Canterbury District Health Board

A Report by the

Health and Disability Commissioner

(Case 11HDC01101)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 10 May 2011 Mrs A, aged 92 years, was referred to Canterbury District Health Board's Older Person's Health Specialist Service. She had presented to her family doctor a few weeks earlier with low back pain and restricted mobility. Mrs A was subsequently admitted to: Hospital 1 from 11 May to 7 June 2011; a rest home from 7-10 June 2011; Hospital 2 from 10-16 June 2011; and again at Hospital 1 from 16-27 June 2011.

2. On admission to Hospital 1 on 11 May 2011, Mrs A had a spinal X-ray showing a compression deformity at the T12 vertebra. She was assessed as a high falls risk. On 14 May 2011 morphine was charted as required. On 16 May 2011 Mrs A was started on slow release morphine because of her increasing pain. Mrs A's mood was very low. Initially she was considered as being suited to hospital level care.

3. A family meeting was arranged for 1 June, and it was planned that Mrs A be discharged to the rest home for rest home level care on 7 June 2011, the day after a long weekend.

4. During her admission, Mrs A had reviews documented by doctors on 11, 13, 16, 17, 20, 24 and 27 May. No subsequent medical review was documented between 28 May 2011 and Mrs A's discharge early on 7 June 2011, despite her deterioration, which included increased levels of pain between 3 and 7 June, and a fall on 6 June. Over the long weekend of 4–6 June 2011 there were no routine ward rounds or multidisciplinary team meetings, and no doctors were asked to see Mrs A.

5. The rest home was not contacted by DHB staff the day before or the day of discharge, and was therefore not ready to accept Mrs A when she arrived early on 7 June. Mrs A stayed at the rest home for three days, before being acutely admitted to the medical ward of another hospital, Hospital 2, with abdominal pain on 10 June 2011.

6. On admission to the medical ward Mrs A had investigations relating to her abdominal pain. She had an unwitnessed fall early on 11 June, and the sensor clip she was wearing was found not to have batteries in it. On 15 June 2011 Mrs A had MRI tests and was placed on antibiotics for presumed cholecystitis[1] and cholangitis.[2] Test results led to an incidental finding of a T12 fracture and spinal canal narrowing.

7. Mrs A was transferred back to Hospital 1 on 16 June 2011 for rehabilitation. A spinal MRI was ordered on 20 June. Initially no sensor mats were available on the ward to assist with falls management. Despite changes to falls strategies, Mrs A had further falls on 22 June and 24 June. The MRI undertaken on 23 June showed a new T11 fracture and further compression of T12 causing spinal stenosis.

8. After discussions with family and neurosurgeons, a conservative approach to care was taken. The hospital assessor arranged a placement for private hospital level care and, on 27 June 2011, Mrs A was transferred to a private hospital. Mrs A died a few weeks later.

[1] Inflammation of the gallbladder.
[2] Infection of the biliary tract.

Findings

9. The DHB team caring for Mrs A failed to interpret and recognise the signs of a declining patient who was in pain, particularly in the days leading up to her 7 June 2011 discharge from Hospital 1. This failure was a significant contributing factor to Mrs A not undergoing medical review between 28 May 2011 and 7 June 2011. Consequently, the level of assessment of Mrs A's degree of vertebral trauma in this period was affected. There were nursing deficiencies in falls management, and a lack of clarity and rigor in the assessment of Mrs A's suitability for discharge to rest home care. The DHB's care and management of Mrs A was below standard. Accordingly, Canterbury DHB breached Right 4(1) of the Code.[3]

10. Hospital 1 staff did not communicate appropriately with the rest home about the arrangements for Mrs A's discharge on 7 June. This included both a failure to confirm transfer arrangements, and a failure to conduct any clinical handover. These failures had significant consequences for Mrs A's quality and continuity of care and, accordingly, Canterbury DHB breached Right 4(5) of the Code.[4]

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Mrs B regarding the care provided to her mother, Mrs A. An investigation was commenced on 16 August 2012. The following issue was identified for investigation:

The appropriateness of the care Canterbury District Health Board provided to Mrs A between 10 May and 27 June 2011.

12. The key parties mentioned in this report are:

Mrs A	Consumer
Mrs B	Complainant, Mrs A's daughter
Canterbury DHB	Provider
Dr C	Consultant physician, Older Person's Health Specialist Service
Dr D	Consultant geriatrician
Ms E	Clinical assessor, Older Person's Health Specialist Service
Dr F	Registrar
Ms G	Manager, rest home

Information from a radiology service was also reviewed.

[3] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[4] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Also mentioned in this report:

RN H	Registered nurse
Dr I	House surgeon

Facilities mentioned in this report:

Hospital 1/Assessment, treatment and rehabilitation ward
Hospital 2/General medical ward
The rest home
The private hospital

13. Independent expert clinical advice was obtained from Dr David Spriggs, a general physician and geriatrician (attached as **Appendix A**).

14. Independent expert nursing advice was provided by a registered general nurse, Ms Jane Lees (attached as **Appendix B**).

Information gathered during investigation

Background

15. On 10 May 2011, Mrs A's family doctor referred Mrs A to Canterbury District Health Board's Older Person's Health Specialist Service (OPHSS), at Hospital 1, for in-patient assessment of low back pain.

16. Mrs A, aged 92 years, had lived alone for more than 50 years. She received some home help, but walked every day, cooked for herself, and played bridge three or four times a week. The referral was made because she had presented to her GP a few weeks earlier with low back pain, which had worsened, and she was unable to look after herself because of her restricted mobility.

Admission to Hospital 1 — 11 May to 7 June 2011

17. On 11 May 2011, Mrs A was admitted to the assessment, treatment and rehabilitation ward (the rehabilitation ward) at Hospital 1. She was admitted under a team led by a consultant physician, Dr C. The rehabilitation ward provides team nursing.

18. Dr C told HDC that a recent audit of documentation on the rehabilitation ward[5] found that patients were typically seen twice a week on a consultant ward round, although in 10% of occasions this was only once on the week audited. He said that on the other three days of the week each patient was seen, on average, every second day by an

[5] Conducted in July 2013. A copy of the audit results was provided to HDC. No information relating to 2011 was provided.

RMO.[6] He said that this was not dissimilar to the usual practice in a large university teaching based rehabilitation service.

Admission

19. The admitting house officer noted that Mrs A had left lower paraspinal[7] pain. He noted that Mrs A had indicated that usually she was able to walk one kilometre, but currently could manage only 10–20 metres. He noted that she had experienced no recent fall or trauma, there was no pain on palpation of the spinal area, and there were no abnormal neurological signs or symptoms.

20. The admitting house officer arranged lumbar spinal X-rays and blood tests, and started Mrs A on pain relief, charting 2.5–5mg morphine elixir every 2–4 hours. Mrs A was also reviewed by a registrar who considered that the lower back pain was likely to be caused by degenerative changes.

21. Mrs A's blood tests were largely unremarkable. The radiology report findings state: "Sagittal alignment is satisfactory. Moderate compression deformity superior endplate of T12. No lumbar compression fracture. Mid/lower lumbar facet arthropathy. Disc height generally well maintained. Normal sacroiliac joints."

22. On 11 May 2011 a registered nurse completed an OPHSS Falls Risk Assessment and Strategies form. The results[8] showed that Mrs A was a high falls risk. Seven strategies to reduce falls, selected from the tick boxes available, were recommended. An episode of care checklist, a functional independence measure (FIM),[9] and a Braden Assessment[10] were also completed.

13 May 2011

23. On 13 May 2011 Mrs A was seen by the consultant physician responsible for her care, Dr C. He arranged for a CT scan of her sacrum and pelvis, which took place later that day. Morphine elixir, 5mg at night, was charted by the house officer.

14–15 May 2011

24. Over the next few days Mrs A's pain was variable. The CT scan showed no evidence of sacral fracture. Nursing notes indicate that Mrs A had to lie on her side to eat as it was too painful for her to sit up. It was recorded that Mrs A's food intake was variable.

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[6] Resident Medical Officer (RMO) is a term covering resident doctors from their last year of undergraduate training until they complete their vocational training. The RMO workforce is not a homogenous group. RMOs range in age and include undergraduate students as well as those with six or more years' post-registration experience. Various job titles including trainee intern, intern, junior doctor, house officer, house surgeon, senior house officer/surgeon, registrar, and advanced trainee are used for RMOs at different stages of their training.

[7] Beside or close to the spine.

[8] Using the Modified Hendrich II Falls Risk Assessment Scale.

[9] A tool that assesses physical and cognitive disability. Items are scored on the level of assistance required for an individual to perform activities of daily living (ADLs).

[10] Mrs A scored 18 — a medium risk for pressure ulcers.

16 May 2011

25. Mrs A was reviewed by a registrar, Dr F. He noted that Mrs A was requesting further doses of morphine to manage her pain. Because of this, she was started on M-Eslon (slow release morphine) twice daily. A multidisciplinary team (MDT) meeting occurred.[11]

26. The notes from the MDT meeting state: "[N]ature of pain appears unusual. T12# noted ?old vs new … previously not coping too well @ home prior to admission … pain under control, mobilise, ascertain barriers to d/c."

27. Further physiotherapy assessment noted that Mrs A was independent when mobilising with a frame, but also that she was unable to sit for longer than a few minutes at a time because of pain.

17 May 2011

28. On 17 May 2011, on Dr C's ward round, Mrs A was noted to be "more mobile compared to last week". Mrs A's daughter, Mrs B, was present during the ward round. It was explained to Mrs B and Mrs A that the CT scan showed no sacral or pelvic fracture, but there was a compression fracture of T12, which was the cause of Mrs A's spasm and pain. The medical team also explained their cautious approach to pain relief because of potential side effects. A bone density scan was ordered, and intravenous zoledronate[12] was charted.

29. An occupational therapist assessed Mrs A in Mrs B's presence. Mrs B suggested that her mother should go home after her discharge from hospital. The occupational therapist recommended that an occupational therapist carry out a home visit at either Mrs B's or Mrs A's home once they had decided where Mrs A was to go.

19–21 May 2011

30. On 19 May 2011 nursing staff noted Mrs A's ongoing poor food intake and persistent back pain.

31. On 20 May 2011, on Dr C's ward round, Mrs A was described as "more slowed", and her gait was slow. It was felt that Mrs A possibly had morphine induced confusion, and the dose was adjusted.

32. From 21 May 2011 onward, nursing observations consistently noted Mrs A's low mood. Mrs A also started experiencing episodes of faecal incontinence.

23 May 2011

33. On 23 May 2011 there was a review by the MDT. It was recorded that Mrs A was not keen to return home, and there were concerns about her low mood. A formal mood assessment was organised. The occupational therapist confirmed arrangements for a home visit assessment at Mrs B's house to assess its suitability for Mrs A.

[11] The DHB told HDC that the MDT meeting is an important clinical assessment typically attended by a number of health professionals who contribute to discussion about the patient and his or her ongoing care and treatment.

[12] Used in the treatment of osteoporosis and in the prevention of fractures.

24 May 2011

34. On 24 May 2011, on Dr C's ward round, Mrs A was noted to be more "perky" but not yet keen to go home, and she was frequently asking for morphine. It was also noted that Mrs A was frail both emotionally and physically. Mrs A had a geriatric depression scale assessment later in the day, which indicated mild to moderate depression. Nortriptyline (an antidepressant) 10mg was charted to be administered at night.

25–26 May 2011

35. On 25 May 2011 the occupational therapist home visit assessment noted that Mrs A mobilised safely and independently with her walking frame around the grounds and within her daughter's house, and that she was independent with functional transfers. Concluding comments included: "It is felt that from a functional perspective [Mrs A] is independent to be able to go home or to her daughter's home with additional services, equipment and pain management strategies. However, it appears that [Mrs A's] family feel this may not be a good idea as they feel 'that she just can't do anything'. It is recommended that a family meeting is arranged." The occupational therapist also recommended that a clinical needs assessment be carried out.

36. That same day, a social worker met with Mrs B. Mrs B was very concerned that "[her mother would] fall and felt [her mother] was wobbly on her feet and too risky to leave unsupervised". Mrs B was "very clear that she wanted her mother to go into rest home care".

37. A referral to the OPHSS Community Service Team clinical assessor, Ms E, went ahead, and arrangements were made for an assessment for possible entry to residential care.[13] The assessment was undertaken on 26 May 2011. Ms E noted: "[Mrs A] is keen to go home if possible with extra services but is aware that her daughter is keen on rest home placement."

27 May 2011

38. On 27 May 2011 Mrs A was assessed at the psychogeriatric unit. A recommendation was made to monitor her mood, and she was to remain on nortriptyline (to help her sleep and complement her analgesia). Overall, it was thought that her episodes of low mood were primarily caused by her pain.

39. Mrs B was present during Dr C's ward round that day. The notes record Mrs A's problems of the compression fracture, back pain, behavioural difficulties, and small vessel disease[14] indicated on the CT scan. It was noted that the social worker was booking respite care and placement in a rest home. The plan was to discuss Mrs A at the upcoming MDT meeting. Mrs A's weight was 47.4kg, down from 52.1kg on admission. She continued to have episodes of faecal incontinence.

[13] A clinical assessor on the rehabilitation ward co-ordinates home-based supports and completes assessments for entry to residential care, as directed by the ward multidisciplinary team.
[14] Cerebral small vessel disease (SVD) is a frequent finding on CT and MRI scans of elderly people, and is related to vascular risk factors and cognitive and motor impairment.

40. This was the last recorded medical review of Mrs A before her discharge 11 days later.

30–31 May 2011 — application for residential care

41. An Application for Residential Care form[15] dated 30 May 2011 was filled out by Ms E, and was co-signed by Dr C. In the "patient diagnosis" section it states: "[B]ack pain, COPD, osteoarthritis of shoulders, osteoporosis. [Mrs A] has been assessed by the IDT [Interdisciplinary Team] who have recommended Hospital level of care."

42. The form outlined that Mrs A met the criteria for both rest home care and hospital care — both options were circled. Dr C explained in his response to HDC that this first form was completed in error, and was superseded on 2 June 2011 by a second form, which stated that Mrs A had been assessed as requiring rest home care.[16]

43. At the MDT meeting on 30 May 2011 there were concerns whether Mrs A would manage at home, although it was noted that she appeared independent with cares. The plan included repeating a cognitive assessment, liaising with Mrs A's daughters, consideration of antidepressants, and "[query] [hospital level care] if daughters happy". A family meeting was arranged for 1 June 2011.

44. On 31 May 2011 a physiotherapy assessment occurred. It was recorded that Mrs A was able to manage extremely well functionally. However, the nursing notes indicate that Mrs A was generally reluctant to initiate activities of daily living, although she was relatively independent once the activity was initiated. Mrs A's complaints about her pain were intermittent but particularly associated with changes in position. She was able to mobilise independently with her walker. She required encouragement to eat and drink.

31 May 2011

45. An entry in the nursing notes for 31 May 2011 states:

> "[S]een by medical team for repeat bloods of sodium and ? to be commenced on Citalopram depending on Sodium results. [Patient] also spoken to by [Dr C] re going into a Rest home …"

46. That entry, made seven days before Mrs A's discharge, is made by and signed by nursing staff. It is not recorded whether there had been a full clinical review, and there is no entry signed by a doctor on that day.

47. Dr C told HDC that he believes this entry relates to his medical ward round. Based on his recollections and knowledge of his usual practice, Dr C believes he must have reviewed Mrs A with only himself, a nurse, Mrs A and her daughter present. He recalls Mrs B having some concerns about her mother's care.

[15] A form authorising placement and eligibility for funding — part of the process for placement used following the outcome of an assessment.
[16] See paragraph 53.

48. Dr C subsequently stated: "In retrospect … it would have been highly desirable for me to keep the house surgeon and registrar present, not for patient safety but to facilitate this inquiry. Alternative options would have been to write the note myself … It is not however routine for me to record a detailed account of all interactions with patients and their relatives in stable situations."

1 June 2011

49. On the morning of 1 June Ms E spoke with Mrs B. It was noted that Mrs B wanted Mrs A to go to the rest home for rest home care. A family meeting was scheduled for 2pm that day. Ms E recorded: "I have put [Mrs A's] name to the bed at RHC in [the rest home] should she go to RHC level of care."

50. The 1 June 2011 nursing notes record: "[Mrs A] was very reluctant to get off bed as says pain in back aggravated by moving." She declined any lunch as she was feeling nauseous, and she required additional doses of morphine.

51. The family meeting was held in the afternoon of 1 June 2011. Mrs A, Mrs B, her husband, and Ms E were present. The notes record: "[Mrs A] is keen to go to [the rest home] especially as it is close to her daughter."

52. It was recorded by Ms E on a Liaison Meeting Summary form that "[Mrs A] needs to get up more and mobilise so that she can go to a rest home". Mrs A was agreeable. It was decided that Mrs A would be discharged to the rest home on Tuesday 7 June for rest home care.

2 June 2011

53. At 10am on 2 June 2011 an Application for Residential Care form was faxed to the rest home by Ms E, indicating the impending planned discharge on 7 June. The form recommended rest home care. The form states: "COPD, osteoarthritis shoulders, osteoporosis lower back pain, low mood. [Mrs A] has been assessed by the IDT who have recommended Rest Home care."

54. The rest home's manager, Ms G, told HDC that the rest home was contacted on 2 June by Ms E, who advised that Mrs A was a patient to be discharged the following week, and enquired as to whether the rest home could accept her. Ms G said that Ms E explained that Mrs A was scoring at hospital level care but the team felt that with more rehabilitation over the long weekend she would qualify as rest home level of care. The rest home was advised that Mrs A had pain, low mood, an old fracture of T12, had been assessed as not depressed but needing to move more frequently, and was up at night independently but not during the day. The rest home agreed to accept Mrs A if she improved to rest home level care and was free of diarrhoea (which had been affecting other patients on the rehabilitation ward at the time). Ms G recalls that Ms E was to call the rest home on 7 June to advise of progress.

55. Over the next few days Mrs A's pain and mobility were variable. On 2 June 2011 Ms E emailed the Clinical Charge Nurse informing her that an agreement had been made with the family for Mrs A to go to the rest home on 7 June 2011. In the clinical notes,

there is a nursing note stating: "[T]ransfer note completed. Nursing handover to R/H still needs to be done prior to transfer please."

Leave cover commenced

56. Dr C went on leave from Thursday evening, 2 June 2011, and was scheduled to return on Monday 20 June 2011. Dr D, a consultant geriatrician, provided cover for Dr C on the ward for the period from 3 June 2011 until 20 June 2011.[17]

57. Dr D said that it was communicated to him by Dr C that the rehabilitation ward was running well and that relevant reviews by the ward's regular medical staff had occurred during the preceding days. Dr D said that both he and Dr C were happy with the cover arrangements.

58. The DHB told HDC that the OPHSS has no documented standard regarding handover, which can be written or verbal depending on the acuity of the patient. Dr C stated that the handover of a low acuity patient who is a planned discharge is very unlikely to be accompanied by a detailed account, this being confined to unstable patients with high acuity. Dr D concurred that he would not routinely expect a detailed individualised handover from a consultant colleague in such circumstances and where other various existing checks and balances are in place.

59. Dr D acknowledged that "this process [handover] is unable to predict deterioration in function and it is obviously because of possible changes in a patient's status that various checks and balances exist in the healthcare system". He pointed to morning ward handovers, handovers prior to on-call shifts, nursing observations and use of Early Warning Score (EWS),[18] and communications to senior medical staff by junior doctors and nursing staff as examples of checks and balances designed to pick up any patient deterioration.

3 June 2011

60. On 3 June 2011 Mrs A indicated that she was frightened to move and was not enthusiastic about going to a rest home. Over the next few days nursing notes indicate that Mrs A remained anxious and depressed, with increased complaints of pain and reduced mobility. Daily nursing care records note that Mrs A had lost 5.3kg since admission.

61. On 3 June 2011 there is a "Transfer Notice of Nursing Care" to the rest home recorded on file.

62. Dr D commented that following Dr C's 31 May contact with Mrs A, the nursing notes and daily care plans do not indicate any concerns suggesting clinical deterioration. The EWS was stable at 1, and opiate use had not increased. The Canterbury DHB

[17] Dr D's cover crossed over two wards on 3 June 2011. Dr D advised that his role in the OPHSS at this time was to provide cover for senior medical officers to enable leave to be taken. It is standard practice that at times consultants will cover more than one ward.

[18] The EWS is a trigger system or tool used to calculate and recognise when a patient's physiological state is deteriorating, to help staff to increase observation frequency and/or escalate care to the most appropriate level. It uses a simple scoring system that can be calculated at the patient's bedside, using key physiological parameters and vital sign monitoring.

EWS pathway states that medical review should be considered at a score of 1–2, but does not require mandatory medical review at this level. Dr D told HDC that on 3 June he was providing cover limited to reviewing new patients and any patients who were currently unstable, or patients the team felt were becoming unstable. Dr D told HDC that because Mrs A was not considered unstable by medical or nursing staff, he was not requested to review her that day.

Queen's Birthday weekend — 4–6 June 2011

63. Mrs A required moderate assistance dressing on 4 June, and full assistance on 5 June. The EWS score was recorded as 1 on the morning of 6 June.

64. At 2.30am on Monday 6 June 2011 Mrs A was found on her knees in the bathroom, and had a skin tear to her left leg below the knee. An incident form was completed.

65. Mrs A spent most of that evening on her bed. Her observations were stable. She complained of some pain and tremor-type movements, but none were witnessed by nurses. Mrs A was apprehensive about the next day. She mobilised to the bathroom using a walking frame.

66. The DHB confirmed that no medical staff were asked to review Mrs A following her fall on Monday 6 June 2011, and that she was seen by other members of the MDT instead (a nurse, a physiotherapist, a social worker and an assessor). However, the clinical notes record only a nursing review at that time. The DHB said that there was "no evidence of physical injury, recordings were stable and it is routine in this service that these patients do not need to see a doctor". The DHB stated that there is no written policy to this effect in OPHSS, but the practice governing this is consistent with other DHB services.

Medical cover for Queen's Birthday weekend

67. Dr D confirmed that he did not see Mrs A in the period between 3 June and 7 June. There was also an on-call consultant on duty for the long weekend of 4–6 June 2011. The DHB confirmed to HDC that there were no routine ward rounds or MDT meetings held over the long weekend 4–6 June 2011.

68. Dr D told HDC that during a weekend it was normal practice for the ward team to notify any concerns they had about patients to on-call RMOs, who review patients. The on-call consultant is not typically informed regarding patients who are deemed stable. Dr C told HDC that if the nurses identified a medical issue then the patient would be reviewed by an RMO.

Discharge — 7 June 2011

69. On the morning of 7 June 2011 Mrs A required full assistance to shower and dress. Her observations were stable.

70. The electronic discharge summary, completed by house surgeon Dr I and dated 9.26am on 7 June 2011, includes the comment: "[Mrs A] is well on transfer today."[19]

[19] Dr I is no longer employed by the DHB, resides overseas, and did not respond to email contact from HDC.

It summarises the admission's clinical management, and notes Mrs A's functioning, her supports in place, and her follow-up arrangements.

71. Dr C told HDC that usually the patient would be assessed at the time of discharge, and the discharge letter would be a summary of the patient's fitness for discharge. The DHB stated that Dr I would have used the RMO morning discussion, as well as progress notes, to assist with preparing the discharge summary.

72. There was no medical review or MDT that morning. The discharge document was drafted on 7 June at 8.58am, saved at 9.18am, and finalised at 9.26am — crossing over into the time that ward rounds are usually conducted.

73. Mrs A was given morphine at 10am on the morning of her discharge and transfer. Mrs B picked up her mother around 10am and left the ward. There is no record of a nursing handover to the rest home having occurred before Mrs A's discharge.

74. As noted above, during Mrs A's admission to Hospital 1, medical reviews were documented on 11, 13, 16, 17, 20, 24 and 27 May 2011. Dr C considered his interaction on 31 May to be a medical review, and so was of the view that the only period without an RMO medical entry in the records was between 1–3 June. He said that he accepts responsibility for the care he personally provided, and believes the diagnoses were accurate and the care appropriate.

Admission to the rest home — 7 June 2011

75. The rest home manager, Ms G, told HDC that there had been a breakdown in communication between the clinical assessor, Ms E, and the rest home, meaning that the rest home was not expecting Mrs A to arrive on 7 June 2011. Ms G stated that the rest home had understood that, based on the conversation with Ms E, 7 June was the provisional planned date of discharge. The rest home had been expecting staff at the hospital to confirm the placement before that date.

76. On the morning of 7 June 2011, the rest home had not heard from the hospital and so its staff called the ward at 10am "to see what was happening" regarding Mrs A. They were informed that Mrs A was already on her way.

77. On arrival at the rest home, staff told Mrs B that the room for Mrs A had not yet been vacated or cleaned. Mrs B told the staff that Mrs A was unwell in her car. Staff found Mrs A lying "almost prostrate in the front of the car, pale, eyes closed and not talking". Mrs B then took Mrs A to her own home and put her in bed, and took her back to the rest home later on 7 June.

78. Rest home staff advised HDC that, soon after Mrs A's admission to the rest home, it became "evident that she needed a higher level of care than what we could provide". The admission forms document that Mrs A was very weak, mobilising with a frame, was anxious and had low mood due to pain, and required full assistance for self cares.

79. Rest home progress notes record concerns regarding Mrs A experiencing pain in her back, being unsteady, and being depressed. Fluids and food were often refused.

80. On 9 June 2011, rest home staff contacted the OPHSS regarding their concerns about Mrs A's falls risk, appetite, lethargy, mobility, and mood. On 10 June 2011 an acute admission to a medical ward at Hospital 2 was arranged owing to abdominal pain Mrs A was experiencing, and because there were no beds available in the OPHSS wards.

Admission to Hospital 2: 10–16 June 2011

81. At approximately 2.30pm on 10 June 2011 Mrs A was admitted to the medical ward at Hospital 2. Mrs A was assessed by an RMO, who recorded that Mrs A was drowsy and unable to speak clearly, but was oriented to place and time. Mrs A's family "felt [Mrs A] needed more pain relief and should not have gone to the rest home".

82. The plan developed at the beginning of Mrs A's admission to the medical ward was to perform a further X-ray to identify any acute cause for her abdominal pain and her continuing back pain, to provide fluids, and to keep Mrs A comfortable at the weekend. If no acute causes were found, the plan was to ask OPHSS to reassess her on Monday and consider placement elsewhere.

83. The initial nursing care assessment and planning documentation noted Mrs A's falls risk and the strategies required to manage this, including using a sensor clip[20] and a falls bracelet.

11 June 2011

84. In the early hours of 11 June (12.05am) a nurse aide found Mrs A on the floor beside her bed. Mrs A was not injured. An incident report was completed.

85. It was discovered that the sensor clip Mrs A was wearing did not have any batteries in it. Mrs A was moved to a bed closer to the nurses' station for observation, and the sensor clip was fixed and replaced. Mrs A was also wearing a falls bracelet. The Charge Nurse Manager reminded staff that all clips need to be checked before being placed on a patient, and detailed this on the incident report.

86. The DHB's response to HDC explained that normal practice on the medical ward involves sensor clip batteries being checked by a nurse aide before the sensors are returned to the box ready for the next patient.

87. Mrs A was reviewed medically early on 11 June. Her observations were stable. She had lumbosacral and lower thoracic pain. Possible Paget's disease[21] and/or cholecystitis[22] were queried. An abdominal X-ray showed an old T12 compression fracture. A chest X-ray was normal. An abdominal ultrasound showed the possibility

[20] Sensor clips are devices that are attached to the patient, with a magnet on the end of the clip, which sits in a unit. When a patient moves, the magnet is pulled off the unit, which sets off an alarm. The clips are used to facilitate the safe monitoring of patients who are at risk of falling, in conjunction with other falls management strategies.
[21] A chronic disease of the bones, most frequently occurring in the elderly.
[22] Inflammation of the gallbladder.

of, but no convincing evidence of, cholecystitis, and mild to moderate biliary dilatation. Antibiotics were commenced and an MRCP[23] investigation suggested.

13 June 2011

88. On 13 June 2011 a physiotherapist reviewed Mrs A. She was "unable to remain awake, refusing to attempt to stand". Also on 13 June 2011, Mrs A was unsettled and was trying to "clamber out of bed" for no clear reason. Bedrails were employed for a short period between 4pm and 7.45pm after discussion with the family.

89. Medical reviews on 13 and 14 June noted that Mrs A was drowsy from morphine elixir, and so the dose was reduced. Her bowel motions were monitored, antibiotics continued, and blood tests repeated. Mrs A was noted to be very depressed, and her treatment plan, discussed with Mrs A and her daughter, included obtaining psychological services input.

15 June 2011

90. On 15 June 2011 Mrs A had an MRCP and was continued on intravenous antibiotics for presumed cholecystitis and cholangitis.[24]

91. The MRCP report, in addition to a finding of bile duct dilation, made an incidental observation of a "T12 fracture with retropulsion of the posterior vertebral body cortex and severe spinal canal narrowing with compression of thoracic spinal cord".

92. On 16 June 2011 the possible causes of the dilated duct were discussed with Mrs B and Mrs A. An ERCP[25] was discussed, but declined by Mrs A.

Transfer to Hospital 1: 16–27 June 2011

93. Mrs A had been reviewed by the OPHSS on 14 June 2011, and a transfer back to Hospital 1 on 16 June 2011 was arranged for rehabilitation and discharge planning. Mrs A remained there from 16 to 27 June 2011.

94. Dr F reviewed Mrs A on admission. He noted Mrs A's ongoing back pain, symptoms of nausea and vomiting, and the possible cholecystitis that had provoked the admission to the medical ward. He changed Mrs A's pain medication to OxyNorm elixir and noted the need for further investigation of her back pain.

95. As part of the admission process, a Falls Risk Assessment & Strategies form was completed on 16 June 2011 (and later revised on 22 and 24 June 2011). The nursing notes from 10.30pm on 16 June record that Mrs A required two people to assist her, she had remained in bed all shift, and her mobility was poor.

[23] Magnetic resonance cholangiopancreatography — imaging of the hepatobiliary and pancreatic system.
[24] Infection of the biliary tract.
[25] Endoscopic retrograde cholangio-pancreatography — a diagnostic procedure used to examine diseases of the liver, bile ducts, and pancreas.

17 June 2011

96. Documentation on 17 June 2011 noted that Mrs A was admitted to the ward on the morning of 16 June, she had a history of falls and decreased mobility, and she had been using a sensor clip on the medical ward. No sensor mats were available. As an alternative, regular checks on Mrs A were implemented, and she was situated in close proximity to the nurses' station.

97. Mrs A was reviewed by Dr D on the morning of 17 June. The notes from this review set out the plan to continue her antibiotics, discuss matters with the family the following week, and repeat the liver function tests (LFTs) on 20 June.

20 –21 June 2011

98. On 20 June, registrar Dr F reviewed Mrs A on the morning ward round. He noted that Mrs A's mood was very low, the pain had moved to her right side and increased on palpation, and that she had no spinal discomfort. The plan was to stop the antibiotics the next day and perform a mid-stream urine test, an INR[26] profile, and LFTs.

99. On 21 June, consultant Dr C returned from leave and reviewed Mrs A. An MRI of the spine was ordered, and issues of persistent low mood and hyponatraemia[27] were noted. Consideration was given to use of the antidepressant mirtazapine. A potential change in focus from rehabilitation to comfort was also recorded.

22 June 2011

100. On 22 June 2011, at 4.05am, Mrs A fell from her bed. She was heard to call out and was found lying on the floor beside her bed. A sensor mat was in situ. The falls risk strategy was revised and Mrs A's bed was placed against the wall for safety.

101. At 9am Dr F reviewed Mrs A. He noted that she had some discomfort in her right shoulder following her fall, but a good range of motion. The MRI ordered by Dr C on 21 June was pending. Dr F planned to discuss with Dr C the possible use of citalopram (an antidepressant).

23 June 2011

102. On 23 June Dr C reviewed Mrs A, who was complaining of middle back pain. The plan was to commence a sedative (temazepam), stop nortriptyline, re-check urea and electrolytes, and start citalopram the following week if Mrs A's sodium levels had increased.

103. Also that morning, Mrs B telephoned Ms E and told her that she wanted her mother in hospital level care. Ms E located a potential placement at a private hospital for Monday 27 June 2011.

104. Dr C and Ms E signed a further Application for Residential Care form on 23 June 2011. The form states: "Back pain, COPD, osteoarthritis, shoulders, osteoporosis.

[26] INR — International Normalised Ratio: An international system established to assist the reporting of blood coagulation (clotting) tests.
[27] Low level of sodium in the blood, which affects which medications can be prescribed.

Decline [in] mobility. [Mrs A] has been assessed by the IDT who recommend Hospital level care."

24 June 2011

105. Mrs A had a further fall at 12.20am on 24 June 2011. The sensor mat alerted staff. Nursing notes later on 24 June 2011 record an inability to obtain bedrails or a low bed, and note that staff had implemented alternative falls management strategies, including placing the existing bed at its lowest level, placing a mattress on the floor next to the bed, and appointing a staff member on bedside watch.

106. The MRI undertaken on 23 June was reported on 24 June. It showed a new fracture of T11 (since the previous X-rays of 11 May 2011) and a marked increase in compression of the fractured T12 vertebra. A large retropulsed bone fragment from T12 was causing severe spinal stenosis[28] at this level. The fractures appeared osteoporotic in nature.

107. Dr C consulted with neurosurgeons and then discussed the situation with the family. It was agreed that a conservative approach (analgesia and bed rest with mobilisation only as tolerated) was appropriate, rather than surgical intervention.

Transfer to private hospital — 27 June 2011

108. On 27 June 2011 Mrs A was transferred to a private hospital. Mrs A died a few weeks later.

Subsequent changes made by DHB

109. As a result of the issues raised by Mrs A's care, the DHB advised HDC that the following changes to services have been made:

- DHB nursing staff now contact rest home facilities the day before a patient is to be discharged, to ensure there is nothing outstanding in the discharge process.
- New staff orientation to the rehabilitation ward includes a Falls Prevention Programme and use of a Falls Minimisation Self Directed Learning Package.
- Falls strategies were reviewed, and each unit now has in place the use of sensor clips and sensor mats (depending on what is suitable for the patient at the time).
- The frequency of medical reviews on OPHSS wards was reviewed by the Chief of Service, and a consultant ward round twice weekly was instituted (usually Monday/Thursday or Tuesday/Friday), with an MDT team meeting occurring weekly. The medical team is responsible for documenting the reviews. On the two remaining days during the Monday to Friday period, RMOs are to review all patients and document this in the patient notes.

[28] Narrowing of the spinal canal. The result is compression of the nerve roots or spinal cord by bony spurs or soft tissues, such as discs, in the spinal canal.

- To avoid any ambiguity, on the day of discharge of any patient from the rehabilitation ward at Hospital 1, the patient is now seen by the registrar or house surgeon for an assessment of whether the patient is fit for discharge. The information is recorded in the patient notes.

- The inclusion of a Malnutrition Screen Tool within a nutrition assessment is being piloted, and will be rolled out on all OPHSS wards.

- Handover and transfer of care forms and processes have been upgraded.

- Documentation of RMO medical notes was added to the OPHSS 2013 clinical audit programme.

In addition, as a result of a Root Cause Analysis investigation into a fall not connected with this case, a policy specific to OPHSS is being developed so that all patients who have a fall are examined by medical staff in a timely manner, to detect injury and possible causes of the fall, and also to review falls prevention strategies.

Opinion: Canterbury District Health Board – Breach

Preliminary comments

110. Mrs A was admitted to Hospital 1 on 11 May 2011 for an assessment of back pain, which was affecting her mobility and ability to care for herself. Over the four weeks of that admission, Mrs A exhibited a steady decline. By the last week of her admission to Hospital 1, Mrs A was significantly disabled by her pain. Despite this decline, Mrs A was discharged to rest home level care.

111. When Mrs A was admitted to hospital, she had the right to receive care of an appropriate standard. In my view, the services — both people and systems — wrapped around Mrs A were not effectively connected. This led to a situation where Mrs A's care was not of an appropriate standard and lacked continuity. A number of systemic shortcomings contributed to the situation, including a lack of recognition of her deteriorating clinical picture and continued pain, and a lack of medical review toward the end of her initial admission to Hospital 1. Consequently, clarification of the degree of Mrs A's vertebral trauma was delayed. In addition, there were nursing deficiencies in relation to falls management; a lack of clarity and robustness in the assessment of Mrs A's suitability for discharge to rest home level care; and deficient communication with the rest home on the day of discharge.

112. As I have previously emphasised, systems and individuals need to work together to ensure that, regardless of when and where a patient presents, he or she receives seamless services. Individual clinicians and nurses need to be competent in their clinical assessment and management of patients, and staff need to be supported by

systems that guide decision-making appropriately and promote a culture of safety.[29] The staff involved in Mrs A's care, in my view, did not work effectively as a team to a level I would expect in a public hospital setting. The DHB as an employer must accept responsibility for these deficiencies.

Admission to Hospital 1: 11 May to 7 June 2011

Lack of medical review — Breach

113. At the time of Mrs A's first admission to Hospital 1, she had a compression fracture of her T12 vertebra, which was causing a mild level of disability. My expert clinical advisor, physician and geriatrician Dr David Spriggs, advised that the management of this in the early stage of Mrs A's first admission to Hospital 1 was as expected.

114. However, towards the end of her stay, Mrs A did not receive sufficient medical review. Dr Spriggs advised me that it would be standard practice on assessment and rehabilitation wards for every patient to be medically reviewed at least daily Monday to Friday, and that weekend reviews would be on an "as needed" basis.

115. It is evident from Mrs A's records that there was no documented medical review on 30 May, 31 May, 1 June, 2 June, 3 June and 7 June 2011 — all week days. There was also no medical review over the weekend of 28–29 May, or over the long weekend of 4–6 June. I am concerned that the last documented medical review during Mrs A's first admission to Hospital 1 was on 27 May 2011 — 11 days prior to her discharge. The settled practice of the ward as to the frequency of medical review was not in line with standard practice as outlined by Dr Spriggs. In my view, this was inadequate.

116. Dr Spriggs advised that had there been a medical review of Mrs A's back pain before her discharge on 7 June 2011, the new fractures of her spine may have been identified at that stage.

117. Given Mrs A's subsequent decline and increasing disability caused by her pain during this admission, there should have been further medical review of Mrs A's condition, including new medical imaging. Dr Spriggs advised:

> "In view of her deteriorating condition while on [the rehabilitation ward] in early June, I believe that had she received a medical assessment, the physicians concerned may have felt that further imaging was appropriate. She did not have such an assessment."

118. This failure did not represent reasonable care and skill. Accordingly, I find that Canterbury DHB breached Right 4(1) of the Code.[30] I consider that a number of factors contributed to the lack of medical review.

[29] Opinion 09HDC02089, 4 July 2012.

[30] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Recognition of patient decline — breach

119. In my view, after 1 June 2011, when a planned discharge date of 7 June 2011 was arrived at, the perception that Mrs A was a long stay, stable, low acuity patient was not revisited despite indications to the contrary.

120. This Office has previously noted the importance of DHBs having systems to help staff identify and respond to patients who become physiologically unstable.[31] The key requirements are to recognise when a patient is deteriorating and respond promptly and appropriately.

121. Canterbury DHB's EWS pathway states that medical review should be considered at a score of 1–2, but does not require mandatory medical review at this level. However, as Dr Spriggs and my expert nursing advisor, Ms Jane Lees, have both advised, although Mrs A's EWS scores indicated stability, there was evidence of Mrs A experiencing a steady decline between 3 and 7 June 2011. This was not recognised, and therefore not acted on, by the whole team caring for Mrs A.

122. Dr Spriggs advised that it was evident from the nursing notes that "[Mrs A's] general functions were declining in the few days prior to her discharge", which is demonstrated by the increasing degree of assistance [Mrs A] required, and her increasing pain.

123. On this point, Ms Lees advised:[32]

> "The EWS, the FIM [Functional Independence Measure] and the nursing commentary tell a story of declining physical and mental health … as her opioid use increased over time, assessment did not lead to question why there was little response to the current treatment and care plan …"

124. Ms Lees explained:

> "A lack of connectivity and analysis of [Mrs A's] physical decline, comprehensive assessment and linking the physical patient presentation in context to a whole of health approach rather than a narrow focus on pain management and low mood appears to have resulted in a delay to further investigate fully [Mrs A's] clinical presentation thus resulting in poor discharge planning and a delay in diagnosis of spinal stenosis. Please note this issue relates to the whole health care team."

125. I agree with the advice of both my experts in this respect. In my view, the failure by staff to recognise clinical signs of Mrs A's deterioration, including ongoing pain, was a key contributing factor to her not receiving further medical review. Without medical review, further clarification of the degree of vertebral trauma could not occur. This

[31] Opinion 05HDC11908 at pages 48–50; Opinion 06HDC19538 at page 8; Opinion 07HDC21742 at pages 13–14, Opinion 08HDC03994 at pages 10-11.

[32] In its response to my provisional report, Canterbury DHB stated that, on review of the clinical notes, Mrs A's FIM scores between 11 May and 7 June in fact show a mild improvement, rather than a decline; and that regular dosing of opioids was stable.

failure to recognise the decline did not represent reasonable care and skill. Accordingly, I find that Canterbury DHB breached Right 4(1) of the Code.

Checks and balances reduced at weekend — adverse comment

126. Dr C went on leave on Friday 3 June, and Dr D took over Mrs A's care. Dr D's role was to provide cover for two wards. He was expected to review new patients and any patients causing concern. As Mrs A was considered ready for discharge and stable, there was a discussion about her care between Dr C and Dr D, but no individualised handover between the two consultants. The OPHSS has no documented standard regarding handover, and handover can be written or verbal, depending on the acuity of a patient. I accept that routinely there may not necessarily be detailed handover between consultants in such circumstances.

127. I accept Dr D's point that "it is obviously because of possible changes in a patient's status that various checks and balances exist in the healthcare system". Dr D points specifically to morning ward handovers, handovers prior to on-call shifts, nursing observations and use of EWS, and communications to senior medical staff by junior doctors and nursing staff, as being such checks and balances.

128. However, over the long weekend of 4–6 June 2011, there were fewer checks and balances in place, and those that did exist did not detect Mrs A's decline. There were no routine ward rounds or MDT meetings, and no doctors were asked to see Mrs A. This was a further factor in her changing status not being recognised.

31 May interaction — adverse comment

129. While I accept that Dr C had an interaction with Mrs A and Mrs B on Tuesday 31 May 2011 — seven days prior to discharge and three days before he went on leave — this was recorded only in the nursing notes by nursing staff. The entry is not signed by a doctor, and contains no clear indication of Mrs A's clinical status.

130. I agree with Dr Spriggs' view that, based on the notes, "this [31 May] episode does not constitute a clinical assessment but a conversation about the current and future plans for [Mrs A]".

131. Dr C was the consultant physician with overall responsibility for Mrs A from her admission on 11 May 2011 until he went on leave on Friday 3 June 2011. I agree with my expert that Dr C had a responsibility when seeing Mrs A on 31 May to make an appropriate record in the medical file or supervise such an entry if made by others.

132. As the house surgeon and registrar were not present, it would have been appropriate for Dr C to record an entry himself, rather than have nursing staff record his 31 May interaction with Mrs A in the routine progress notes.

Falls management, Hospital 1 — breach

133. I acknowledge that falls in older people are common and occur across different healthcare settings, and that the management of elderly patients who present with a falls risk can be challenging.

134. However, I agree with Ms Lees' advice, which identifies key areas where the falls management by nursing staff was lacking:

- Initial falls assessment and strategies could have included consideration of more comprehensive interventions, given Mrs A's high falls risk on admission.

- Ongoing multidisciplinary reassessment of falls management and consideration of underlying factors (such as the opiate use) following a fall were not evident from 11 May to 7 June. Ms Lees advised that "[Mrs A's] assessment and care planning appears to focus on pain management — there does seem a lack of connectivity between the falls and opioid use". In addition, there is no evidence of an analysis of [Mrs A's] later falls patterns.

- Ms Lees stated that the quality of nursing documentation in this regard was basic. There are deficiencies in documentation in the assessment of falls risk, falls history, and suitable interventions not being appropriately communicated in care plans or in the transfer of care documentation.

- Ms Lees observed that "there is no evidence of any analysis of fall patterns. Night times strategies are not evident; no differentiation of fall risk or care planning from night or day was made."

135. In my view, Mrs A's fall on 6 June was also a lost opportunity for both nursing and MDT members to ask themselves appropriate questions and/or seek medical review, especially as Mrs A was due to be discharged early the next day.

136. In my opinion, the falls management by nursing staff during Mrs A's first admission to Hospital 1 was not conducted to an appropriate level. Accordingly, I find that Canterbury DHB breached Right 4(1) of the Code.

Assessment of suitability for discharge to rest home level care — breach

137. I have concerns about the robustness of the process adopted for coming to the decision that Mrs A was an appropriate candidate for rest home level care, and about the lack of critical thinking regarding Mrs A's condition at the time of her discharge on 7 June 2011.

138. There is evidence to support the conclusion that, between 26 May and 2 June 2011, staff recognised that Mrs A was most suited to hospital level care. Specifically:

- The initial Application for Residential Care form, dated 30 May 2011, states that Mrs A had been recommended for hospital level care.

- The Discharge Planning form in Mrs A's records contains a note, dated 30 May, stating that Mrs A had been assessed as requiring hospital level care, and recommended that a place be found for her accordingly.

- Ms E's note of a discussion with Mrs A's daughter on 1 June states: "I have put [Mrs A's] name to the bed at RHC in [the rest home] should she go to RHC level

of care" (implying that a decision was yet to be made about which level of care was appropriate).

- Ms E comments on the Liaison Meeting Summary form, dated 1 June, that "[Mrs A] needs to get up more and mobilise so that she can go to a Rest Home". This is also noted as having been discussed with Mrs A directly at the family meeting on 1 June.

- The manager of the rest home recollects that Ms E told her on 2 June that Mrs A had been assessed as requiring hospital level care, but that she should improve over the long weekend to the extent that she would be suitable for rest home level care.

139. Despite this, on 2 June 2011 the decision was made that Mrs A would go to rest home level care. It is unclear why this decision was made, other than because Mrs A's family wanted her to go to a facility close to them. I acknowledge that Dr C has explained in his response that the first Application for Residential Care form (recommending hospital level care) was completed "in error" and was superseded by the 2 June form (recommending rest home level care). I also acknowledge the influence the 1 June 2011 family meeting discussions had on the eventual decision. However, I consider that the process for reaching this decision was not robust, and ultimately led to Mrs A being discharged to a facility that was not able to meet her needs, and having to return to hospital for further treatment and assessment.

140. I am also concerned at the apparent lack of critical thinking by staff, at the time of Mrs A's discharge, about whether she was in a suitable condition to be discharged to rest home level care. It is clear that by 7 June Mrs A's needs had increased to the extent that she should not have been discharged to rest home level care. As Dr Spriggs advised me, it is "very clear from [Mrs A's] poor clinical condition and disability on arrival at [the rest home] that she was in no way suitable for rest home care at that stage". The rest home's manager, Ms G, told me that, when Mrs A was admitted to the rest home, "it was soon evident she needed a higher level of care" than the rest home could provide. Mrs A was readmitted to hospital after only three days at the rest home.

141. In my view, it is concerning that none of the staff involved in Mrs A's care stopped to reassess the situation at the time of discharge.

142. I do not consider that staff followed a robust process in deciding that Mrs A was an appropriate candidate for rest home level care. I also do not consider that staff appropriately considered whether Mrs A was in a safe condition for discharge on 7 June 2011. I find that Canterbury DHB breached Right 4(1) of the Code for these failures.

Communication with the rest home — breach

143. A transfer notice was completed by Hospital 1 nursing staff on 3 June. However, the staff did not contact the rest home again before Mrs A was discharged. This resulted in the rest home staff telephoning the hospital on the morning of 7 June 2011, when

Mrs A had already left the ward and was on her way to the rest home. The rest home was not in a position to admit Mrs A at that stage, because of the lack of notice. Mrs B was left to take her mother home for a period and return to the rest home later in the day.

144. I would have expected hospital staff to have been in contact with the receiving rest home either the day before or on the day of discharge. Dr Spriggs advised me that this would be usual practice. I also would have expected a clinical handover to have occurred during that time.[33] Dr Spriggs advised that the communication between Hospital 1 and the rest home was a moderate departure from expected practice, and that the failings were not excused by the fact that discharge occurred the day after a long weekend.

145. In my opinion, hospital staff did not communicate appropriately with the rest home about Mrs A's discharge on 7 June. This includes both a failure to confirm transfer arrangements, and a failure to conduct any clinical handover. In my view, these failures had significant consequences for Mrs A's continuity of care. Accordingly, I find that Canterbury DHB breached Right 4(5) of the Code.[34]

Admission to Medical Ward, Hospital 2, 10–16 June 2011

Medical assessment — no breach

146. Dr Spriggs advised that once Mrs A was admitted to the medical ward of Hospital 2 on 10 June, medical assessments appropriately concentrated on concerns about her liver, bile duct and pancreatic systems.

147. On 15 June 2011 Mrs A underwent an MRCP, which showed that the T12 vertebra was disrupted. Dr Spriggs advised that this scan clearly showed an "abnormal [vertebra]". He is of the view that the increasing pain that Mrs A endured was due to further vertebral collapse, which probably occurred between 11 May and 15 June, and may have been the result of her falls.

148. Mrs A's next MRI was on 23 June 2011, during her second admission to Hospital 1. Dr Spriggs did not consider that the interval between the two MRIs indicates a poor level of care. He advised that most physicians would understand and approve of Dr C's course of action.

149. I accept Dr Spriggs' advice that Mrs A's medical management at Hospital 2 from 10-16 June 2011 was of an appropriate standard.

Sensor clip — adverse comment

150. The initial medical ward nursing care assessment and planning documents included noting a sensor clip and a falls bracelet being used. However, it was discovered after

[33] This may include processes such as the Yellow Envelope Project, used in many regions, which supports the safe handover of clinical information and a checklist of important handover information to be included when a resident is transferred to or from hospital.

[34] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Mrs A fell in the early hours of 11 June that the sensor clip being used did not have any batteries in it.

151. Whether this would have necessarily prevented the fall is not known, but I agree with Ms Lees' advice that if such equipment is to be used as part of a suite of stated interventions, there must be effective processes in place to ensure that tools are available, fit for purpose, and functioning.

Readmission to Hospital 1, 16–27 June 2011

Medical assessment — no breach

152. Mrs A was transferred back to Hospital 1 on 16 June 2011 for rehabilitation. An ERCP procedure was declined by Mrs A. A spinal MRI was undertaken on 23 June, and showed a new T11 fracture and further compression of T12 causing spinal stenosis. A conservative approach to care was then taken.

153. I accept Dr Spriggs' advice that Mrs A's medical management at Hospital 1 from 16-27 June 2011 was of an appropriate standard.

Sensor mats — adverse comment

154. As part of the admission process back to Hospital 1, falls risk assessment strategies were documented. On 17 June 2011 an incident form was completed by a staff member because no sensor mats were available at that stage.

155. This was later rectified and regular checks on Mrs A were implemented, and she was situated in close proximity to the nurses' station. However, on 22 June 2011 Mrs A fell when moving out of bed despite a sensor mat being in situ. She had a further fall at night on 24 June 2011 when the sensor mat alerted staff.

Summary

156. The DHB has acknowledged the shortcomings in its systems in Mrs A's case. Since these events the DHB has clearly reflected on the case and implemented some positive remedial improvements as a result of learning from Mrs A's experience.

157. Nevertheless, the DHB team caring for Mrs A failed to interpret and recognise the signs of a declining patient who was in pain, particularly in the days leading up to her 7 June 2011 discharge. This failure was a significant contributing factor to Mrs A not undergoing medical review between 28 May 2011 and 7 June 2011. Consequently, the level of assessment of Mrs A's degree of vertebral trauma in this period was affected. There were nursing deficiencies in falls management, and a lack of clarity and rigor in the assessment of Mrs A's suitability for discharge to rest home care. The DHB's care and management of Mrs A was below standard. In my opinion, Canterbury DHB breached Right 4(1) of the Code.

158. Hospital 1 staff did not communicate appropriately with the rest home about Mrs A's discharge on 7 June. This included both a failure to confirm transfer arrangements, and a failure to conduct any clinical handover. In my view, these failures had significant consequences for Mrs A's quality and continuity of care. Accordingly, I find that Canterbury DHB breached Right 4(5) of the Code.

159. In response to my provisional report, Canterbury District Health Board staff provided some clarifying comments which have been incorporated into the opinion where relevant. The DHB accepted the breach findings and had no further comment.

Recommendations

160. I recommend that Canterbury DHB provide Mrs B with a formal written apology for its breaches of the Code. This is to be sent to HDC within three weeks of issue of this report, for forwarding to Mrs B.

161. I also recommend that Canterbury DHB take the following actions and report back to me within **three months** of issue of this report:

- Develop clear and documented processes governing communication and handover between OPHSS staff, and discharge/transfer of care from the DHB to aged care facilities. These should be guided by communication tools such as the ISBAR[35] model or the Yellow Envelope project.

- Conduct a review of OPHSS nursing staff's approach to, and use of, EWS, FIM, and observational recordings.

- Undertake a review of processes to identify and respond to signs of deterioration in adult patients and processes to audit staff compliance with the procedures.

- Provide HDC with a copy of nursing staff orientation to the rehabilitation ward, including the Falls Prevention Programme and Falls Minimisation Self-Directed Learning Package.

- Update HDC on the outcome and results of the DHB review of falls management and strategies.

- Provide HDC with an update on the effectiveness of the processes developed specific to OPHSS wards governing the timely examination by medical staff of patients who have had a fall.

- Conduct a further audit regarding the expected frequency of medical reviews on OPHSS wards.

[35] ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of important information. Originating from SBAR, the most frequently used mnemonic in health and other high risk environments, the "I" in ISBAR is to ensure that accurate identification of those participating in handover of the patient is established.

- Conduct a review of the rehabilitation ward's discharge summaries and evaluate the degree to which registrars and house surgeons are reviewing patients as being fit for discharge and recording that information in patients' clinical notes.

Follow-up actions

162. • A copy of this report with details identifying the parties removed, except Canterbury DHB and the experts who advised on this case, will be sent to the Royal Australasian College of Physicians (RACP) and the College of Nurses (Aotearoa) NZ Inc.

- A copy of this report with details identifying the parties removed, except Canterbury DHB and the experts who advised on this case, will be placed on the Health and Disability Commissioner website, for educational purposes.

Appendix A — Independent physician's advice to the Commissioner

The following expert advice was obtained from a physician and geriatrician, Dr David Spriggs:

> "I have been asked to advise the Commissioner on the care provided to [Mrs A] by Canterbury District Health Board following her admission to [Hospital 1] on 11th May 2011, her subsequent discharge on 7th June 2011 to [a rest home] and her readmission to the General Medical ward at [Hospital 2] on 10th June 2011 and further transfer to the Assessment and Rehab Ward from 16th June. She was subsequently discharged to [a private hospital] for palliative care and eventually dying [a few weeks later].
>
> I have read and agree to follow the Commissioner's guidelines for independent advisors. I practice as a General Physician and Geriatrician at Auckland District Health Board and am vocationally registered in Internal Medicine and have been a Fellow of the Royal Australasian College of Physicians since 1993.
>
> I have been asked to comment specifically on:
>
> 1. Falls risk assessment and management
> 2. Lack of documented medical input in the 10 days prior to [Mrs A's] discharge to [the rest home]
> 3. The level of care assessment prior to discharge to [the rest home]
> 4. Delays in clarifying the degree of [Mrs A's] vertebral trauma
>
> **Summary of Events:**
>
> [Mrs A] was referred by her GP at [a] Medical Centre to the Older Persons Health Service on the 10th May 2011. She had presented with 'two days of low back ache, unable to look after herself now.' The GP goes on to say that there was no history of trauma. Her admission note on 11th May by [the house officer] confirms left lower paraspinal back pain but there was no pain on palpation or percussion. [The house officer] arranged for some x-rays which I have not seen and [Mrs A] was reviewed by the Registrar who also felt that there was mechanical lower back pain which was likely to be degenerative. There were no neurological signs. She was reviewed the following day by the Physiotherapist, whose assessment was 'not incapacitated at all with back pain this morning, but I'm not sure what her pain pattern has been like over the past 24 hours'. The physiotherapist arranged review the following day. Over the ensuing days [Mrs A's] pain was very variable and by the 13th May she was noticed to be 'very tired today and declined a wash'. On that day [Dr C], her consultant, reviewed her and arranged for a CT scan of her pelvis and sacrum. She required variable but gradually increasing doses of morphine for her pain, such that by the 16th May she was started on slow release morphine. The Multidisciplinary Team assessment on the 16th May was that 'her pain was under control and she was mobilising'. However the physiotherapist on that day states that 'she was unable to sit for more than 2 minutes because of the pain in her back'. By the 17th May on [Dr C's] ward round she was said to be

'more mobile compared to last week' and on the 20th May [Dr C] found her 'more slowed' and her gait was also slow. She was becoming confused. [Dr C] felt that she had had too much morphine. At the team review on 23rd May [Mrs A] was not keen to return home and there were concerns about her mood. On the 25th May the Social Worker met with [Mrs A's] daughter [Mrs B]. [Mrs B] was very concerned 'the patient will fall and felt the patient was wobbly on her feet and too risky to leave unsupervised'. [Mrs B] was 'very clear that she wanted her mother to go into rest home care'. A referral to the Clinical Assessor was made. On the 26th May the Residential Care Assessment Form was filled out by the Needs Assessor [Ms E] and co-signed by [Dr C] stating that [Mrs A] met the criteria for both rest home care and hospital care. This form is dated 30th May. In the letter from [the service manager] which seems undated, it is explained that 'this reflected her frailty and her discharge destination depended on the outcome of her rehabilitation'. There is a further Residential Care Assessment form with the same date of assessment signed by [Ms E] on 1st June and [Dr C] on 2nd June recommending Rest Home care.

On the 27th May [Mrs A] was assessed by the Psycho-Geriatric Unit. She was seen again on that day by [Dr C]. That is the last documentation confirming that [Dr C] or any other medical officer reviewed [Mrs A] during that admission. At the Multidisciplinary Team Meeting on 30th May there were concerns whether [Mrs A] would manage at home and a family meeting was arranged. This happened on the 1st June 2011. On the morning of the 1st June the nursing report states that '[Mrs A] was very reluctant to get off bed as says pain in back aggravated by moving'. She declined any lunch as she was feeling nauseated and she was requiring her additional doses of morphine. At the family meeting in the afternoon of 1st June it was decided that [Mrs A] would be discharged to [the rest home] on Tuesday the 7th June. However there is yet another Residential care Assessment form from 1st June recommending Private Hospital care signed by [Ms E] and [Dr C] on 23rd June. Over the next few days [Mrs A's] pain and mobility was very variable such as on the 2nd June she was able to change herself for bed and had not requested any heat packs, however on the 3rd June she 'spent most of the day on her bed' and stated that 'she was frightened to move'. In the early hours of 6th June she was heard to be calling out from the toilet and she was found on her knees in the bathroom. An incident form was filled out, subsequent to that fall during the day she was independent most of the time but at night she had further pain. There was no record of any clinical assessment on that day and she was discharged to the rest home on 7th June.

The letter from [Ms G and RN H] at [the rest home] states that 'they had been contacted on 2nd June by [Ms E] to advise that [Mrs A] was due to be discharged the following week'. On the 7th June they had not heard from the hospital and so they rang 'to see what was happening'. They were informed that [Mrs A] was already on her way. On arrival they told [Mrs B] ([Mrs A's] daughter) that the room had not yet been vacated or cleaned, however [Mrs B] said that [Mrs A] was in a bad way in her car. The staff from [the rest home] found [Mrs A] lying 'almost prostrate in the front of the car, pale, eyes closed and not talking'. [Mrs B] then took [Mrs A] to her own place, put her in bed and brought her back later.

Things did not go well at [the rest home] and she was readmitted to [Hospital 2] on the 10th June.

On the 10th June she was admitted to the hospital complaining of abdominal pain, she was 'drowsy, lacking dentures, unable to speak clearly'. She was oriented to place and time. [Mrs A's] granddaughter 'felt ([Mrs A]) needed more pain relief and should not have gone to rest home'. In the early hours of the 11th June [Mrs A] was found on the floor next to her bed. The sensor clip that she was wearing did not have any batteries in it. She was moved closer to the nurses' station and a sensor clip was provided. In view of her abnormal liver function tests she was investigated for gallbladder and biliary disease and she was reviewed by the physiotherapist on 13th June, but she was 'unable to remain awake, refusing to attempt to stand'. She was reviewed by the Older People's Health Service on the 14th June and it was arranged for her to be transferred back to [Hospital 1] on 16th. The nursing note from 2230 hours on that day states that [Mrs A] required two to assist her, she had remained in bed all shift and her mobility was poor. At 0050 on the 17th June an incident form was completed, it is not clear what provoked this but the nurses state that they were 'not able to obtain the use of a sensor mat for this patient. She has a history of falls and had one when on ward 30. She had the use of a sensor clip when on [the medical ward]. Regular checks will be made and patient reminded to ring for assist'. She was reviewed by [Dr D] on the 17th June. On the 22nd June at 0405 hrs she was heard to call out and was found lying on the floor beside her bed. She had only been checked 5 minutes prior to this and I believe a sensor mat was in situ at that stage. She had a further fall at 0020 hrs on 24th June when the sensor mat alerted the staff who found her on the floor. Again she had apparently rolled out of bed. The MR scan was performed on 23rd June and reported on the 24th June. This showed a large bony fragment at T12 causing severe spinal stenosis. Neurosurgical intervention was not thought to be appropriate and on 26th June she was very restless and agitated overnight and remained confused. On the night of the 26th/27th June she had a watch in place and on the 27th she was discharged to [the private hospital].

Advice to the Commissioner:

1. Falls Risk Assessment and Management

There is an inherent tension between maximising mobility and prevention of falls. One of the principles of geriatric rehabilitation is to maximise the former. I believe it inevitable that patients occasionally fall in rehabilitation settings. [Mrs A] first fell in the hospital on the day prior to her discharge on the 6th June. She was then discharged to [the rest home] and readmitted to the General Medical ward on the 10th June. She was considered to be at high falls risk and a sensor clip was given. However she fell in the early hours of the following morning and the sensor clip was found not to be working as there were no batteries in it. As far as I can tell she had no further falls while on the acute medical wards. However on admission to the Rehabilitation ward (16th June) she was identified as being high falls risk and she had current 'falls risk strategies'. Despite this she fell in the early hours of the following morning. A sensor mat was not available. She did not

have a sensor clip at that stage. She fell again on the 22nd June as she rolled out of bed and again on the 24th June.

I am not aware of the precise nursing processes with respect to handover of nursing information between units, however it is acknowledged by [the service manager] that there was no nursing handover from [the medical ward] to [the rehabilitation ward], and that the sensor mat was not available on [her admission] on the 16th June. I am not sure when the sensor mat became available. Clearly the use of a sensor clip without batteries is inappropriate. It seems that bed rails were only used for a very short period while on the medical ward and when she was transferred to the rehabilitation she had an electric bed but would go down within 6 inches of the floor. I am not sure if the bed was at floor level when she subsequently fell.

Such recurrent falls would usually be considered to indicate suboptimal nursing care and monitoring.

2. Lack of documented medical input towards the end of her admission of 10th May.

I note medical entries in the notes on the 11th, 13th, 16th, 17th, 20th, 24th and 27th of May. There are multidisciplinary notes from the 30th May written by the Trainee Intern, but I am uncertain whether this reflects a clinical assessment. On the 31st May the nursing notes state 'seen by Medical Team for repeat bloods … patient also spoken to by [Dr C] re going into a rest home …'. I can see no medical entry in the notes on that day. There is no subsequent medical entry into the notes during that admission. This is despite a fall on the 6th June.

It would be standard practice on Assessment and Rehabilitation wards for every patient to be seen medically at least daily Monday to Friday. Weekend reviews would only be as needed. The lack of medical assessment over the last week of [Mrs A's] first admission is way below accepted standard. It is not clear whether this is a matter of poor note keeping or whether [Mrs A] was just not seen. I note that on the 26th May it was decided that she would be discharged to residential care and it may be that the medical staff felt that there was nothing more to be done medically, however this would not be usual practice. I also note that the new run of House Officers started on, I think, the 30th May and it may be that a new doctor was not made aware of his/her responsibilities with regard to note keeping.

I believe the lack of medical review and/or documentation is a significant departure from expected standards.

3. Level of care assessment

I note that the joint assessment dated 26th May and signed by [Ms E], Assessor and [Dr C] on 30th May, indicates that [Mrs A] met the criteria for both rest home and hospital care. It is explained in [the service manager's] letter that the eventual place of discharge 'depended on the outcome of her rehabilitation'. Despite this and her continued deterioration she was eventually discharged to the rest home. It is very clear from her poor clinical condition and disability on arrival at [the rest

home] that she was in no way suitable for rest home care at that stage. If we accept the second assessment from 26th (signed on 1st and 2nd June) as being valid, then the assessor and the geriatrician felt that hospital level care was appropriate. It is not clear to me how she could then have been discharged to a rest home. However there is a third assessment dated 1st June and signed on 23rd recommending Private Hospital level care.

I believe it the responsibility of the assessor and the geriatrician jointly to ensure that the place of discharge is appropriate and I believe that [Mrs A's] discharge to [the rest home] was inappropriate and represents a significant departure from usual standard of care. The discrepancies between the three documented assessments and their dates suggest a lack of rigor in the assessment process.

4. Delays in clarifying degree of [Mrs A's] vertebral trauma.

On arrival at hospital on 10th May, [Mrs A] had a crush fracture of T12. At that stage her level of disability was mild. It is very typical for vertebral crush fractures to have a very fluctuating pain often exacerbated by movement, coughing etc. [Mrs A] received appropriate management at that stage however the pain continued to get worse and she had a fall on the 6th June. On representation on the 10th June to the Acute Medical Wards there was concern about the liver and gallbladder and further assessment of her back was not undertaken. However when [Mrs A] returned to the rehabilitation ward she underwent an MR of her spine. This showed very significant damage. It is not clear when this damage occurred, it may have occurred during one of the several falls or it may have been present on presentation. In view of her deteriorating condition while on [the rehabilitation ward] in early June, I believe that had she received a medical assessment, the physicians concerned may have felt that further imaging was appropriate. She did not have such an assessment. When [Dr C] reviewed her on readmission to [the rehabilitation ward] he felt that further imaging was needed.

The delay in imaging may reflect the lack of appropriate clinical assessment on the previous admission. I am uncertain why she was admitted to [the medical ward] under the General Medical Unit rather [than] back to [the rehabilitation ward]. This might be because she was considered an 'acute' admission requiring the facilities of the acute hospital. The day of admission was a Friday and it may [be] that admission to [the rehabilitation ward] was considered inappropriate before the weekend.

Summary:

The documents that I have available suggest that there has been a significant departure from the usual standards of care with regards to [Mrs A's] medical assessment during her stay at [Hospital 1] from the 11th May to the 7th June 2011. Particularly concerning is the lack of medical review during the last week of her stay.

The failure to hand over nursing concerns between units and to provide working monitoring equipment suggests a significant departure from standard of nursing cares expected.

The three differing assessments for the level of care lack consistency and are without contemporaneous signatures. This also reflects a standard of care below what is expected.

I would also like to bring to the Commissioner's attention the failure to communicate with [the rest home] in a timely manner about the discharge plan and the failure to reassess [Mrs A] immediately prior to discharge on the 7th June.

Should you wish further information please do not hesitate to contact me.

Please note that this report is done in the absence of any of the back x-rays which have not been made available to me.

Yours sincerely

David Spriggs, MBChB, FRCP(Lond), FRACP, MD
General Physician & Geriatrician, Auckland District Health Board"

The following further expert advice was obtained from Dr Spriggs:

"Further to your letter from 06/08/13, I have reviewed my opinion given to the Commissioner on 23/05/12. You have supplied me with the following documents:

[Documents listed here redacted for the purpose of brevity.]

You have requested that I comment on the overall standard of care provided to [Mrs A] by Canterbury DHB during her hospital admissions:

a. at [Hospital 1] during her admission from 11 May 2011 to 7 June 2011;
b. at [Hospital 2] during her admission from 10 June 2011 to 16 June 2011;
c. at [Hospital 1] during her readmission from 16 June to 27 June 2011.

In addition to addressing the points raised in your previous advice, we would be grateful if you could comment on any changes to your preliminary advice in light of the additional information detailed above, noting that your previous advice made reference to:

1. the lack of documented medical input/review towards the end of [Mrs A's] admission of 11 May 2011 to 7 June 2011;
2. the overall level of care assessment and communication with the rest home;
3. delays in clarifying the degree of [Mrs A's] vertebral trauma;

Please also provide your comments on:

4. the appropriateness of the remedial actions taken by the DHB as a result of issues raised by this complaint.

I note that the HDC has already received expert nursing advice on the nursing management of [Mrs A's] care.

I have read and agree to follow the Commissioner's guidelines for independent advisors. I practice as a General Physician and Geriatrician at Auckland District Health Board and am vocationally registered in Internal Medicine. I have been a Fellow of the Royal Australasian College of Physicians since 1993.

This report follows on from my report of 23/5/12 and I will not repeat the summary of events which, I believe, is accepted by all parties.

Opinion

1. Lack of documented medical input/review towards the end of [Mrs A's] admission.
   I have reviewed the letters of 01/10/12 and 22/5/2012 from [Dr C] and the letters of 28/09/12 and 6/6/2013 from [Dr D]. I have also had a further review of the clinical notes.

   As stated in my initial opinion the last entry by a doctor in the clinical notes of the first admission is on the 27/05/12, 11 days prior to discharge. [Dr C] points out that on 31/05/11 [Mrs A's] nurse, in her end of shift summary, recorded that [Mrs A] was reviewed by the Medical Team. There is however no entry made by a doctor at that time.

   [Dr C] explains that he probably reviewed [Mrs A] with 'just myself, the nurse, the relative and patient'. This was because the junior doctors would have been 'standing around' and [Mrs A's] daughter 'had significant concerns' which needed to be approached 'sensitively'. [Dr C] subsequently states that 'In retrospect … it would have been highly desirable for me to keep the house surgeon and registrar present, not for patient safety but to facilitate this inquiry. Alternative options would have been to write the note myself … It is not however routine for me to record a detailed account of all interactions with patients and their relatives in stable situations'. My opinion is that it is routine practice for Geriatricians and other Physicians, recognising the concerns of the family and the sensitive nature of such a discussion, to write in the notes themselves.

   There is no indication that [Dr C's] discussion with the family and patient included review of her back, her drugs or her clinical status. As such, this episode does not constitute a clinical assessment but a conversation about the current and future plans for [Mrs A].

   There is no indication that she was seen by any doctor for the rest of the admission. [Dr C] states 'of course there is also an electronic record'. He states that at the beginning of each day there is a multidisciplinary team meeting attended by the Junior Doctors and 'if a medical issue is identified by the patient's nurse then the patient will definitely be reviewed by the RMOs'. He goes on to say that the RMOs will not write an entry into the file every day. He is not sure of the expected standard of note keeping in the DHB. He states that 'once a situation of a planned discharge was defined … the House

Surgeon would switch to the electronic record.' This record is not available to me.

[Dr D] took over the care of [Mrs A] on 03/06/11. At that stage he was covering two different teams and understood that he was only expected to review new patients and presumably any patients causing concern. There was no handover of [Mrs A] to [Dr D] as she was 'not considered to be unstable by medical or nursing staff'. Over the long weekend of June 4th, 5th and 6th no doctors were asked to see [Mrs A]. It being a long weekend, there were no routine ward rounds or, I assume, multidisciplinary meetings on those days.

On 07/06/11 [Mrs A's] discharge summary was finalised stating 'she is well on transfer today'. Again there is no medical review. There is no evidence that the doctors were asked to see [Mrs A] on that day despite her fall the night before. Although the early warning scores for [Mrs A] remained stable and satisfactory, it is very clear from the nursing notes that there had been a very significant decline over the preceding few days probably culminating in her fall on the night of 6th :

03/06/11, she required 'minimal assistance' with dressing,

04/06/11 'moderate assistance',

05/06/11 'full assistance'

06/06/11 'declined wash or dress'.

07/06/11 'full assistance'. On the day of discharge she wasn't even able to clean her own teeth.

I believe that there is clear evidence from the nursing notes that [Mrs A's] general function was declining in the few days prior to her discharge. The nurses should have recognised this and should have contacted the medical staff particularly as she was due to be discharged on 07/06/13. I recognise that at the start of a Tuesday following a long weekend the usual medical priority is to see the new and unstable patients and I believe that [Mrs A] had probably left the ward by the time the medical staff would have routinely got around to assessing her. This should not have been the case had the nurses identified the decline and let the medical staff know during the multidisciplinary meeting at the start of the day.

It is not acceptable that no medical records are kept in the last 11 days of a patient's stay in hospital. Leaving the nursing staff in their routine clinical notes, written at the end of shift, to record the medical ward round is not an acceptable standard of care. This does not constitute a medical review. It is the responsibility of the medical staff when reviewing a patient to make appropriate record in the medical files or supervise such an entry by others. If there is an electronic record of such, we need to see it. The audit of RMO documentation (this should have included SMO notes), referred to by [Dr C],

will clarify whether the absence of a medical entry in the clinical notes of an inpatient for the last 11 days of the admission at [Hospital 1] is usual.

2. Level of care, assessment and communication with [the rest home].
In the letter from [customer services at Hospital 1] dated 22/10/12 and in [Dr C's] letter and in the report from [clinical manager at Hospital 1] dated 07/09/12, there is an explanation as to the confusion on the 'Application for Residential Care Form'. I accept that the form dated 30/05/11, which is apparently approving rest home and hospital care, is an error.

   On reviewing the daily nursing care notes from 01/06/13 it would seem very appropriate that [Mrs A] was, at that stage, assessed at rest home level of care. We have a record of an email from [Ms E] to [the rest home] dated 02/06/11. On the 03/06/11 there is a 'Transfer Notice of Nursing Care' to [the rest home]. [Ms G and RN H] from [the rest home], state that they had not heard from the hospital on 07/06/11 so they rang 'to see what was happening'. At that time [Mrs A] was already on her way to them. On arrival at [the rest home] she was 'almost prostrate in the front of the car, pale, eyes closed and not talking'. As [Dr D] suggests, some of this may have been due to the higher dose of morphine that she received prior to transfer, presumably to allow her to travel more comfortably.

   While I acknowledge that the discharge of [Mrs A] was the day after a long weekend, I do not believe that this excuses the ward from contacting [the rest home] either the day before or on the day of transfer. Had that occurred it might have alerted the nursing staff to her apparent deteriorating condition. I believe it is standard practice for nursing staff in hospitals to perform a formal nursing handover to the receiving rest home. Your Nurse Advisor will be able to comment on this.

   The discharge letter was apparently drafted on the morning of discharge by the house officer, and I believe this reflects what the house officer was told. There was no reason to believe the house officer was aware of [Mrs A's] deterioration and the discharge summary reflects that. It would not be expected that he/she review all the nursing notes to identify their concerns over the preceding long weekend.

3. Delays in clarifying the degree of vertebral trauma
As [Dr C] states, such delays are common. Vertebral fractures are often missed. In the early days of her admission starting on 11/05/11, the management of [Mrs A's] vertebral fracture was as expected. The degree of pain suffered by such patients is very variable and often intermittent. However in the week prior to discharge her function was declining and she had increasing problems with pain, such that she required a high dose of morphine to allow her to be transferred to the rest home on 7/6/11. This transfer occurred the morning after a fall.

Once she was re-admitted to [Hospital 2] on 10/06/11, there was concern about her biliary tree and I agree that the initial medical assessment was right to concentrate on this. She underwent an MR examination of the biliary tree on 15/6/11. These images included the T12 vertebrum which was disrupted. She was transferred back to [Hospital 1] and she received an MR scan of the spine on 23/06/11. This scan and the report confirm retropulsion of a fragment of T12 and there is an acute fracture at T11. Although the modalities are different the vertebral height of T11 and T12 have both reduced compared to her admission plain x-ray 11/5/11. I have no doubt that the increasing pain that [Mrs A] suffered was due to further vertebral collapse. It is clear however that the MRCP on 15/06/11 showed an abnormal vertebrum and I believe that the further collapse probably occurred between 11/5/11 and 15/6/11 and may have been a result of one or more of her falls. I do not believe that the interval between the two MRIs indicates a poor level of care. The justification for proceeding to MR spine is outlined in [Dr C's] letter and I believe most physicians would understand and approve of his course of action.

It should be noted however that had there been a medical review of [Mrs A's] back pain before her discharge on 07/06/11, the new fractures of her spine may have been identified at that stage.

4. <u>Remedial actions by DHB.</u>
I am delighted to see the actions that Canterbury DHB has taken following this episode. I believe it is important that all patients are reviewed medically before they are discharged from a Rehabilitation Ward. I believe it is essential that doctors write in the notes when they perform their ward rounds and that at least two consultant ward rounds a week are expected. I recognise that covering leave is difficult and I would not expect a consultant covering two teams, as was the case of [Dr D], to double up the total workload.

I have not commented on the changes suggested to nursing processes particularly with regard to sensor alarms as I believe your Nurse Advisor will do this. It is however important that the nurses are empowered to request a medical review prior to discharge if they believe patients are deteriorating or are unfit to be discharged.

I believe the Canterbury District Health Board has responded positively to [Mrs A's] complaint and I compliment them on their falls audit, the audit of note keeping, the policy with regards to ward rounds and the need to be seen prior to discharge.

Additional Comments:
I am concerned by [Dr C's] comments on Section 10 in his letter of 01/10/12. It is accepted medical practice that the consultant responsible for the patient has overall responsibility for the care of that patient. Clearly that care is constrained by the services and infrastructure available. [Dr C's] job sizing does not excuse his responsibility for the overall care of [Mrs A] up to the time when he went on leave on the evening of 2/06/11. I accept that he has a busy job.

I also note his comment on the high falls rate. He points out that [Mrs A] 'fell on two different wards under the care of multiple different nurses, doctors and other health professionals. It is statistically unlikely that all these individuals care was to blame'. I agree with [Dr C]. As stated in my report of 23/5/12, 'I believe it inevitable that patients occasionally fall in rehabilitation settings'. However the purpose of HDC investigation is to identify not individuals to blame but systems which could be improved. In the care of [Mrs A], there are areas of improvement that can be identified. This has been acknowledged by the DHB and they have taken appropriate action.

Summary

I believe that the medical care of [Mrs A] during her admission to [Hospital 1] between 11/05/11 and 07/06/11 fell below accepted standards of care. In particular the failure to clinically assess [Mrs A] between 28/5/11 and 7/6/2011 and to record the assessment contemporaneously in the notes is a severe departure from accepted standards.

The communication between [Hospital 1] and [the rest home] falls below acceptable standards. I believe this departure to be of moderate severity.

The assessment of [Mrs A's] vertebral trauma during her stay in [Hospital 1] up to the 07/06/11 is inadequate. In particular the failure to repeat the clinical examination when she was deteriorating is not acceptable. This departure from accepted standards is of moderate severity.

The subsequent management at [Hospital 2] from 10/06/11 to 16/06/11 and at [Hospital 1] 16/06/11 to 27/06/11 is of a high and acceptable standard.

The DHB has taken appropriate remedial actions however I would hope that the DHB can ensure that all their senior medical staff are aware of their overall responsibility for the clinical care of patients who are admitted in the hospital under their care.

Should you wish for further information please do not hesitate to contact me.

Yours sincerely

David Spriggs, MBChB, FRACP, FRCP(Lond), MD

General Physician and Geriatrician, General Medicine
Auckland District Health Board"

Appendix B — Independent nursing advice to the Commissioner

The following expert advice was obtained from a registered general nurse, Ms (Elizabeth) Jane Lees:

"**Response to request to provide expert advice**

[Mrs A]

Your ref 11/01101

Response prepared by Jane Lees RGN, PgDipHSc, MN(hons)

[…]

You have requested that I provide the Commissioner an opinion on the overall standard of nursing care provided to [Mrs A] during three hospital admissions

1. at [Hospital 1] during her admission from 11 May 2011 to 7 June 2011
2. at [Hospital 2] during her admission from 10th June to 16th June 2011
3. at [Hospital 1] during her readmission from June 16th to June 27th 2011

You have also requested opinion on the appropriateness of falls management risk assessments and strategies in place for [Mrs A] including the availability or otherwise of sensor devices, bed rails and low beds throughout [Mrs A's] admissions.

You have asked for comment regarding the DHB's response to the HDC query why strategies initiated in [Hospital 2] were not continued on transfer and the availability of these resources.

Finally you have asked for comment of the EWS scores recorded, pain scores and FIMs based on the recorded nursing observations and clinical notes entries, and whether the nursing observations should have initiated review by a medical officer.

I will start with comment on the appropriateness of falls management, risk assessment and strategy for managing the risk of further falls.

[Mrs A] was admitted into hospital with a recent history of general physical decline due to unmanageable back pain. Early investigation through CT imaging identified 'an old compression fracture at T12' there was no reported history of falls.

Fall assessment with strategies to reduce falls was completed on 11/5/11 it was partly reviewed once 1/6/11. On the 11/5/11 the assessment identified that [Mrs A] was at high risk of falls.

Clinical assessment, management and investigation of patients who present with a falls risk can be challenging. Assessing an individual comprehensively to ensure the risk of future falls in particular those with harm is paramount to safety. [Mrs

A] has three out of three of the risk factors associated with falls with harm; age, bone disease and anticoagulation therapy.

The OPHSS falls Risk Assessment and Strategies form was completed, the strategies ticked on 11/5/11 go some way to address supporting [Mrs A's] safety however in light of the high risk that a fall may result in harm there was opportunity to ensure that interventions be more comprehensive and that the use of a floor level bed, increased observation, and clutter free environment should have been considered and implemented.

Ongoing nursing reassessment for falls management during the 11/5/11–7/6/11 admission to [Hospital 1] is not evident in particular following the first and subsequent falls.

Falls should not be looked at in isolation of other health detriments a fall can be an indicator of underlying intrinsic factors, attributing a cause can be difficult, culprit medications such as night sedation and opioid, cognitive impairment, infection and gait disorders are some of the factors that should be considered following a fall. Key to prevention of falls is the use of an appropriate multidisciplinary falls assessment and intervention programme (PROFET trail).

In [Mrs A's] case this was not the experience, multidisciplinary team falls reassessment is not evident in the clinical record, medication reconciliation appears not to have occurred or is not evident nor is a change to the fall prevention strategies.

It is pleasing to read that as a result of an unrelated root cause analysis conducted due to a fall unrelated to this case that medical staff are to examine all patients who experience a fall 'in a timely manner'. Pertinent here would be to determine, standardise and communicate what 'a timely manner' constitutes.

A number of the falls over the admissions occurred at night, again there is no evidence of any analysis of fall patterns. Night-time strategies are not evident; no differentiation of fall risk or care planning from night or day was made.

The question of availability of interventions such as sensor equipment, low beds and bed rails should be made as part of ongoing assessment and reassessment and be individualised with rationale for use. If such equipment features on a menu of interventions they should be available, fit for purpose and prescribed.

It was unfortunate that a sensor alarm did not have a battery, however whether this would have prevented a fall will remain unanswered. At one point during her healthcare journey [Mrs A] fell despite a functional sensor mat in situ.

Equipment should not be used in isolation, rather, should be part of 'a suite or bundle' of interventions individualised to a patient, communicated to the patient, healthcare team and family/whanau.

Bed rails are contraindicated for use for confused patients. Bed rails were used on the request of the family, the staff had reiterated this to the daughter, it was at her insistence they were used.

Falls in older people are very common, the risk of a fall with harm increases by 15% for those people aged 75 years and over. The combination of high frequency and susceptibility to injury in older people makes falling a syndrome of particular importance to clinicians, and yet despite experiencing several falls during her various hospital and residential care admissions falls does not appear on [Mrs A's] problem list or transfer of care documentation.

In summary [Mrs A's] assessment and care planning appears to focus on pain management, there does seem a lack of connectivity between the falls and opioid use. Comprehensive assessment of falls risk linked to appropriate plans of care is not evident nor is the transfer of information regarding the falls risk and falls history clear when [Mrs A] transferred care to the Aged Residential Care Facility.

The interRAI completed on 1/6/11 lacks consistency when compared with the clinical record, for example in section b — screener a score of 0 was given for cognition; independent in making daily decisions, and ability to manage personal hygiene independently, weight loss in section 13 (b) — nutritional issues failed to identify the recent weight loss.

Nearing discharge date 6–7/6/11 the daily nursing care plan stated full assistance required for showering with assistance of x1 required when transferring, there was also a fall in the bathroom recorded sustaining a skin tear. Despite the increased care need there is no indication of any multidisciplinary discussion that a higher level of care on discharge would be required.

Furthermore there was a lost opportunity when [Mrs A] did not respond to treatment in a timely manner that further imagining — MRI — to exclude further clinical issues was not undertaken.

Also of note there does not appear to be any ACC documentation completed in relation to the various falls [Mrs A] experienced.

The DHB's response to the HDC query why strategies initiated in [the medical ward] were not continued on transfer and the availability of these resources.

Much of the previous discussion highlights the lack of focus, connectivity and assessment of [Mrs A's] clinical presentation and risk management in particular in relation to falls management

Written communication is of basic quality and inconsistent for example, the transfer of care to Aged Residential Care completed by [an enrolled nurse], is dated 3/6/11 does not refer to a risk of falls nor does the discharge letter completed by [Dr I].

The lack of identification of the physical decline that [Mrs A] was demonstrating; the connectivity of that physical decline to risk identification may have led to the lack of importance of highlighting a falls risk, which in turn resulted in the subsequent lack of required and recommended interventions to prevent further falls being communicated on transfer to the Residential care facility.

The appropriateness of EWS scores recorded, pain scores and FIM based on the nursing observations and clinic notes entries and whether any nursing observations should have been initiated by a medical officer.

The EWS, the FIM and the nursing commentary tell a story of declining physical and mental health of [Mrs A], whether any further observations would have prevented the outcome is unclear. Whether further targeted observations would have led to an earlier MRI scan is also unclear. [Mrs A] presented with pain, she was comfortable when lying down, as her opioid use increased over time assessment did not lead to question why there was little response to the current treatment and care plan other than to reflect on a 'low mood'. It is unfortunate that further investigations of the back pain with MRI was not undertaken sooner, should that have been the case and an earlier diagnosis be made of the spinal stenosis rather than the belief that the injury was musculoskeletal then the care delivery, discharge planning and discharge destination for [Mrs A] may have looked very different.

In reviewing this case I believe that there has been a mild departure from the standard.

The overall standard of everyday nursing care appears to have been delivered to an acceptable standard, however the approach to care delivery appears task focused.

A lack of connectivity and analysis of [Mrs A's] physical decline, comprehensive assessment and linking the physical patient presentation in context to a whole of health approach rather than a narrow focus on pain management and low mood appears to have resulted in a delay to further investigate fully [Mrs A's] clinical presentation thus resulting in poor discharge planning and a delay in diagnosis of spinal stenosis. Please note this issue relates to the whole health care team.

The inconsistency seen in the nursing documentation is of concern, as is the lack of robust analysis of the presenting clinical picture. ISBAR is said to [be] utilised along with the NZNO documentation practice guidelines, regular auditing of clinical records should be undertaken to ensure a whole of health approach is being undertaken.

I am of the opinion that risk assessment needs to have more focus and that the transfer of care from one health care setting to another should include all aspects of risk assessment.

It is pleasing to observe the subsequent improved focus on falls assessment and falls management in the DHB however I would think it necessary to observe the changes that have been implemented to monitor sustainability.

This has been a comprehensive case to review.

If you require any further information through more targeted questions please do not hesitate to contact me

Yours Sincerely

Jane Lees, RGN, PgDipHSc., MN(hons)"