> *If you are facing any problems in your professional practice, you are welcome to discuss them with either the Charge Nurse or myself.*
>
> *This letter constitutes a formal warning.*"

The hospital has a policy regarding the notification requirements of the next of kin for terminally ill consumers, and this policy was current from 1989. The policy called "*Care of the terminally ill client*" states that the charge nurse has a responsibility "*To notify the* [next of kin] *of the client with the terminal illness of any significant change in the client's condition. When the* [next of kin] *is not able to* [be] *contacted or is unable to come to the Hospital immediately notify the emergency contact*".

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The principal nurse advised the Commissioner that the hospital had an informal policy regarding notification of next of kin of the occurrence of an incident or accident. The person listed as the next of kin should be notified in the first instance if the injury sustained is serious, and requires the consumer to be transferred to another facility. Where the injury is serious but the consumer can be nursed at the hospital it is a matter of judgement for the registered nurse on duty to decide whether to call the next of kin.

The principal nurse advised the Commissioner that for both accident/incident notification and terminal illness notification where the next of kin are unavailable, the emergency contact person is to be contacted, with the next of kin being notified as soon as they can be reached. If the next of kin are available, it is left to them to notify any other persons they choose. The hospital had no specific policy which related to the protocol to be followed where an altercation occurs between a staff member and a consumer.

The consumer's son advised the Commissioner that he was not "*EVER informed of problems re: medication/food/whatever, I am next of kin, but I always found out about things through my mother's cousin, never the hospital*".

The principal nurse advised the Commissioner:

> "*The nursing challenges* [the consumer] *posed were not insurmountable. We were able to keep her happy most of the time. Her family visited her with unfailing regularity and had numerous informal discussions with staff re* [the consumer]. [the consumer's son] *called his mother frequently and took the opportunity to informally discuss* [the consumer's] *progress with staff. I myself have discussed with* [the consumer's son] *(during his visits to New Zealand) various aspects of* [his mother's] *care. I am unable to understand why* [the consumer's son] *is stating that he was unaware of* [his mother's] *'problems'*."

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The hospital did not formally make the complainant aware of this incident until he received a letter from the principal nurse, dated approximately one week after the incident, concerning her investigation. The following day the complainant called the hospital and spoke to the deputy principal nurse regarding the incident. The deputy principal nurse documented in the consumer's clinical notes the following:

> "[Mid-March 1998].... *His call to me, prompted by a phone call to him from* [the consumer's cousin] *regarding the incident.* [The consumer's son] *concerned that* [the consumer] *had had medication forced upon her. Discussed with* [the consumer's son] *needs for regular bowel medication due to* [the consumer's] *chronic constipation – compounded by her immobility since her stroke. ...* [The consumer's son] *states he is aware from his visits here, after* [the consumer] *has suppositories, that she certainly doesn't like it. I have informed* [the consumer's son] *that* [the consumer's grand niece] *has spoken to me regarding a change of GP* – [the consumer's son] *concerned that* [the consumer's grand niece] *and* [the consumer's cousin] *have no right to make such a decision on* [the consumer's] *behalf. He states they are visitors and that he is* [next of kin] *and any such matter must be discussed with him.*"

Fall

In early April 1998 at about 9.20am the consumer fell from her bed following the administration of suppositories. A staff nurse who was acting as charge nurse that day assessed the consumer, notified the doctor who was on the premises at the time, and filled out an incident form. In a letter to the consumer's son, dated four days later, the principal nurse described the fall as follows:

> "[The consumer] *sat herself up for breakfast – which she sometimes does, and was helped to lie down after breakfast. Her nurse administered suppositories to* [the consumer] *and explained to her that she would return in 15-20 minutes.* [The consumer] *was noticed to be sitting up on the side of her bed soon after the nurse left the room.* [The consumer] *was helped to lie down and advised to give the suppositories time to 'work'. After about fifteen minutes* [the consumer] *was found on the floor beside her bed by her nurse, who then informed the charge nurse.*

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

> *… We have tried to put cot sides on* [the consumer's] *bed but* [the consumer] *strongly refuses to use them. She sometimes also refuses to use the safety belt in her chair. The risk involved has been explained to* [the consumer], *but we have not been successful in gaining her cooperation.*
>
> *We are extremely sorry that* [the consumer] *has been hurt, but* [the consumer] *did not want to accept safety at the expense of her independence.*"

The principal nurse also stated that the charge nurse advised the caregiver to continue with the consumer's cares after ascertaining that there were no signs or symptoms of injury, and contacted the hospital doctor only after the caregiver informed the charge nurse that the consumer did not appear very comfortable. The charge nurse documented in the consumer's notes:

> "*Fell approx 0920 – Refer accident form.* [Seen by hospital doctor] *0930. Obvious discomfort and swelling right hip. Probable* [fracture] *right neck of femur. BP 170/100 P 84. Referred to orthopaedic registrar* [at a public Hospital]. *Transferred for assessment and probable surgery.*"

The principal nurse advised the Commissioner that every fall is to be reported to the registered nurse by caregivers. The registered nurse assesses the consumer as soon as is practical and explains to the caregiver when the consumer can be moved. The decision whether or not to contact the doctor is made by the registered nurse.

The hospital doctor assessed the consumer ten minutes after the fall was discovered, at 9.30am and referred her to a public hospital with a suspected hip fracture. The doctor described the consumer's condition in the records as:

> "*Fell off bed. ?* [fractured] *right hip/femur. Refer to* [public hospital]."

The consumer's vital signs were recorded as "[blood pressure] *170/90* [pulse] *84*".

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The accident form which the charge nurse filled out states the accident occurred at approximately 9.20am and includes the following information:

> "[The consumer] *was found by* [a hospital aid] *sitting on edge of her bed early* [morning] *and had put her back on the bed.* [The consumer] *then was given* [suppositories] *as* [bowels not open] *3 days. I assume that* [the consumer] *must have got herself up again and fell. When* [the hospital aid] *went back in the room* [the consumer] *was found sitting on her bottom with both legs outstretched.*
>
> *Injury Sustained? YES*
>
> *Type of Injury? SUSPECTED FRACTURE RIGHT HIP*
>
> *Further treatment required? YES*
> *REFERRED TO* [public hospital] *ORTHOPAEDIC REGISTRAR FOR ASSESSMENT FOR PROBABLE ADMISSION AND SURGERY FOR ? # R NOF* [fractured right neck of femur].
>
> *Relatives informed? YES* [consumer's sister, cousin and grand niece] *all informed.*
>
> *Doctor informed? YES*
>
> *Witness to accident? NO*"

In the consumer's clinical notes recorded that day, the charge nurse wrote that she tried on two occasions to contact the consumer's son. The charge nurse advised the Commissioner that the reason she could not reach him was that the telephone lines were overloaded. The charge nurse documented the following in the consumer's clinical notes:

> "[The consumer's sister, cousin and grand niece] *all informed. Still unable to contact* [the consumer's son] *via 2.40 p.m. ... still unable to contact* [the consumer's son] *1500* [3.00pm]. [The afternoon staff nurse] *will try again later.*"

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The consumer's son advised the Commissioner:

> "*On the day of* [the consumer's] *fall* [in early April 1998] *I found out because my cousin had left a message on our answering machine, which my wife received in the afternoon and after speaking to my cousin, phoned the hospital and asked why hadn't they phoned us. Their answer was, they couldn't get through, although, my cousin was able to get through on a number of times that day.*"

The consumer returned to the private hospital from the public hospital four days later following surgery for her fractured right neck of femur, accompanied by her cousin. The consumer had an indwelling urinary catheter in place and her wound was to be dressed daily with removal of the wound closures in ten days. The hospital doctor assessed the consumer and prescribed panadiene for pain relief. The consumer had the urinary catheter removed three days after discharge and her wound was noted to be healing well each dressing change, with instructions given by the doctor five days later for the wound closure devices to be removed after another four days.

On the morning of the day the wound closure devices were to be removed, the doctor prescribed frusemide tablets (diuretics) for reducing fluid in the consumer's lungs. The consumer had a normal temperature. Two days later the consumer developed a fever of 38.3ºC in the evening and refused all food, fluids, and medication, prompting staff to contact the on-call doctor from an accident and emergency centre. The doctor prescribed the consumer an antibiotic to treat a probable chest infection. That day the consumer was visited by her grand niece and niece. The notes record that attempts were made by the hospital to contact the consumer's cousin but the telephone was engaged.

The consumer's son advised the Commissioner that when he rang the hospital from his home country that day to speak with his mother, "*as we did every* [week on the same day], *we felt she was not happy, so I phoned* [the hospital the following day] *to speak* [to] *them about* [his mother]".

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Information Gathered During Investigation *continued*

The consumer's son and the principal nurse advised the Commissioner that on this day the consumer telephoned the hospital and spoke to staff and his mother at around lunchtime. The records state "[The consumer] *called from* [his home country], *has been informed of* [his mother's] *condition*". The consumer's son disputes that he was told that his mother was unwell on this date. He advised "*When I phoned* […], *the hospital staff didn't say a thing to me about* [the previous] *evening & the Dr's concern*". The principal nurse advised the Commissioner that she telephoned the consumer's son later that day and notified him that his mother had deteriorated since his earlier call. The consumer died that evening. The hospital telephone records show two calls were made from the hospital to the consumer's son that afternoon for approximately three minutes and again around three and a half hours later for approximately four minutes. This was approximately 20 minutes after the consumer had died.

The consumer's son met with the principal nurse and deputy principal nurse in late April 1998 to discuss his mother's sudden death, and questioned why he was not informed of her worsening condition. The principal nurse informed him that she had spoken to him on the telephone on the afternoon of his mother's death. The meeting records stated that the complainant denied receiving a call in the afternoon from hospital staff. The record stated that a copy of the telephone records were faxed to the complainant's motel later that day.

The complainant advised the Commissioner it was not possible for him to have received such a call, as he was not at home at that time. The complainant said that he received an answer phone message from his cousin in the afternoon advising him his mother "*had taken a turn for the worst*". The complainant said after listening to his cousin's message "*about 5-10mins later, I received a call from* [the] *Hospital to say my mother had passed away*".

Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

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

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

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

7) Every consumer has the right to refuse services and to withdraw consent to services.

Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Opinion: Breach First Charge Nurse

In my opinion the charge nurse involved in the incident in early March 1998 breached Right 4(1), Right 4(2), and Right 7(7) of the Code.

Right 4(1)

In my opinion the charge nurse did not exercise reasonable care and skill when she injured the consumer while administering the consumer's medications in early March 1998. The consumer sustained injuries to both her hand and mouth while attempting to refuse her medication. The charge nurse continued to pursue the consumer's compliance despite the consumer's obvious agitation.

The charge nurse accepts that she made physical contact with the consumer, but states that the injury to the consumer's hand was caused when the charge nurse attempted to stop the consumer hurting herself or the charge nurse. I do not accept this as an excuse. The charge nurse was aware the consumer had refused to take the medications and was agitated, but proceeded to try and administer them anyway despite obvious signs that the consumer did not wish to take the medication. The injuries were caused during the charge nurse's attempt to try and persuade the consumer to take the medication. In my opinion the charge nurse failed to provide services to the consumer with reasonable care and skill and therefore breached Right 4(1) of the Code.

Right 4(2)

The charge nurse failed to act in a professional manner in early March 1998 when she attempted to administer medication to the consumer. The consumer was known to be reluctant to take her medication at times. The hospital had a clear protocol (of which the charge nurse was, or should have been, aware) that stated that clients have a right to refuse medication and that when a client is reluctant to take medication, information should be given to the client to ensure that the client is informed of the reason that the medication is prescribed. If a client continues to refuse medication the protocol required that the issue be referred to the doctor. Despite the protocol, the charge nurse continued in her efforts to have the consumer accept her prescribed codalax. In my opinion the charge nurse's failure to comply with these protocols is a breach of Right 4(2) of the Code.

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Opinion: Breach First Charge Nurse *continued*

The charge nurse also failed to comply with hospital protocols when she neglected to document the incident, including the consumer's injuries, in the nursing notes and on the appropriate incident reporting form. The need to do so was brought to her attention on the day of the incident by the caregiver. By failing to complete the incident report, the charge nurse breached Right 4(2) of the Code.

Right 7(7)

The consumer had the right to refuse services or to withdraw consent to services.

Before placing the medicine spoon to the consumer's lips, the charge nurse was aware that the consumer wanted to refuse the medication. First, when told by the staff nurse that the consumer did not want to take her medicine, and secondly when the consumer "*lashed out with her unaffected arm and leg*" to the charge nurse. The charge nurse had observed that the consumer was agitated when she entered her room. In proceeding to administer the medication notwithstanding this clear evidence of refusal, the charge nurse failed to give effect to the consumer's right to refuse a health service, and therefore breached Right 7(7) of the Code.

Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Opinion: No Breach Second Charge Nurse

In my opinion the charge nurse involved in the incident in early April 1998 did not breach Right 4(2) of the Code.

The charge nurse assessed the consumer promptly when notified of the consumer's fall in early April 1998, and notified the doctor who saw the consumer within ten minutes of her fall. The charge nurse filled out the required documentation appropriately, including nursing notes and an accident form. The charge nurse acted according to the guidelines from her employers in assessing the consumer as soon as was practical and in calling the doctor for an apparent fracture.

The records show that the charge nurse endeavoured to notify the consumer's son, as the next of kin, on the same duty that the consumer's fall occurred on, and, when she was unable to do so, left instructions for staff on the next duty to continue trying. Other relatives who were listed as emergency contacts and were known to be regular visitors were notified of the consumer's fall. In my opinion the charge nurse acted in accordance with the standards set by the hospital when she provided care to the consumer in early April 1998.

Opinion: No Breach Private Hospital

In my opinion the private hospital did not breach Right 4(2) of the Code.

Medication administration

The consumer's son, as next of kin, was not formally made aware of the incident by the hospital until he received a letter from the principal nurse, dated eight days after the incident occurred, concerning her investigation.

Although no specific protocol is in place regarding notification of next of kin following an altercation, in my opinion the hospital took appropriate steps to deal with the matter. The day after the incident, the deputy principal nurse discussed the situation with the consumer's cousin, who was monitoring the consumer. The incident was appropriately investigated and the consumer's son was notified of the outcome in a timely manner.

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Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Opinion: No Breach Private Hospital *continued*

Fall

I am satisfied that the private hospital attempted to contact the consumer's son in early April 1998, but was unsuccessful due to the telephone lines being overloaded. The hospital then contacted the emergency contacts. In my opinion this was an appropriate step in the circumstances. The consumer was able to be comforted by having family members present when she was admitted to the public hospital.

Notification of Final Illness

The records of the day the consumer died state that the complainant was informed of his mother's condition during a telephone call that day and I am satisfied that this occurred. The '*Care of the terminally ill client*' policy requires that the next of kin of the client with a terminal illness be notified of any significant change in the client's condition. The consumer's condition took a turn for the worse around the last two days of her life. The telephone records show that a call was made in the afternoon from the hospital to the consumer's son's home telephone number on the day of his mother's death, a call that lasted approximately three minutes, and I accept that the principal nurse made this call to notify the consumer's son of his mother's deteriorating condition.

In my opinion the hospital did not breach the Code in relation to notifying the consumer's son of his mother's condition on the day of her death.

I am unable to conclude that the consumer's fall in early April 1998 subsequently led to her death fifteen days later. In my opinion, the hospital did not breach the Code in denying that the consumer's death was caused by the fall.

Private Hospital / Two Charge Nurses

Report on Opinion – Case 98HDC15375, continued

Actions

I recommend that the first charge nurse takes the following actions:

- Apologises in writing to the complainant for the breach of the Code in relation to the treatment his mother received in early March 1998. This apology is to be sent to the Commissioner, who will forward it to the complainant.

- Familiarises herself with the medication administration policy of the hospital.

I recommend that the hospital takes the following actions:

- Formalises the unwritten policy regarding notification of next of kin in the event of an accident/incident, clearly stating the criteria for such notification.

Other Actions

A copy of this opinion will be sent to the Nursing Council of New Zealand.

A copy of this opinion with identifying features removed will be sent to the Ministry of Health Licensing Office, Residential Care New Zealand, and Quality Health New Zealand.

I am referring this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994.

Other Comments

This complaint arose in part because of the complainant's concern that he, as next of kin, was not kept fully informed of aspects of his mother's care. I acknowledge that where next of kin are unable to visit a family member regularly it is more difficult for providers to maintain contact. It is important that a concerted effort is made to do so. In the complainant's case he made regular telephone calls to the hospital and he could easily have been advised of all aspects of his mother's care.