Hawke's Bay District Health Board

A Report by the
Health and Disability Commissioner

(Case 18HDC02226)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a prisoner by Hawke's Bay District Health Board (HBDHB), and highlights the importance of hospitals having robust systems in place to detect when regular medications have not been charted for patients.

2. On 16 November 2018, the man was transferred from the prison to hospital, as he had severe flank pain. He was reviewed in the Emergency Department (ED), and his regular medications were noted in the ED notes.

3. The man was then reviewed by the General Surgery team and admitted to the General Surgery ward. However, his regular medications were not charted. The man remained in hospital from 17 to 20 November 2018, but it was not until the time of his discharge that it was discovered that his regular medications had not been charted or administered during his admission.

Findings

4. The Commissioner found that HBDHB failed to provide appropriate care to the man and breached Right 4(1) of the Code. The Commissioner considered that several systemic issues at HBDHB contributed to the failure to chart and administer regular medications, including the lack of clarity among surgical and ED staff about the responsibility for charting regular medications, staffing issues and high registrar workload, and ineffective post-admission and ward-round mechanisms.

Recommendations

5. The Commissioner recommended that HBDHB provide a written apology; randomly audit whether regular medications had been charted for 30 patients who were admitted to the General Surgery ward; confirm development of a formal checklist and action plan for admissions to the General Surgery ward from the ED; provide evidence of on-going development on the use of the Surgical Ward Round form; and report back to HDC regarding the plan to roster an additional registrar.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Hawke's Bay District Health Board (HBDHB). The following issue was identified for investigation:

- *Whether Hawke's Bay District Health Board provided Mr A with an appropriate standard of care in November 2018.*

7. This report is the opinion of the Health and Disability Commissioner.

8. The parties directly involved in the investigation were:

Mr A	Complainant/consumer
HBDHB	Provider

9. Also mentioned in this report:

Dr C	ED registrar
Dr D	General Surgery consultant

10. Further information was received from Dr B, a general surgery registrar.

11. Independent clinical advice was obtained from a consultant general surgeon, Dr Mark Sanders (Appendix A), and an emergency physician, Dr Shameem Safih (Appendix B).

Information gathered during investigation

Introduction

12. On 16 November 2018, Mr A, a prisoner, was transferred to HBDHB by ambulance and admitted to the General Surgery ward. Mr A had a medical history of high blood pressure and depression, and was taking anti-hypertensives and anti-depressants.

13. Mr A was discharged on 20 November 2018.

Presentation to ED

14. At 12.30pm on 16 November 2018, Mr A was reviewed by a nurse at the prison, as he had severe flank pain. At 1.23pm, Mr A was transferred to HBDHB by ambulance. The prison referral form provided to the hospital stated that Mr A had "sharp stabbing pain" at his right flank, and listed Mr A's regular medications as felodipine,[1] mirtazapine,[2] losartan potassium,[3] fluoxetine,[4] and hydrochlorothiazide.[5]

15. Mr A arrived at the hospital around 1.45pm and was admitted to the Emergency Department (ED). At 2.35pm, Mr A was reviewed by an ED nurse and allocated a triage Code 3.[6] Around 2.45pm, Mr A was reviewed by an ED registrar, Dr C. Dr C recorded in the clinical notes that Mr A continued to have severe pain in his right flank, and that following a discussion with the ED consultant, it was agreed that a referral to the General Surgery ward should be made. Dr C documented Mr A's regular medications in the ED notes.

[1] Used to treat high blood pressure (hypertension).
[2] Used to treat depression.
[3] Used to treat hypertension.
[4] Used to treat depression.
[5] Used to treat hypertension.
[6] Recommended waiting time of 30 minutes.

16. An ISBAR[7] Patient Assessment and Transfer form (ISBAR form) was completed by the ED nurse and provided to the General Surgery ward. Mr A's regular medications were listed on the ISBAR form.

17. Around 9pm, Mr A was reviewed in ED by the on-call General Surgery registrar, Dr B. Dr B completed his review at 9.21pm and planned to admit Mr A to the General Surgery ward. Dr B's assessment noted "background as above", but did not specifically document Mr A's regular medications. Dr B told HDC that he "did take note and was aware of [Mr A's] regular medications".

Medication charting responsibilities

18. Dr B told HDC that he was not responsible for charting Mr A's regular medication, and said:

> "The usual practice for all duty registrars is to telephone the duty consultant at [10pm] and discuss each patient who had been admitted, which I believe occurred on this day. My duty ended at [10pm] and as I was not [Dr D's] regular team registrar, I did not have any further involvement in [Mr A's] care.
>
> …
>
> My understanding is that the prescription of [a] patient's regular medications is the responsibility of the admitting team, but not exclusively the duty of the admitting surgical registrar on duty who is also responsible for other duties … it may not always be practical for the admitting registrar to also chart all [the] patient's regular medications. This responsibility then falls to the house officer covering the wards."

19. Initially, HBDHB told HDC that it was the role of the ED registrar to prescribe Mr A's regular medications or delegate this to the surgical house officer and record this in the patient's notes, and that the ED registrar omitted to do this. However, subsequently HBDHB told HDC:

> "We have taken time to further review the complaint with our ED and Surgical Department senior leaders … our teams have agreed that the responsibility of the ED service is to chart medications that are administered in the ED. Once a patient has been accepted for admission by an admitting team (in this case the Surgical Department), responsibility for charting regular medications that will be administered on the ward during an admission lies with a member of the admitting team (usually a surgical house officer or registrar)."

20. HBDHB stated that at the time of events, there were some inconsistencies as to which team would be prescribing patients' medications. It said:

> "Staff understanding of the acceptable process for charting regular medications was variable, in part, due to a previous verbal opinion by the CMO at the time, advising

[7] ISBAR (Identify, Situation, Background, Assessment, and Recommendation) is a tool created to improve safety in the transfer of critical information.

that due to the time restraint of the ward House Surgeon, the ED staff would assist to chart regular medications for patients being admitted, which they did help with at times."

21. HBDHB also stated:

> "The patient admission and charting of usual medications is usually shared with the acute team House Surgeons working with the Registrar in ED. Between [8am] and [4pm] this is not usually a problem. However, after [4pm] there is no dedicated house surgeon support for this process in ED. Previously the [General Surgery] registrar was on call for 24 hours, this along with the lack of junior support led to a practice of the ED staff helping with patient admissions and charting the patient's medications especially between [11pm] and [8am]. This practice was supported by a previous Chief Medical Officer and became accepted practice for many years."

22. HBDHB acknowledged the lack of any formal written documentation regarding this practice, and said that there were only verbal directions by the CMO that ED staff would assist to chart regular medications.

General Surgery ward staffing levels

23. Dr D, a General Surgery consultant, said that during evening shifts (from 4pm to 10pm), surgical registrars normally had a high workload, and in this case Dr B admitted six surgical patients from the ED and took part in two operations in the acute theatre. Dr D stated:

> "The surgical registrar is often called away from the emergency department to another area, such as the operating theatre … if a call is urgent, the registrar's responsibility is to respond as quickly as possible. In these instances, they must leave the Emergency Department without completing documentation. They may find that they are not able to return to the Emergency Department for the rest of the evening, and this paperwork remains incomplete."

24. Dr D also told HDC:

> "We need to recognise that our admitting and ward staff are working in a busy environment with multiple demands from different areas of the hospital and frequent interruptions. Under these circumstances it is very easy for tasks not to be fully completed, despite their best intention."

25. HBDHB told HDC that from 4pm to 11pm there is one on-call house officer covering the adult inpatient wards (approximately 160 patients), and after 11pm there is no house officer support for general surgery admissions.

Admission to General Surgery ward

26. Around 11pm, Mr A was transferred to the General Surgery ward and admitted under Dr D's team. However, Mr A's regular medications were not charted.

27. HBDHB told HDC that "the admission process is usually checked the following morning", but this did not occur. On 17 November 2018, Mr A was reviewed during a ward round, and a "General Surgery Ward Round" form (the GS form)[8] was completed. The GS form includes a check box for "Drug Chart reviewed", but this was not ticked.

28. On 18 and 20 November 2018, Mr A was reviewed during the ward round and a GS form completed, but on both occasions the "Drug Chart reviewed" check box was not ticked. Accordingly, during Mr A's admission to the General Surgery ward, it was not detected that Mr A's regular medications had not been charted.

29. Mr A told HDC: "[W]hile I was there, I got asked if I was on any other medication and I told them more than once I am on depression pills and high blood pressure pills." However, HBDHB stated:

> "On checking the medical notes there is nothing written in the progress notes about his regular medications … Nor is there any indication that [Mr A] raised any concerns about the omission of this regular medication."

30. HBDHB said that thorough medication histories by admitting prescribers is an important component of medication safety, and one that the DHB has been trying to target in education for junior doctors.

Subsequent events

31. At 11.45pm on 20 November 2018, a medicine reconciliation was completed by a pharmacist, who discovered that Mr A's regular medications had not been charted throughout his admission. The pharmacist noted in the clinical notes: "[Mr A] has missed four days of regular med[ications]."

32. Around 1pm, Mr A was discharged from the hospital and transferred back to the prison.

Further information

33. HBDHB told HDC: "After a full enquiry with staff involved we have determined that [Mr A's] regular medications were not charted during his admission due to a lapse in process."

34. HBDHB also stated:

> "We would agree that the error, while ultimately the responsibility of the admitting team members, was compounded by previously accepted practice that the Emergency Department doctors would chart medication for admission after [11pm] … We believe that we have supplied sufficient information previously to acknowledge that the verbal understanding leading to the miscommunication, is systemic and an issue which our team is working hard to rectify."

35. Dr D also told HDC: "We need to have systems in place to check that all necessary steps have been completed for every patient."

[8] The General Surgery ward had a form to standardise the recording of ward rounds.

Changes made since incident

36. HBDHB told HDC that the following occurred as a result of this incident:

> "a. There is intent to review and develop a formal checklist and action plan for admission from the Emergency Department to General Surgery. This will be piloted within the General Surgery department and any learnings will be shared with the surgical group within the hospital. The development of an admission checklist and education around it will include consultation with Pharmacy staff, consultants, junior doctors, nurses, and the Chief Medical Officer and ED staff.
>
> b. There will be on-going development and education around the use of the Surgical Ward Round form.
>
> c. HBDHB recognises that the workload of the General Surgical Registrar in the evenings means it is difficult for competing demands to be managed well and within satisfactory timeframes. In light of this there are plans to roster an additional Registrar on weekday evenings from December 2019 when there are sufficient registrars available."

HBDHB's policies

37. HBDHB told HDC:

> "[HBDHB] does not have any formal policies or protocols with respect to admission or transfer from the Emergency Department to other wards, the general principle is that:
>
> a. Responsibility for the assessment and management of any patient physically in the Emergency Department lies within the ED medical staff. This includes documentation of assessment and treatment, and documentation of all medications and therapies administered to the patient in ED.
>
> b. Responsibility for the ongoing management of patients admitted to wards or units in the hospital lies with the medical staff of the admitting team. This includes documentation of assessment and treatment, and documentation of all medications and therapies administered in clinical areas for which the admitting team have clinically responsibility including the ward environment, high acuity areas and operating theatre."

38. HBDHB said that a document based on ISBAR principles exists to guide nursing staff when completing admissions to the General Surgery ward. A copy of the ISBAR document was provided to HDC. The document includes a check box to indicate whether the patient's Drug Chart has been provided to the admitting team, but there is no check box to indicate whether a patient's usual medication has been charted by the medical team.

39. HBDHB's admission process and policy does not specifically comment on the responsibility for charting a patient's usual medications, or on any process for checking that this action has occurred.

Responses to provisional opinion

Mr A

40. Mr A was provided with an opportunity to comment on the "Information gathered" section of the provisional opinion. He stated: "I appreciate the work and stress the Hospital staff do and have. I feel after reading through the documents, they were passing the blame."

HBDHB

41. HBDHB was provided with an opportunity to comment on the provisional opinion, and stated:

> "The surgical service acknowledges your review and accept the provisional decision and associated recommendations. They note and are grateful that no apparent harm occurred to [Mr A].
>
> The Emergency Department agree with the expert opinion that it is the responsibility of the admitting service to chart regular medications for administration on the ward whilst under the care of that service."

Opinion: Hawke's Bay District Health Board — breach

Introduction

42. This opinion concerns the standard of care provided by HBDHB to Mr A in November 2018.

43. On 16 November 2018, Mr A was transferred from prison to HBDHB. Mr A suffers from depression and high blood pressure, and was receiving regular medication for these conditions. He was assessed in the ED and then admitted to the General Surgery ward for the next four days. During his admission, his regular medications were not charted. Mr A was discharged on 20 November 2018.

44. When Mr A was admitted to hospital, HBDHB had the information it needed for Mr A's regular medications to be prescribed, but the systems in place were not sufficiently robust to identify the omission that occurred.

Lack of clarity about charting of regular medications

45. Initially, HBDHB told HDC that it was the role of the ED registrar to prescribe Mr A's regular medications, and that the ED registrar omitted to do this. Subsequently, HBDHB told HDC that the responsibility of the ED service is to chart medications that are administered in the ED only, and once a patient has been accepted for admission, the responsibility for charting regular medications lies with a member of the admitting team, which in this case was the General Surgery team.

46. HBDHB stated that at the time of events, verbal direction had been given by the CMO that because of the time restraints of ward house officers, ED staff could assist by charting regular medications for patients being admitted during the night shift (from 11pm–8am). This practice was not documented in internal policies or procedures. HBDHB told HDC that staff understanding of the acceptable process for charting regular medications was "variable".

47. Expert advice was obtained from a consultant general surgeon, Dr Mark Sanders, and an emergency physician, Dr Shameem Safih. Both experts agree that it was the responsibility of the General Surgery team to chart Mr A's regular medications following his admission to that team.

48. Dr Sanders advised:

> "Whereas obviously it is incumbent upon some individual to actually undertake the prescription of the drugs, if the system in place at the time … was that it would be done by the Emergency Department staff then I would agree with the Hawkes Bay District Health Board response that the issue was a system shortcoming rather than it being the responsibility of the individual themselves."

49. I accept Dr Sanders' advice. In my opinion, the failure of HBDHB staff to chart Mr A's regular medication can be attributed to the lack of clarity about who was responsible for charting medications when a patient was transferred from the ED to the General Surgery ward. I am critical that the lines of responsibility were blurred, and that as a result, Mr A's anti-depressants and anti-hypertensives were not charted on admission.

Staffing and workload

50. HBDHB said that at the time, only one house officer was covering the adult inpatient wards during the night shift, and surgical registrars normally had high workloads and therefore did not necessarily complete admission documentation.

51. Dr Sanders advised:

> "I see staff workload at the time of [Mr A's] admission did likely impact on this issue as the patient was admitted at a night handover time after which just one house surgeon is covering the whole of adult inpatients."

52. I agree that Mr A was admitted at a high-risk time in terms of staffing levels and workload, and this also contributed to the omission to chart Mr A's regular medications. I am concerned that HBDHB's surgical staffing levels during the night shift meant that essential admission documentation was not being processed, and that where a high workload was unavoidable, the system did not have a feedback loop to ensure that all necessary admission processes were being carried out.

Detection of error

53. Mr A was admitted to the General Surgery ward at 11pm on 16 November 2018, and for four days, the omission to chart Mr A's regular medications went unnoticed.

Consequently, HBDHB failed to provide Mr A with the appropriate medications for that period.

54. HBDHB told HDC that usually the admission process is checked the following morning, and that the General Surgery ward used a form to standardise the recording of ward rounds. The form included a check box for review of the medication chart. However, despite Mr A being reviewed on several occasions following his admission, and three GS forms having been utilised, the "Drug Chart reviewed" check box remained unticked.

55. HBDHB's admission process and policy does not specifically comment on the responsibility for charting a patient's usual medications, or whether there is a check that the action has occurred.

56. HBDHB stated: "On checking the medical notes there is nothing written in the progress notes about his regular medications until the medicine reconciliation." It said that thorough medication histories by admitting prescribers is an important component of medication safety, and one the DHB has been trying to target in education for junior doctors.

57. Dr Sanders stated: "The admitting team, House officers and Registrars, should ... have identified this lapse at the post-acute ward round time."

58. I accept Dr Sanders' advice. The system provided several opportunities to detect that Mr A had not been receiving his regular medications, yet these opportunities were missed. In my opinion, there was a lack of awareness or effective use of the GS form by General Surgery staff. I am also critical of the absence of medication histories taken during General Surgery ward rounds. I also note that Mr A was admitted to the hospital for four days and he recalls telling hospital staff that he had not received his regular medications, although HBDHB has no record of this. If Mr A did advise staff about this, I would be very critical that no further action occurred. I remind HBDHB of the importance of listening to patients.

Conclusion

59. HBDHB accepts that the failure to chart Mr A's regular medications was "systemic" and "a lapse in process". I note that my expert, Dr Sanders, agrees and advised:

> "There has obviously been a failure to prescribe [Mr A's] usual medications from admission and throughout his hospital stay and this would have to be a significant departure from the accepted standard of care."

60. Dr Sanders also advised: "[E]ven though it is eventually up to one person to do the prescribing, if the system doesn't direct them to that then it is the system itself that is at fault."

61. I accept Dr Sanders' advice. Several systems issues at HBDHB contributed to the failure to chart and administer Mr A's regular medications, including:

a) A lack of clarity among surgical and ED staff about the responsibility for charting regular medications between 11pm and 8am;

b) Staffing issues and high registrar workload; and

c) Ineffective post-admission and ward round mechanisms to detect that Mr A had not received his regular medications for several days.

62. As a result of the above, Mr A was put at unnecessary risk in the treatment of his depression and high blood pressure. Accordingly, I consider that HBDHB did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

Recommendations

63. I recommend that HBDHB:

a) Provide a written apology to Mr A for its breach of the Code. The apology is to be sent to HDC, for forwarding to Mr A, within three weeks of the date of this report.

b) Randomly audit whether regular medications have been charted for 30 patients who were admitted to the General Surgery ward from the ED, and report the results of the audit to HDC within five months of the date of this report. Where the audit results do not show 100% compliance, HBDHB is to advise what further steps will be taken to address the issue.

c) Within five months of the date of this report, confirm the development of a formal checklist and action plan for admissions to the General Surgery ward from the ED, as stated in paragraph 36(a) above.

d) Within five months of the date of this report, provide HDC with evidence of the on-going development and education around the use of the Surgical Ward Round form, as stated in paragraph 36(b) above.

e) Report back to HDC regarding the plan to roster an additional registrar, as stated in paragraph 36(c) above, within three weeks of the date of this report.

Follow-up actions

64. A copy of this report with details identifying the parties removed, except the experts who advised on this case and HBDHB, will be sent to the Ministry of Health, the New Zealand Association of General Surgeons, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Mark Sanders, a consultant general surgeon:

"**Independent advice to Health & Disability Commissioner**

Expert Witness Report provided by Mr Mark Sanders, general surgeon

Subject: Complaint regarding [Mr A], November 2018 — Hawkes Bay District Health Board

HDC reference: 18HDC02226

Date submitted: 03 February 2020

I have been requested by the commissioner to provide an expert opinion on case number 18HDC02226. I have read and agreed to follow the commissioner's guidelines for independent advisors.

Professional Credentials of 'Expert Advisor' relevant to this report

My name is Mark Nathan Sanders and I am a vocationally registered consultant general surgeon employed by Northland District Health Board.

I hold an MBBS from the University of Newcastle upon Tyne, U.K., awarded in 1988. I hold a fellowship of the Royal College of Surgeons of London, England, and a fellowship of the Royal College of Surgeons of Edinburgh both gained by examination in 1993. I also hold a fellowship of the Royal Australasian College of Surgeons gained by examination in 2001. Following fellowship training I was appointed a consultant senior lecturer at the University of Bristol and the Bristol Royal Infirmary in the U.K. Since 2002 I have worked as a consultant general surgeon based at Whangarei Area Hospital. Since 2007 I have also worked in private practice at Kensington Hospital, Whangarei. My practice in Whangarei encompasses a wide range of general surgical conditions in this provincial hospital setting. I have previously been Head of the Dept of Surgery. I have held various training and committee positions for the Royal Australasian College of Surgeons and I am currently an Examiner for the final fellowship in General Surgery.

CONFLICT OF INTEREST IN THIS CASE

I have no conflicts of interest in this case.

SYNOPSIS OF THE CASE

[Mr A], hereafter known as the patient, had been referred to the Emergency Department of [HBDHB] by the medical service at [the] prison with pain in the right flank region and he was transported to the Emergency Department at [HBDHB] by ambulance for review. [Mr A] remained in hospital until the 20/11/2018 when he was discharged. He had investigations and appropriate pain management for his

presenting complaint however the issue of note is that he did not have his normal medications prescribed at any point during his assessment, admission or hospital stay and therefore was without his normal medications for the four days while in hospital. At the time of discharge a medicine reconciliation was performed by the pharmacist who noted the omission of his normal medication.

I have specifically been asked to provide comment on the care provided to [Mr A] in this specific respect and in particular:

1. The omission by the general surgical team to prescribe [Mr A's] regular medication at the time of his admission into the ward and subsequently during his stay.
2. If the general surgical team had the responsibility to prescribe [Mr A's] regular medications, please advise who had the overall responsibility in the general surgical team to ensure this occurred, and
3. Any other matters in this case that you consider warrant a comment.

EVIDENCE TO SUPPORT CONCLUSION

I have been furnished with information from the Commissioner's office which includes:

1. The complaint letter from [Mr A] of [date]
2. A letter of reply from Hawkes Bay DHB dated 08/07/2019
3. A letter from Hawkes Bay DHB dated 22/02/2018 (I presume this is a typographical error as this was before the date of the admission). The HDC letter to me says that this letter is likely to be dated 14/01/2019.
4. Clinical records from Hawkes Bay DHB covering the period of the admission.

TIMELINE OF EVENTS

[Mr A] was referred on 16/11/2018 by [a registered nurse] at [the prison] medical service with right flank pain. His referral letter listed his usual medications. These are

- Mirtazapine
- Losartan
- Fluoxetine, and
- Felodipine

(hereafter referred to as the patient's usual medications).

A copy of his prison drug chart was also forwarded with the patient and included the drugs noted above and their relevant dosage. The patient was seen by the Emergency Department registrar [Dr C]. One of his typed summaries does include a list of the patient's usual medications, and an Emergency Department nursing assessment of the day of admission also includes this list. The patient subsequently had pain relief prescribed by the Emergency Department doctor but when the patient failed to settle he was referred to the General Surgical service for assessment and admission. The patient was subsequently admitted later on that day. The inpatient medication sheet

from that time only includes Paracetamol and Span-K as any regular medications charted.

While in hospital the patient had further assessments with a CT scan and ultrasound scan but no specific cause for the pain was found. I see that he was monitored regularly for pulse and blood pressure throughout his stay. Several of his medications are for hypertension. At no point during his stay did his blood pressure climb to the degree where it would seem to trigger an 'early warning score'.

There is nothing recorded in the notes that were forwarded to me to show that any doctor or nurse had queried whether there were any usual medications that hadn't been charted. Similarly there is no documented evidence that the patient brought it to the attention of any of the staff while in hospital although I see from his letter that [Mr A] did apparently state that he brought this to their attention.

The patient was discharged on 20/11/2018. I see on the discharge medications that his usual medications are in fact documented. The omission appears to have been identified as part of the medicine reconciliation done by the pharmacist on the day of discharge who first noticed that the patient had missed four days of regular medication.

SPECIFIC ISSUES

There has obviously been a failure to prescribe [Mr A's] usual medications from admission and throughout his hospital stay and this would have to be a significant departure from the accepted standard of care.

I would have expected the patient's usual medications to have been charted at the time of admission to the ward as that would be when the patient would be staying beyond time in the Emergency Department and therefore would be due their normal medications. I see there have been two letters of correspondence clarifying the responsibility of usual medication charting from Hawkes Bay DHB. It would appear that their policy is that it should be charted by the admitting team and is not the responsibility of the Emergency Department doctor. They, it would seem, are responsible for charting medications used in the Emergency Department only. Charting should be done at the time of admission and there certainly was evidence from the patient referral letter and indeed the Emergency Department summary of the list, including dosage and timing of dosage for his usual medications. This omission was obviously not picked up at any stage during his hospital stay nor did it appear in any documentation to indicate it had been queried or mentioned by the patient to the nursing staff. It was only picked up at the time of discharge by the pharmacist undertaking medicine reconciliation.

It would be my feeling that a patient's usual medication should be charted by the admitting team, in this case General Surgery, and this would have been expected to have been done by the admitting junior staff, be that either a house surgeon or a registrar. If a house surgeon it should likely have been checked by the registrar

admitting and I feel that this is the part of the team that has the responsibility for such prescribing. The named consultant under which a patient is admitted has overall responsibility however I would not expect a consultant to normally have a direct role in such usual medicine charting or checking.

Looking through the information forwarded to me I do not feel that there are any other matters of note in this case.

Early pharmacy medicine reconciliation may be of help in preventing similar occurrences. If a check list is undertaken prior to the patient moving from the Emergency Department to a ward for an inpatient stay this should include whether the patient is on any usual medications and if so whether they have been charted or not as a prompt to the ward based team to check and chart if not completed.

Submitted for your review and consideration

Yours sincerely

MARK SANDERS MDBS FRCS (Eng) FRCS (Ed) FRACS
Consultant General Surgeon
Northland District Health Board"

The following further expert advice was obtained from Dr Sanders:

"**Independent advice to Health & Disability Commissioner**

Supplementary Report provided by Mr Mark Sanders, general surgeon

Subject: **Complaint regarding [Mr A], November 2018 — Hawkes Bay District Health Board**

HDC reference: **18HDCO2226**

Date submitted: **5 November 2019**

I have been asked to provide further opinion on the above case by the Commissioner.

I have been forwarded further new documentation regarding this. This includes the letter from Hawkes Bay DHB dated 14/10/2019 along with annexures regarding documentation from the DHB and a statement from [Dr B].

Expert Advice requested

I have been asked whether this new documentation amends any conclusions from my earlier report and specifically:

1. Whether the error identified was due to a systemic issue at Hawkes Bay DHB or more attributable to an individual.
2. To make comments about the care provided by a) [Dr B], general surgical registrar, and b) [Dr D], general surgical consultant.

3. To provide comment on the appropriateness of Hawkes Bay DHB's a) admission process including the checking process at the ward round, b) explanation about pharmacy reconciliation process, and c) staff workload at the time of [Mr A's] admission.
4. Any other matters that warranted comment.

Report

Overall the new information provided would not make me alter my original findings, which have been accepted by Hawkes Bay DHB, that there was significant departure from the standard of care in not prescribing [Mr A's] usual medications.

The documentation provided by Hawkes Bay DHB however does provide some explanation while still accepting this oversight, and gives an understanding of the processes involved. This includes amendments to these processes which the DHB have commented will be implemented.

Question 1 response

In response to whether the error was due to a systemic issue or more attributable to an individual I feel that this is primarily an oversight by the admitting team members, compounded however by previously accepted practice and confusion that the Emergency Dept doctors would chart medication between 2300 and 0800 hours. The responsible individual(s) in this scenario would be either the general surgical registrar admitting or the general surgical house surgeon on the ward if the usual medications had not been prescribed by the former while they were in the Emergency Department. It appears from the DHB's response that the accepted practice over years (as supported by a previous Chief Medical Officer) was that after 2300hrs the Emergency Dept doctors would be charting the usual medication. There does not appear to be any actual documentation for this that has been forwarded to me. It appears that this has been more of an unwritten understanding that may well have been passed on verbally to the admitting teams over the years but has obviously led to some confusion, as has been commented on by myself previously and appears backed up the DHB's documents. [Dr D], the general surgical consultant also comments that the responsibility to chart the patient's usual medications is a responsibility of the admitting team not the Emergency Department. This type of approach would be consistent with how other DHB's, certainly my own included, would operate in this area.

Further comments regarding this will be made in answer to question 3.

Question 2 response

The care provided by [Dr B] is acceptable given the above-mentioned previously accepted practice which seemed to be in place at Hawkes Bay DHB at that time. There is a departure from the standard of care by the admitting house officer covering the general surgical admissions at the time [Mr A] was actually admitted to the ward but

would have to be mitigated by; similar understanding of overnight charting practices, workload issues being the sole house officer covering and likely not being made aware of the oversight by the nursing staff after their handover. The admitting team, House officers and Registrars, should also have identified this lapse at the post-acute ward round time. There would also have been an opportunity for this oversight to have been identified by the ward nursing staff had an appropriate admission checklist been available and used.

Even though the consultant in charge of [Mr A's] case, [Dr D], has overall responsibility, usually it would not be part of a consultant's role to ensure that usual medications had been charted and I do not think there is any departure from the usual standard of care from [Dr D].

Question 3 response

Hawkes Bay DHB's admission process and policy that have been forwarded to me do not specifically comment on the responsibility for charting the patient's usual medications nor as to whether there is a check specifically as to whether this action has occurred or not. A couple of documents hint at this. The first is the ISBAR driven nursing checklist but this does not specifically seem to include a segment checking whether charting the patient's usual medication has been undertaken by the medical part of the team. There is an opportunity here for a modification of this form to achieve this.

Similarly any checklist when the patient leaves the Emergency Dept to the ward, the point of which 'transfer of care' occurs, offers an opportunity for a tick box to ensure that this action has already happened. The use of the ward round pro forma to check admissions is more as an aid memoir for a day to day ward round but again a modification of this could straightforwardly be undertaken for the morning after any admission to check that charting of the usual medication has been undertaken.

I think it should be acknowledged that the response from Hawkes Bay DHB has highlighted all of these areas already and it appears that modification of their processes has already started. The medical staff orientation booklets that have been forwarded to me do not specifically include this responsibility and there is an opportunity for this to be updated.

The pharmacy reconciliation process would be consistent with the practice at most DHBs and even though obviously an earlier pharmacy reconciliation would have identified this, the timing, both day and hour, of [Mr A's] admission did not make this practicable and I have no other comments to make regarding Hawkes Bay DHB's pharmacy reconciliation process.

I see staff workload at the time of [Mr A's] admission did likely impact on this issue as the patient was admitted at a night handover time after which just one house surgeon is covering the whole of adult inpatients. The charting of regular medication may well not have been a priority for a sole practitioner at what could be a very busy time,

however it does appear that this oversight was not highlighted to them anyway. The same would be true for a general surgical registrar covering the Emergency Department, operating theatre as well as other commitments. The busyness of the individuals is therefore a factor, however lack of identification of the oversight for the whole time that [Mr A] was in hospital, remains the primary factor. This could be corrected with an appropriately implemented checklist.

Question 4 response

I think it warrants comment that some of the remedial actions and changes that have been mentioned in the Hawkes Bay DHB's response that are being implemented would be consistent with how other DHBs would respond to a similar situation and are all quite appropriate.

Only one other minor point that I would mention is that [Dr D] mentions in her report that pagers are still being used for contact between doctors and between nurses and the medical staff. This does in itself have an in-built delay with pagers being called, waiting for replies, finding free telephones etc. which wouldn't help the communication within a busy team. Direct contact with cell phones, voice and/or text messaging, would I feel offer some advantages in this respect.

Submitted for your consideration

Yours sincerely

MARK SANDERS MDBS FRCS (Eng) FRCS (Ed) FRACS
Consultant General Surgeon"

The following further advice was obtained from Dr Sanders:

"**Independent advice to Health & Disability Commissioner**

Supplementary Report provided by Mr Mark Sanders, general surgeon

Subject: **Complaint regarding [Mr A], November 2018 — Hawkes Bay District Health Board**

HDC reference: **18HDCO2226**

Date submitted: **20 January 2020**

I have been asked to provide further opinion on the above case by the Commissioner.

I have been forwarded a document from Hawkes Bay District Health Board dated 12/12/2019 regarding this. That is the response to questions from the HDC regarding some of the issues raised. These largely relate to the understanding of the process for

admitting patients and therefore the charting of medications from the Emergency Department at the time of the event. It is also in response to my earlier comment that there had been departures from the standard of care by the admitting House Officer at the time.

Report

Based on the response from Hawkes Bay District Health Board I think this serves to further clarify that this is a systems failure. Whereas obviously it is incumbent upon some individual to actually undertake the prescription of the drugs, if the system in place at the time, even though this sounds as if it was largely based on several years of practice rather than a particular written protocol, was that it would be done by the Emergency Department staff then I would agree with the Hawkes Bay District Health Board response that the issue was a system shortcoming rather than it being the responsibility of the individual themselves.

Summary: Even though it is eventually up to one person to do the prescribing, if the system doesn't direct them to that then it is the system itself that is at fault.

Implementation of a standardised practice with appropriate education and the use of check-lists, as has been indicated by the District Health Board in the final paragraph, all seem appropriate remedial measures.

Submitted for your consideration.

Yours sincerely

MARK SANDERS MDBS FRCS (Eng) FRCS (Ed) FRACS
Consultant General Surgeon
Northland District Health Board"

Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Dr Shameem Safih, an emergency physician:

"**Re C18HDC0226**

My name is Shameem Safih. I am an Emergency Physician in current practice. I have over 20 years of experience working as a specialist in various sized emergency departments in New Zealand.

The Health and Disability Commissioner (HDC) has asked my opinion on treatment provided to [Mr A] at the Emergency Department of [HBDHB] on 16th November 2018.

The HDC has requested me to comment on

1. The appropriateness of the wait time to be seen by [Mr A]
2. Whether it was appropriate/standard practice for a prisoner to wait in the ED general waiting area
3. The omission by the ED registrar to
    a. prescribe [Mr A's] regular medications
    b. delegate this to the surgical house officer, and
    c. record his medications in [Mr A's] notes
4. Any other matters in the case that I consider warrant comment.

For each question, I have been asked to advise

1. What the standard of care/accepted practice is
2. If there was a departure from standard of care or accepted practice how significant this was
3. How this would be viewed by my peers
4. Recommendations for improvement that may help to prevent a similar occurrence

I have read the following documents

1. The letter of complaint from [Mr A]
2. The clinical notes and
3. The response from Hawkes Bay DHB

Review of presentation

[Mr A] was [a prisoner]. He developed acute right flank pain. He was referred by [the prison nurse] to [the] Emergency Department for further assessment and treatment.

She wrote a detailed referral letter. In her letter she described the current problem (the reason for the referral), the relevant past history and the history of allergy to medications. She documented a complete list of [Mr A's] current medications, which included his antidepressants and the anti-hypertensives. These were Felodipine, Losartan, Fluoxetine and Mitrazapine.

[Mr A] was brought by ambulance to the hospital. On the way he received 3 doses of morphine to a total of 10 mg. This brought his pain level from 8 out of 10 down to 2 out of 10. The ambulance officer did not note [Mr A's] usual antidepressant and antihypertensive medications in the ambulance notes.

On arrival [Mr A] was assigned a Triage score of 3 (recommended waiting time 30 minutes) on the basis of normal vital signs, no apparent distress, and a pain score of 5/10.

The triage score of 3 was appropriate for his presentation.

[Mr A] was then placed in the waiting room with the accompanying two prison officers. In his complaint letter [Mr A] says he felt discriminated against and felt like he was on display.

He alleges one of the nurses told one of his accompanying wardens that they were not worried about him and they didn't care about him. The DHB has responded to this.

He has also complained about the fact that he was not given his usual medications (the antihypertensive and the antidepressants) until the 4th day of admission. He says he told staff more than once that he was on these medications. He says missing the medications for those days affected him adversely.

[Mr A] waited for 45 minutes to an hour to be seen by a doctor. The times are not clearly documented. He was seen by Emergency Department registrar [Dr C] who noted the clinical history. He has also documented all the medications [Mr A] was on including the antihypertensives and the antidepressants. Medication review is a usual part of patient assessment. He also noted the results of previous investigation for similar pains. He opted to treat [Mr A's] pain and review the response before making a decision on disposition. Paracetamol, diclofenac and tramadol were administered to manage the pain. Appropriate blood and urine tests had been done.

At next review [Dr C] found that [Mr A] still appeared to be in significant pain.

After discussion with his consultant he referred [Mr A] to the general surgical registrar.

In this instance [Dr C] had charted the pain killers on the hospital medication chart. [Dr C] did not chart the regular antihypertensive and antidepressants that [Mr A] was on. The surgical doctors have charted further pain killers on the same medication chart for

continuation on the ward but they too did not chart the antidepressants and the antihypertensives.

The question arises as to who should have charted [Mr A's] regular medications on the drug chart. ED doctors prescribe medications required to acutely treat the presenting condition. They can do this on the hospital admission drug chart or an ED specific drug chart. They usually would not chart long term medications. Thus [Dr C's] action is in keeping with standard practice in most emergency departments. The admitting speciality registrar or house officer is responsible for charting medications that are to be administered in the ward. The exceptions will be smaller rural hospitals where the ED doctor is also the admitting officer.

My responses to the HDC questions are as follows

1. The appropriateness of the wait time to be seen by [Mr A]

While the wait time of 45 minutes to 1 hour for a category 3 patient does not meet the ACEM (Australasian College of Emergency Medicine) recommended time of half an hour, this time is not unusual in busy EDs … In fact in some very busy EDs the wait time can be much longer.

I feel there was no departure from standard practice here.

2. Whether it was appropriate/standard practice for a prisoner to wait in the ED general waiting area

There is no clear standard. The general rule is that patients are placed according to clinical need. In the case of a prisoner it would be prudent to place him or her as much out of everyone's view in the ED as much as possible. A cubicle would be ideal. Given limited space resource and the busyness of emergency departments, many times this is not possible. It should be noted that there are other considerations involved in the management of a prisoner in the ED, such as staff safety.

I feel there has been no departure from standard.

3. The omission by the ED registrar to

a. prescribe [Mr A's] regular medications

ED registrars do not prescribe regular medications for admitted patients. Therefore there has been no departure from standard.

b. delegate this to the surgical house officer

This is not a delegated duty. This represents a difference in core roles. The ED treats the acute and urgent aspects of the patient's needs; the admitting speciality takes the role of ensuring all other aspects of admission are covered. It is helpful if the ED doctor does a thorough handover of the patient to the speciality registrar. The busy and fast pace of the emergency department often means this handover is brief and to

the point. Further, the surgical registrar may take the handover, but the admitting doctor may be the house officer.

There has been no departure from standard ED practice.

c. record his medications in [Mr A's] notes

I actually found the medications in question recorded by the ED registrar in the body of the ED notes. While the ED doctor does not have to chart the regular medications for an admitted patient, they need to be aware of the regular medications the patient is on, because the medications may impact on the patient's presenting problem. Therefore, taking a medication history is part of usual history taking and in this case it was done.

Comment: there has been no departure from ED standard of care.

4. Any other matters in the case that I consider warrant comment.

It is good practice to read the referral letter thoroughly. If this had been done the regular medications [Mr A] was on would have been noted by the admitting doctor.

Emergency departments often provide emergency care to prisoners. Prisoners should be afforded equal and unprejudiced health care in the emergency department. Having an expedient pathway for care of prisoners which includes prudent placement in the department should be considered by EDs.

Shameem Safih
Emergency Physician.
29/07/19"