Registrar, Dr C

House Officer, Dr D

Consultant, Dr E

Capital & Coast District Health Board

A Report by the

Health and Disability Commissioner

(Case 12HDC01608)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On a Wednesday in mid 2012, Mr A was admitted to a public hospital for the management of an acutely ischaemic left leg. His pain was managed by paracetamol and fentanyl (an opiate painkiller similar to morphine). Mr A was admitted under the care of consultant Dr E.

2. On Friday, Mr A underwent an angioplasty, during which a stent was inserted to improve the blood flow to his leg. Mr A's pain was noted to have improved postoperatively.

3. On Saturday, Mr A was reviewed by surgical registrar Dr C during a routine ward round. Dr C documented the plan for Mr A to be discharged home on either Sunday or Monday. Dr C contacted Dr E and informed him that Mr A's pain had improved, and that Mr A was no longer using regular opiate pain relief.

4. On Sunday morning, Dr C reviewed Mr A and changed his medications from fentanyl to Sevredol. The ward round book records "discharge + script". Dr C did not document a discharge management plan, any details of her decision to prescribe Sevredol, or her plan with regard to monitoring and reporting Mr A's Sevredol requirements.

5. Later that day, the on-call surgical house officer, Dr D, was contacted by a nurse who requested that Dr D write a prescription for antibiotics for Mr A, so that he could be discharged. Dr D reviewed the medication chart and noted that Mr A was on a reduced dose of antibiotic because of his renal failure. Because Dr D was busy with an acute patient, she agreed to go to the ward later to complete the prescription.

6. A few hours later, Dr D arrived on the ward and prescribed Mr A an antibiotic in accordance with the Capital & Coast District Health Board (CCDHB) guidelines for antibiotic prescription. As she was leaving the ward, she was asked to write Mr A a prescription for analgesia. Dr D noted that Mr A had been prescribed Sevredol earlier that day, so wrote a prescription for the same dose that had already been prescribed. Dr D did not complete the discharge documentation.

7. Mr A was then discharged and returned home. He took his medications as prescribed, including a total of five 10mg Sevredol tablets.

8. On Tuesday, Mr A was found unconscious by his daughter. He was later admitted to hospital and treated for opioid toxicity. Sadly, a few days later, Mr A died.

Decision

9. It was held that Dr C's decision to prescribe Mr A Sevredol was suboptimal and, having made the decision to prescribe such medication to Mr A, Dr C should have proceeded with caution. Dr C's failure to document her discharge plan and her decision to prescribe Sevredol, and its monitoring requirements, demonstrates a lack of caution that placed Mr A at unnecessary risk of harm. Accordingly, Dr C was

found to have breached Right 4(4)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

10. Dr D was not found to have breached the Code. However, criticisms were made of aspects of the care she provided, in particular her failure to critically question the prescription of Sevredol in a man who had renal failure, and her failure to complete any discharge documentation.

11. Dr E was not aware that Mr A had been prescribed Sevredol, and there was no expectation that he should be involved in Mr A's discharge. Accordingly, Dr E did not breach the Code.

12. It was held that, by failing to ensure adequate communication, documentation, and coordination of care, CCDHB failed to ensure that its staff provided services to Mr A with reasonable care and skill and, as such, breached Right 4(1) of the Code.

13. Adverse comment is made about a retrospective change being made to Mr A's medication chart.

Complaint and investigation

14. The Commissioner received a complaint from Ms B about the care provided to her father, Mr A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Dr C in 2012.*
- *The appropriateness of the care provided to Mr A by Dr D in 2012.*
- *The appropriateness of the care provided to Mr A by Dr E in 2012.*
- *The appropriateness of the care provided to Mr A by Capital & Coast District Health Board in 2012.*

15. An investigation was commenced on 20 August 2013.

16. The parties involved in the investigation were:

Ms B	Complainant/daughter
Dr C	Provider/registrar
Dr D	Provider/house officer
Dr E	Provider/consultant
Capital & Coast District Health Board	Provider

[1] Right 4(4) of the Code states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises quality of life of, that consumer."

17. Independent expert advice was obtained from general surgeon Dr Patrick Alley (**Appendix A**).

Information gathered during investigation

Background

18. Mr A, aged 82 years at the time of these events, had complex co-morbidities including chronic renal impairment secondary to diabetic nephropathy,[2] chronic anaemia,[3] hypertension,[4] type 2 diabetes,[5] osteoarthritis,[6] Paget's disease,[7] and gout.[8] He had some short-term memory loss, and his regular medications were blister packed to facilitate adherence to his medication regimen.

19. Mr A was under the care of a hospice in the community for palliative care, but lived alone and was largely independent.

20. Mr A was also under the care of the CCDHB vascular outpatient clinic for the management of chronic foot ulcers.

Admission to hospital — Wednesday

21. On Wednesday, Mr A was seen in the Vascular Outpatient Clinic by general surgical registrar Dr C,[9] for follow-up of a chronic foot ulcer. During this appointment, Dr C noted that Mr A had an acutely ischaemic left leg.[10] Dr C advised HDC that she spoke at length with Mr A about the possibility of managing this by palliative amputation, but Mr A did not want that. Dr C therefore recommended attempting to insert a stent,[11] to try to salvage the limb. Mr A consented to that and was subsequently admitted for ongoing management.

22. After his admission to the ward, Mr A was commenced on IV antibiotics (cefazolin and metronidazole) and prescribed pain relief medications (regular paracetamol 1g QID (four times a day) and PRN (when required) fentanyl[12] 12.5–25 micrograms (mcg) up to Q30mins (given up to every 30 minutes)).

[2] Nerve damage associated with diabetes mellitus.
[3] Low iron levels.
[4] High blood pressure.
[5] Non-insulin-dependent diabetes.
[6] Breakdown of cartilage in the joints.
[7] A disease that can cause an alteration of the shape of the bones.
[8] A form of arthritis.
[9] Dr C has worked at two DHBs as a general surgical registrar for several years. At the time of these events, as part of a rotation on the general surgical registrar training programme, Dr C was working as a vascular registrar.
[10] Restricted blood flow to the leg.
[11] A tube inserted into an artery.
[12] An opiate analgesic similar to morphine.

23. Later that day, an angiogram[13] of Mr A's left leg was carried out, which revealed the need for an angioplasty.[14]

24. After returning from the angiogram, Mr A was noted to have "moderate" pain in his toes and, at 8pm, was administered 12.5mcg fentanyl and 1g paracetamol, with "good effect".

25. Mr A was reported to have continued pain overnight, and his leg and foot were very sensitive to touch.

26. An Admission to Discharge Plan[15] was commenced. However, with the exception of the first page, which included the patient's name, reason for admission and past medical history, the Admission to Discharge Plan for Mr A was not completed.

Ongoing management

Thursday

27. On Thursday, monitoring of Mr A continued. Mr A was administered 1g of paracetamol at 5.15am and 12.5mcg of fentanyl at 8am.

28. The plan was to perform a left leg angioplasty the following day.

29. At 9.30pm, it is recorded in the nursing notes that Mr A's pain was "mild".

Friday

30. On Friday at 5.35am, the nursing notes document that Mr A was complaining of level 8/10 pain in his left leg, for which he was given fentanyl with "good effect". According to the medication chart, Mr A was given fentanyl 12.5mcg at 2am, 5am, and 5.35am, and Panadol at 9am and 12.45pm.

31. At 7.40am, Mr A was reviewed during the vascular ward round. The plan remained for him to have an angioplasty later that day.

32. The nursing notes document at 1.40pm that Mr A had not complained of pain throughout the morning.

33. At approximately 4pm, consultant Dr E performed the angioplasty, in which a stent was inserted into Mr A's femoral artery. Mr A was then returned to the ward.

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[13] A test that examines the flow of blood through an artery.

[14] A technique to widen an obstructed artery.

[15] The "Admission to Discharge Plan" is a "comprehensive written assessment, plan of care and discharge plan". The CCDHB Admission to Discharge Plan policy requires an Admission to Discharge Plan to be completed for all patients admitted as an inpatient in the "Medical/Surgical, Gynaecology and AT&R [Assessment, Treatment and Rehabilitation]" settings. With regard to discharge planning, the Admission to Discharge Plan policy states:

> "Discharge planning starts in pre-assessment for planned admission or on admission for all other patients. Intervention by visiting health professionals are signed off on completion of treatment. With active treatment plans/ongoing education requirements or supply needs, discussion with relevant health professional **prior** to discharge or transfer to facilitate a safe discharge/ongoing intervention."

34. Mr A was administered 12.5mcg fentanyl at 5.10pm and 9.25pm, and paracetamol at 6.30pm.

35. The nursing notes for the night shift note that all of Mr A's observations were stable, and that he appeared to have slept well. Mr A was not administered any pain relief throughout the night.

Saturday

36. On Saturday, Mr A was reviewed by Dr C during the morning ward round. The records from this review document that the plan was for Mr A to mobilise and be discharged home on Sunday or Monday.

37. The consultant responsible for Mr A, Dr E, advised HDC that following the morning ward round, Dr C informed him that Mr A's pain was much improved, and that he was no longer using regular opiate pain relief. Dr E advised that it was his understanding that Mr A was using simple analgesia such as paracetamol.

38. At 3.15pm, the nursing notes document that Mr A had not complained of any pain during the day, and that he was walking to the bathroom independently.

39. At 10pm, the nursing notes document that Mr A was complaining of pain in his right foot, for which he was given fentanyl as charted. According to the medication chart, Mr A was administered paracetamol at 2pm and 5.50pm. He was given 12.5mcg fentanyl at 4.45pm and 9pm.

Sunday — charting of Sevredol

40. On Sunday at 4am, the nursing notes record that Mr A was complaining of mild pain in his toes and left heel. He was noted to be on regular analgesics.

41. Dr C advised HDC that she reviewed Mr A during the morning ward round, at which time she charted Sevredol[16] 10–20mg 2 hourly or PRN, and crossed off fentanyl.

42. In a statement to HDC, Dr C explained that her rationale for changing the prescription to Sevredol while Mr A was an inpatient was to ensure that he was comfortable and not in pain. Dr C stated:

> "[Mr A] was a very stoic man having presented with an ischaemic limb, which had been managed in the community for a reasonable period of time. We often chart oral analgesics to be used in a tiered manner … and it was important for him to have the option of stronger analgesia if required whilst an inpatient. He came in for a palliative procedure and comfort was paramount."

43. Furthermore, Dr C explained:

> "Fentanyl is not available in an oral form in the community and would accordingly not be available to him on discharge, which was anticipated to be imminent. I had charted Sevredol prn 10mg orally [two hourly] PRN (as required) to monitor his

[16] A fast-acting morphine.

> requirements in-hospital so that appropriate analgesia could be ensured at discharge. A switch from IV/SC [intravenous/subcutaneous] to oral medications is a standard part of discharge planning to assess the analgesic requirements of a patient prior to discharge, as the former is often not available in the community."

44. However, Dr C also stated:

> "It was not my intention that [Mr A] be discharged with a script for Sevredol, and certainly not if he did not require this whilst an inpatient. … There should at least have been some consultation with me or my equivalent on duty at the time to review the discharge, in particular, to the requirement of Sevredol in the community."

45. In a subsequent statement to HDC, Dr C said: "[T]he routine should be that the inpatient requirement is assessed and prescribed accordingly for use in the community." Dr C stated that had she been consulted at the time of Mr A's discharge, she "would not have given Mr A a script to take away for Sevredol; because he had not required any Sevredol whilst in hospital". Furthermore, Dr C stated that had Mr A experienced increasing analgesia requirements while an inpatient, the success of the stent would have been questioned, and the possibility of amputation would have been revisited.

46. Dr C advised that the charge nurse on duty would have been present at the ward round, and Dr C "requested to be contacted by nursing staff if [Mr A's] daughter arrived on the ward on the Sunday to ensure that if he was to go home, this was in a supportive manner".

47. Dr C stated that because it is not routine to carry out a ward round on a Sunday, she would have seen Mr A between other patients. As a result, she did not make any formal documentation of the ward round, or write a discharge plan. The only documentation in relation to this was in the "ward round book", which states that Mr A was for "discharge + script". There is no documentation that Dr C should be contacted prior to Mr A's discharge.

48. Dr E advised HDC that, following Dr C's ward round, she contacted him again, advising that Mr A was no longer requiring opiate analgesia. Dr E said that it seemed appropriate to discharge Mr A given his significant improvement. Dr E recalls that Dr C informed him that a social assessment had been made, and that Mr A would be discharged to a supportive environment with supervision from his family, and that he was also under the care of the palliative care team. Dr E said that he trusted Dr C's assessment and agreed that the decision to discharge was correct.

49. Dr E said that he was not aware that Dr C had prescribed PRN Sevredol, but does not consider that the decision to do so was unreasonable in case Mr A developed more severe pain again on the ward.

Discharge — Sunday

50. Mr A was discharged during Sunday afternoon.

51. During the time of these events, Dr D was working as a surgical house officer, covering general surgery, vascular surgery and cardiothoracics. The CCDHB incident review report identified that Dr D was covering a shift for another house officer, and did not normally cover vascular patients and was therefore unfamiliar with Mr A. On Sunday, Dr D had to attend a number of outlying acute patients on different wards.

52. Dr D recalls that she was in the middle of reviewing another acute patient when a nurse requested a prescription for antibiotics for Mr A because he was to be discharged that day. Dr D stated: "[Writing the prescription] was presented to me as being a quick task, which wasn't complicated and which could be done in another pod, away from the patient."

53. Dr D advised that she had not met Mr A previously, so was surprised to be asked to write the prescription for his discharge. Dr D explained that "[i]n the surgical department, in the weekend the rounding registrars complete any discharge jobs themselves, the patient will have any paperwork needed and the house surgeon would not normally be involved in the discharge process". However, because quick discharges are always emphasised as being important, she said that she agreed to write the prescription.

54. Dr D said that before she wrote the prescription she asked the nurse what was documented in Mr A's clinical records. The nurse went away to look, and returned to advise Dr D that there was nothing documented. Dr D said that because of this she then looked at Mr A's medication chart herself to see if the prescription could be done quickly. Dr D stated:

> "When I saw that [Mr A] was on IV antibiotics on a decreased dose and saw that his bloods showed abnormal renal function, I knew that it was not something that I could do quickly."

55. Dr D explained that at the time of the nurse's request, her attention was focused on her other patient. Because she had found that Mr A had renal impairment, which meant that not all antibiotics would be appropriate, she considered it safer to go to the ward later to complete the request.

56. Dr D said that, after advising the nurse that she would come to the ward to complete the prescription, she was paged twice by ward staff advising her that Mr A's family were waiting for him to be discharged. However, because she was very busy she was not able to get to the ward until about four hours after the initial request for her to write the prescription.

57. Dr D recalls that before she went to the ward to discharge Mr A she saw Dr C. Because she knew that Dr C was the "rounding" doctor, she asked her what the antibiotic of choice was for Mr A. Dr D advised HDC:

> "I can't remember the exact details of the brief conversation, but I do remember leaving without the answer I needed, and having the feeling that I still needed to

look up what antibiotic I would need to prescribe. We did not discuss the issue of pain relief and there was definitely no mention of sevredol."

58. Dr D said that when she arrived on the ward she looked for a ward round note to guide her on which antibiotic to prescribe, but there was no medical documentation about Mr A's condition or care that day, which she considered to be unusual, given that Mr A was to be discharged. Dr D then spoke to the nurse looking after Mr A, as well as the charge nurse, to check that Mr A had been seen and discharge had in fact been requested by Dr C. Dr D said that the only documentation was in the nurses' ward round book, which said "discharge + script".

59. Dr D then referred to the CCDHB guidelines for antibiotic prescription, and wrote a prescription for a reduced dose of flucloxacillin, taking into account Mr A's renal impairment.

60. Dr D recalls that as she was leaving the ward she was asked to write a prescription for Mr A for analgesia. Dr D asked the nurse her impression of his pain, and what his analgesia requirement would be. Dr D advised:

> "I cannot remember the exact response, but I remember it made me think he would need more than just paracetamol, in the form of an opioid. I saw he was on regular paracetamol which I believe I also prescribed. … I then turned to the PRN (as required) section in his drug chart and saw that he had been prescribed Fentanyl while on the ward and that this had been crossed out and that sevredol had been prescribed instead. I wrote a script for a small supply of sevredol at the same dose that had already been prescribed by [Dr C]. Usually before charting someone morphine based drug I would consider their renal function but in this case because it had already been prescribed by the doctor in charge of his care I saw no reason to second guess what had already been prescribed for him by the Doctor who had cared for him."

61. Dr D wrote the prescription for Sevredol 10mg, one to two tablets (i.e. 10–20mg) every two hours as needed. Mr A was prescribed a total of 20 tablets.

62. Dr D explained that because she was very busy and under pressure she did not complete a discharge summary for Mr A or the necessary documentation for the medication she had prescribed. She advised that, when a patient is discharged over the weekend from the surgical department, the paperwork would normally be completed by the rounding registrar, and that the house officer would not normally be involved in the process.

Alteration of prescription

63. On the medication chart received by HDC from CCDHB, Sevredol is recorded as being charted on Sunday. The dose is documented to be 10–20mg, but "20" has been crossed out.

64. In a statement to HDC, Dr C confirmed that the Sevredol dose she prescribed during the ward round on Sunday was 10–20mg. She denied changing the medication chart retrospectively.

65. Similarly, in a statement to HDC Dr D stated that she did not make any changes to the medication chart. Dr D confirmed that she wrote the prescription for the same dose that had already been prescribed (10–20mg). She said that at the time she wrote the prescription, "20mg" had not been crossed off.

Following discharge

66. Mr A returned home after he had been discharged. He took the medications as prescribed, including a total of five 10mg Sevredol tablets.

67. Mr A's daughter, Ms B, told HDC she recalls that on the day following his discharge, Mr A complained of being "very light headed". She said that he was unsteady when he walked, that he did not get dressed, and spent much of the day sleeping.

Tuesday

68. On Tuesday morning, Mr A was found unconscious by Ms B. Ms B contacted the hospice community team and asked them to come to review Mr A. On arrival, Mr A was noted to be unconscious and could not be roused to voice or pin prick. An ambulance was called, and Mr A was readmitted to hospital.

69. On arrival at the Emergency Department, Mr A was noted to have a Glasgow Coma Scale (GCS) of 11.[17] He was given naloxone,[18] and his GCS improved to 14.

70. Mr A was admitted to the High Dependency Unit and diagnosed with metabolic acidosis secondary to uraemia,[19] opioid toxicity,[20] and sepsis.[21] He was treated with naloxone. At 12.15am two days later Mr A was noted to have lost consciousness and began having seizures. Active care was withdrawn and, sadly, Mr A died.

CCDHB incident review

71. Following this incident, CCDHB carried out an adverse event review, which noted the following:

- The Patient Admission to Discharge Plan had not been fully completed.
- Mr A was not assessed by the allied health team because he was already under the care of the hospice.
- Mr A should not have been discharged on a Sunday until the method of administration and type of pain relief had been adequately assessed.

[17] The GCS is a 15-point objective measure of a patient's conscious state, with 15 being fully conscious and alert and 8 or less a severe brain injury.
[18] A medication used to counteract the effects of opioid medications.
[19] Acidosis caused by renal impairment.
[20] Toxicity caused by an excessive amount of opioid medication.
[21] A systemic body response to infection that can lead to multi-organ failure.

- The outcome of the ward round on Sunday was not documented.
- There was no documentation following the change in prescription.
- The house officer did not review Mr A owing to workload and other competing clinical demands, and based the prescription on the medication chart.
- It was reasonable for the house officer to assume that the discharge analgesia was what had been written on the prescription chart, which had been altered that morning.
- No discharge summary was completed owing to the house officer's workload.
- Sevredol was an inappropriate form of analgesia for a patient with chronic renal failure.

Actions taken by CCDHB

72. CCDHB has amended its prescribing policy to include a minimum discharge prescribing practice, including the requirement that careful consideration be given to stopping opioid analgesia at the time of discharge, and communication with senior medical staff.

73. CCDHB advised that it has used this case for education of its staff of the risks of opioid medications for patients with chronic renal failure. Further to this, in response to the provisional opinion, CCDHB advised that it is currently undertaking an "opiate safety project", and that it has "identified medication safety as a key strategy for the organisation". As part of the opiate safety project a number of changes have been made, including:

- the introduction of an acute pain management guideline which includes a Preferred Medicines List;
- the introduction of a mobile app to enable direct access to CCDHB's Preferred Medicines List;
- the development of an opioid patient information sheet for use on discharge and when opioid prescriptions are being filled; and
- inclusion of the administration of naloxone as an incident type on the reportable events database to encourage prompt review of cases involving opioid narcosis.

74. Since these changes, CCDHB has seen a drop in adverse events related to renal impaired patients developing opioid narcosis.

75. There is now formal reporting and close monitoring of the Patient Admission to Discharge Plan (PADP) compliance audit results, and CCDHB continues to work on improving use of this document. CCDHB advised that it has undertaken a review of the PADP and issued a revised document in March 2014. Following the release of the revised PADP, CCDHB has carried out organisation-wide communication relating to the mandatory use of the document.

76. CCDHB advised that Surgical Services is reviewing how discharge planning is undertaken by "better coordinating discharge planning and documentation by Registrars, and ensuring house surgeons on weekend are informed".

77. As a result of the issues raised by the expert advisor, CCDHB advised that it has reviewed the rates of weekend discharges, which were noted to have increased over recent years. As a result, CCDHB is now undertaking a review of the medical staffing over weekends.

78. Following this incident, CCDHB met with Mr A's family in an attempt to address their concerns.

Further comment by Dr C

79. Dr C advised HDC:

> "On reflection, I now appreciate that the charting of Sevredol was not optimal or appropriate in [Mr A's] case …
>
> Because of this, I wish to tender my apology to [Mr A's] family for my failing in this regard. I do not seek to excuse that in any way and make that apology unreservedly."

80. Dr C advised that in the past it was always her practice that if a patient required morphine on discharge, she would ensure that the patient had enough to get through to the next GP visit. However, since this incident she is now more "tentative" about prescribing morphine for use in the community. Dr C added that she would never prescribe a patient morphine at the time of discharge if the patient had not required it as an inpatient.

81. Dr C said that she now uses fentanyl patches more frequently for inpatient use and on discharge, and has increased her use of the Palliative Care and Acute Pain services at the hospital.

82. In addition, Dr C advised that she now often writes her own prescriptions, rather than relying on the house officer, if there is the chance of a patient discharge. She advised that she is now less likely to discharge elderly, complex patients over the weekend, instead waiting for a complete multidisciplinary review on the Monday.

83. Dr C stated that she now always ensures that she personally reviews any of her patients due to be discharged.

Further comment by Dr D

84. Dr D advised HDC:

> "I do recognise that [Mr A] was a complex patient who, in hindsight, should have been discharged with a discharge summary, however he was not well known to me nor was he under my care during the week. I was not best placed to provide this

> information, and had I been this would likely have led to a poorly written summary or one which would have taken a very long time."

85. However, Dr D said that she accepts that discharge documentation was her responsibility and apologises for not completing it.

86. Dr D said that since this incident she now ensures that all relevant paperwork is completed, and that she meets with the patient to go over the plan and new medications.

87. Dr D advised that following this incident she met with her intern supervisor, as well as discussing the case with one of the renal consultants, and both consultants considered that the incident involved a series of systems errors at CCDHB.

88. Dr D stated:

> "I have learnt now that no job on the ward can be done quickly, and proper documentation is needed for patient safety. To be safe, I should not simply rely on other people's documentation, prescribing, or voiced opinion, but speak directly to the patient to gain my own views on their care. Although already aware, this has heightened my awareness of prescribing medications in those with renal failure."

Response to provisional opinion

Dr D

89. Dr D did not wish to provide any further comment on the findings of the provisional opinion relating to her.

Dr C

90. In response to the provisional opinion, Dr C accepts that "the prescription of narcotic analgesia in a patient with renal impairment was flawed".

91. In relation to the fact that Dr C prescribed Mr A Sevredol to ensure that he had the option of stronger pain relief if required, Dr C reiterated that, if a patient is expected to have pain it is routine to "prescribe analgesia in a tiered manner". Dr C stated:

> "This is to ensure that the nurses are able to give patients analgesia in a timely manner and that patients are not left without sufficient analgesia for unnecessary lengthy periods."

Dr E

92. Dr E did not wish to provide any further comment on the findings of the provisional opinion relating to him.

CCDHB

93. CCDHB advised that it "accept[s] the recommendations provided in the Provisional Opinion". It also updated HDC on the changes it has made since this incident. These have been incorporated into this report.

Mr A's family

94. Having reviewed the "information gathered" section of the provisional opinion, Mr A's family made a number of comments, which have been taken into account in my consideration of this investigation.

Opinion: Dr C

95. Dr C was an experienced general surgical registrar who had been working at CCDHB since 2006. At the time of these events she was working in the specialty of vascular surgery.

96. Dr C had been involved in Mr A's care since his admission to hospital, and was familiar with Mr A's medical history, including the fact that he had renal failure and was under the care of the hospice in the community.

97. On Saturday, Dr C reviewed Mr A during the morning ward round. At that time she assessed Mr A as being ready for discharge, and she documented in the clinical records the plan for him to be discharged home on Sunday or Monday. Dr C informed the consultant responsible for Mr A, Dr E, of her plan, advising him that Mr A was no longer requiring regular opiate pain relief.

98. On Sunday, Dr C reviewed Mr A again during the morning ward round. At that time Dr C crossed "fentanyl" off Mr A's medication chart and prescribed PRN Sevredol. Dr C explained that her rationale for this change was that Mr A was "a very stoic man" and "it was important for him to have the option of stronger analgesia if required whilst an inpatient". Dr C submitted that it is standard practice to prescribe analgesia in a case where the patient is expected to have pain.

99. Dr C explained that fentanyl cannot be prescribed orally in the community, so it would not have been available to Mr A upon discharge. Dr C said that she charted the PRN Sevredol "to monitor his requirements in-hospital so that appropriate analgesia could be ensured at discharge".

Decision to prescribe Sevredol — adverse comment

100. I accept that it is common practise to prescribe analgesia in situations where the patient is expected to have pain, such as postoperatively. However, as noted by my general surgery expert, consultant Dr Patrick Alley, Mr A's angioplasty appears to have been successful in improving his pain and as a result following the angioplasty Mr A had been managed without regular opioid (narcotic) pain relief. In addition, Mr

A had mild renal impairment, which Dr Alley advised "would be a reasonable indication to avoid (or be very cautious at least) in prescribing narcotic pain relief". Furthermore, Mr A was under the palliative care team, and had access to pain relief if required through the hospice.[22]

101. Overall, while I do not consider Dr C's decision to prescribe Sevredol to Mr A warrants a finding that she breached the Code, I consider Dr C failed to critically assess the appropriateness of prescribing this medication to Mr A given that his pain was already well managed and he had renal impairment. I note that in response to the provisional opinion Dr C accepts that the prescription of narcotic analgesia in a patient with renal impairment was flawed.

Failure to document management plan — breach

102. Dr C told HDC that she charted the PRN Sevredol "to monitor his requirements in-hospital so that appropriate analgesia could be ensured at discharge". Dr C said that it was never her intention for Mr A to be discharged on Sevredol and, if he had required an increased amount of analgesia, the success of the stent would have been questioned. However, there is no documentation to indicate that this was Dr C's plan. In my view, if this was Dr C's plan, she should have documented it with regard to monitoring and reporting of Mr A's Sevredol requirement. However, there is no documentation to this effect in the records.

103. A detailed and clear record of a patient's history, assessment, and management plan is central to the provision of effective and coordinated care. This is particularly important in the DHB context, where multiple providers are involved in a patient's management.

104. As noted above, Dr C's decision to prescribe Sevredol to Mr A was suboptimal. However, in my opinion, having made the decision to prescribe such medication to Mr A, Dr C should have proceeded with caution. The fact that there is no documentation of the planned discharge, the decision to prescribe Sevredol, or of the monitoring requirements, is concerning and placed Mr A at unnecessary risk of harm. It follows that Dr C breached Right 4(4) of the Code.

Opinion: Adverse comment — Dr D

105. On Sunday, Dr D was working as the surgical house officer, covering general surgery, vascular surgery, and cardiothoracics.

106. Dr D first became involved in Mr A's care on Sunday afternoon when she was asked to write a prescription for antibiotics in preparation for Mr A's discharge later that afternoon. Dr D said that this request came from a nurse and was presented to her "as

[22] I note that Ms B has advised HDC of her understanding that Mr A would have had access to fentanyl orally or in the form of patches from the hospice.

being a quick task, which wasn't complicated and which could be done in another pod, away from the patient".

107. Dr D said that when she reviewed Mr A's medication chart she became aware that he had renal impairment and therefore should not be given some antibiotics. Because of this, Dr D decided that she needed to go to the ward to complete the prescription. When she arrived on the ward, Dr D reviewed Mr A's clinical records and, after referring to the DHB guidelines for antibiotic prescription, prescribed flucloxacillin.

108. Dr D said that as she was leaving the ward, the nurse asked if she would also write a prescription for Mr A for pain relief. Accordingly, after referring to Mr A's medication chart, Dr D prescribed Mr A paracetamol and Sevredol. Dr D told HDC:

> "Usually before charting someone morphine based drug I would consider their renal function but in this case because it had already been prescribed by the doctor in charge of his care I saw no reason to second guess what had already been prescribed for him by the Doctor who had cared for him."

109. While Dr D took care to check that she was prescribing an appropriate antibiotic given Mr A's circumstances, she made the decision to repeat the pain relief medication that had been prescribed to Mr A as an inpatient. I note Dr Alley's advice that it is the responsibility of the person writing the prescription to "attend to the particular circumstances of the patient who is being discharged". There is no doubt that Dr D should have questioned this prescription. However, I also acknowledge that Dr D was placed in a difficult situation as a junior staff member with no prior knowledge of Mr A's circumstances. Furthermore, she was acting on instructions of nursing staff who requested she write the prescription, with no documented information with regard to the discharge plan. I also accept the DHB's advice that Dr D had a number of other acute outlying patients.

110. Dr D also failed to complete any discharge documentation for Mr A. She said that this was because of her workload, and that discharge paperwork would normally be completed by the rounding registrar when a weekend discharge was planned. In addition, she said that she was unfamiliar with Mr A.

Conclusion

111. It is regrettable that Dr D did not critically question the prescription of Sevredol in a man who had renal impairment and had not had any requirement for Sevredol while on the ward.

112. Furthermore, it was far from ideal that Dr D did not complete any discharge documentation. However, I note that the Admission to Discharge plan was also not completed, nor was there any documentation following the ward round by Dr C on Sunday.

113. While I am critical of aspects of Dr D's care, I note that she was a relatively inexperienced doctor, working in a less than ideal environment. In particular, Dr D had a number of other acute patients and was expected to complete discharge

documentation for a patient with whom she was unfamiliar, and where there was little documentation or communication with regard to the discharge management plan. Accordingly, in these circumstances, I do not find that Dr D's failings amount to a breach of the Code.

Opinion: No breach — Dr E

114. Dr E was the supervising consultant for Mr A's care, and was the on-call consultant on the weekend of Mr A's discharge. Dr E first became involved with Mr A following his acute admission on Wednesday, and performed the angioplasty on Friday.

115. Dr E advised that he saw Mr A postoperatively on Friday, but was not present during the Saturday morning ward round performed by Dr C. Dr E told HDC that following the ward round, Dr C informed him that she had noted that Mr A's pain was much improved, and that he had stopped his regular opiate medications. Dr E said that his "understanding from this was that Mr A was now on simple analgesia such as Panadol regularly".

116. Dr E told HDC that he was not present at the Sunday morning ward round conducted by Dr C, but Dr C informed him that Mr A was no longer requiring opiate analgesia, a social assessment had been completed and he was returning to a supportive environment with supervision from close family members, and he was also under the care of the palliative care team. Dr E agreed that discharge was appropriate. Dr E said that he was not aware that Dr C had charted PRN Sevredol.

117. Dr E was not contacted again with regard to Mr A.

118. I accept that Dr E was not aware that Mr A had been prescribed Sevredol. I note Dr Alley's advice that Dr E would not normally expect to be contacted about a routine discharge.

119. In my view, in light of the fact that Dr E was not informed that Mr A had been prescribed Sevredol, and there was no expectation that he should be involved in Mr A's discharge, the care provided by Dr E was appropriate in the circumstances. Accordingly, I find that Dr E did not breach the Code.

Opinion: Breach — Capital and Coast District Health Board

120. In my opinion, CCDHB did not provide Mr A with an appropriate standard of care as a result of a sequence of missed opportunities and communication breakdowns as outlined below.

Policies and procedures/discharge planning

121. CCDHB has a tool, the "Admission to Discharge Plan", which is a "comprehensive written assessment, plan of care and discharge plan" completed for all patients admitted as an inpatient in the "Medical/Surgical, Gynaecology and AT&R" settings. The requirement is for nursing staff to complete the initial assessment within 24 hours of the patient's admission, with relevant referrals being actioned immediately. With regard to discharge planning, the Admission to Discharge Plan policy states:

> "Discharge planning starts in pre-assessment for planned admission or on admission for all other patients. Intervention by visiting health professionals are signed off on completion of treatment. With active treatment plans/ongoing education requirements or supply needs, discussion with relevant health professional **prior** to discharge or transfer to facilitate a safe discharge/ongoing intervention."

122. With the exception of the first page, which included the patient's name, reason for admission and past medical history, Mr A's Admission to Discharge Plan was not completed.

123. Effective guidelines for staff that are relevant and consistent with good practice are an important part of the quality assurance processes at any DHB. That said, these are of little use unless they are followed consistently.

Communication

124. The system in place at CCDHB that allowed patients to be discharged by junior doctors on a Sunday is not unusual. As noted by Dr Alley, "DHBs operate a 24/7 enterprise. To discharge patients on a Sunday is an expected event." However, adequate communication and coordination of care is central to ensure that this works effectively and safely. The DHB has an organisational duty to ensure that this occurs. I have previously noted that "not only are discharge documents and prescriptions essential for handover, but they also create the opportunity to inform, clarify, and educate".[23]

125. As noted by Dr Alley: "The striking feature is the lack of co-ordination of the medical staff involved. There seems to have been poor handover of this patient particularly in respect of his pain relief requirement."

126. I consider that CCDHB failed in its duty of care to Mr A. While I am satisfied that Dr C's decision to discharge Mr A on Sunday was reasonable, she should have clearly documented in the clinical records her reasoning and plan, in particular the requirement that nurses should monitor Mr A's pain management, and her expectation that she should be contacted if discharge was to occur. This was especially important in this case in light of her decision that morning to prescribe PRN Sevredol. Had Dr C clearly documented her rationale for prescribing Sevredol, including her intention that Mr A's pain relief would be monitored and the prescription reviewed prior to Mr A's

[23] See opinion 12HDC00599, page 6.

discharge, it is likely that this would have prompted more careful consideration by Dr D when she was asked to facilitate the discharge.

127. Further to this, Dr D apparently felt under some pressure to discharge Mr A and, as a result, failed to review Mr A's circumstances carefully and complete the relevant discharge paperwork.

128. Communication is central to ensuring the provision of seamless, coordinated care. Failing to communicate introduces opportunity for things to go wrong, such as important information not being handed over adequately. This is particularly so in a hospital setting, where multiple staff are involved in a patient's care.

129. As noted by Dr Alley: "Secondary care facilities such as CCDHB operate on a clinical standard of delegation of clinical tasks. These extend from the specialist staff ... to the junior medical staff. These delegations are entirely dependent on frequent accurate communication at all times. … [T]his seems not to have occurred in the management of [Mr A's] condition so the standard of secondary care fell well below what I would regard as usual."

Conclusion

130. In my view, a sequence of poor communication and coordination of care, coupled with suboptimal documentation of the discharge plan, led to Mr A being inappropriately discharged on Sevredol. There is limited information documented in the clinical records about the discharge plan, and no information and guidance about the decision to prescribe Sevredol. Furthermore, there is no documentation by either the nursing staff or house officer with regard to Mr A's discharge, and the requisite discharge documentation was not completed.

131. CCDHB has a responsibility to ensure that its staff provide services of an appropriate standard. I find that services were not provided to Mr A with reasonable care and skill and, accordingly, CCDHB breached Right 4(1) of the Code.

Other comment — Alteration of prescription

132. Sevredol was charted by Dr C on Sunday morning. The dose documented on the medication chart provided to HDC by CCDHB is 10–20mg, but "20" has been crossed out.

133. In a statement to HDC, Dr C confirmed that the Sevredol dose she prescribed during the ward round on Sunday was 10–20mg. Dr C denied changing the medication chart in retrospect.

134. Similarly, in a statement to HDC Dr D stated that she did not make any changes to the medication chart. Dr D confirmed that she wrote the prescription on Sunday afternoon

for the same dose that had already been prescribed (10–20mg). Dr D said that at the time she wrote the prescription, "20mg" had not been crossed off.

135. The prescription written by Dr D at the time of discharge was for Sevredol 10mg, one to two tablets every two hours as needed.

136. I am unable to conclude who made the change to Mr A's medication chart, or why this was done. However, it is very concerning that the change was made. In my view, these actions raise concerns about the culture in place at CCDHB. I consider that there are lessons to be learnt from this case, and trust that CCDHB will use it as an opportunity to review its culture and support of its junior medical staff.

Recommendations

137. In accordance with the recommendations of my provisional opinion, Dr C has agreed to provide a written apology to Mr A's family for the shortcomings in Mr A's care. The apology should be sent to this Office within three weeks of the date of this report, and will be forwarded to the family.

138. In accordance with the recommendations of my provisional opinion, CCDHB has agreed to:

a) Provide a written apology to Mr A's family for the shortcomings in his care. The apology should be sent to this Office within three weeks of the date of this report, and will be forwarded to the family.
b) Undertake monthly monitoring of discharge summaries to ensure its ongoing supervision and monitoring of staff in relation to compliance with its discharge policies.
c) Review its current policies and procedures with regard to discharges, in particular weekend discharges, especially in relation to the communication of discharge plans.
d) Provide a report to HDC on the outcome of its most recent audit of compliance with the Admission to Discharge Plan and other aspects of discharge planning.
e) Use the anonymised version of this report for educational purposes, highlighting in particular the concerns raised about culture, communication and coordination of care.

139. This information should be provided to this Office within three months of the date of this report.

Follow-up actions

140. • A copy of this report with details identifying the parties removed, except CCDHB and the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of the names of Dr C, Dr D and Dr E.

• A copy of this report with details identifying the parties removed, except CCDHB and the expert who advised on this case, will be sent to the Health Quality & Safety Commission, and DHB Shared Services, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent advice from Dr Patrick Alley

The following expert advice was obtained from Dr Patrick Alley, a vocationally registered general surgeon:

"My name is Patrick Geoffrey Alley. I am a vocationally registered general surgeon employed by Waitemata District Health Board. Additionally I am the Director of Clinical Training for that DHB.

I graduated M.B.Ch.B from the University of Otago in 1967. I gained Fellowship of the Royal Australasian College of Surgeons by examination in 1973. After postgraduate work in England I was appointed as Full Time Surgeon at Green Lane Hospital in 1977. In 1978 I joined the University Department of Surgery in 1978 as Senior Lecturer in Surgery. I was appointed as Full Time Surgeon at North Shore Hospital when it opened in 1984. My present principal role in that DHB is as Director of Clinical Training. I am a clinical director for two other hospitals in Auckland — Ormiston and Rodney Surgical Centre.

I am a Clinical Associate Professor of Surgery at the University of Auckland, have chaired the Auckland branch of the Doctors Health Advisory Service for many years and have formal qualification in Ethics which is utilised as a member of two institutional ethics committees. One is at Waitemata DHB, the other at Mercy Ascot Hospital. I declare no conflict of interest in this case.

Clinical background

This has been well covered in a number of submissions but the essential features are as follows.

This elderly patient suffering mild to short term memory loss presented with an ischaemic left leg on [Wednesday]. In his community he was under some care by [a] Hospice. After clinical review by the consultant in charge ([Dr E]) it was concluded that an angioplasty was a realistic option and he went for this on the day of admission. Pain, an inevitable accompaniment of such conditions, was managed with paracetamol 1 four times per day and Fentanyl l 12–250micrograms on PRN basis. Fentanyl is potent narcotic analgesic. After his angioplasty the pain subsided and was perfectly controlled with Fentanyl and paracetamol. It was noted that during this admission an admission to discharge planner was not completed.

On [Thursday] the day following his angioplasty he was found to be dehydrated. He was treated with intravenous fluid with good effect. On [Friday] 3 doses of Fentanyl and 2 paracetamol were administered for his pain but it is recorded in the patient's notes that the angioplasty had had good effect in re-establishing circulation to his affected leg.

On [Saturday] he was deemed ready for discharge. His pain had been controlled in large measure to paracetamol although he had required in the previous 24 hours 2 x doses of Fentanyl. Discharge actually occurred on [Sunday], the discharge

prescription was for Sevredol 10–20mgs which had been prescribed on the previous day, [Saturday]. It was written by the on-call house surgeon Dr D.

He was found unconscious on [Tuesday] at home. He was readmitted to hospital and found to have a metabolic acidosis. He died soon [afterwards in hospital].

You have asked me to comment on the following aspects of this case.

1. Please comment generally on the standard of care provided to [Mr A] by [Dr C], [Dr D], [Dr E] and CCDHB.

The striking feature is the lack of co-ordination of the medical staff involved. There seems to have been poor handover of this patient particularly in respect of his pain relief requirement. The decision to give sevredol has been justified by the prescribing doctor ([Dr C]) but was probably unnecessary, even unwise (see below). I also note an amendment of the sevredol prescription in his inpatient medication chart. This must have been done by someone at or soon after his discharge. No-one has claimed responsibility for this and therefore the reflection of this behaviour (which I find egregious) must rest with CCDHB. […]

2. What standards apply in this case?

Secondary care facilities such as CCDHB operate on a clinical standard of delegation of clinical tasks. These extend from the specialist staff — [Dr E] in this case — to the junior medical staff. These delegations are entirely dependent on frequent accurate communication at all times. Sadly this seems not to have occurred in the management of [Mr A's] condition so the standard of secondary care fell well below what I would regard as usual. I also emphasise that this is not a 'gold standard' but rather it is a normal standard that all DHBs aspire to, and, usually, achieve.

3. Were those standards complied with?

No.

4. The appropriateness of [Dr C's] prescription of Sevredol. Please include comment on the appropriateness of the dose at which this was prescribed.

I note [Dr C's] statements about her rationale for prescribing Sevredol. In essence she states that it was of concern that [Mr A] might experience severe pain and would therefore need strong analgesia. This seems strange on several counts. Firstly, his recent pain control had been adequate without narcotic pain relief. The intervention (angioplasty) sounds to have been very successful in abating the cause of his pain. Secondly he had access through the hospice for contact had his pain become severe. Thirdly, on general principle I believe it is better to manage pain relief on the basis of what the patient requires now rather than later. This is especially so in elderly patients with known, if minor, cognitive deficit. Such patients may be adversely affected by narcotics. Finally [Mr A] was suffering mild

renal impairment which would be a reasonable indication to avoid (or be very cautious at least) in prescribing narcotic pain relief.

5. The appropriateness of [Dr C's] decision to discharge [Mr A] on Sunday. Please include comment on the adequacy of [Dr C's] communication and documentation in relation to this decision.

DHBs operate a 24/7 enterprise. To discharge patients on a Sunday is an expected event and it is up to the DHB to provide the necessary support and co-ordination for this to occur. A Sunday discharge, in my view, is no excuse for the events that took place leading to the patient's demise. There appears to have been no communication between the junior medical staff about [Mr A's] discharge.

6. Was it reasonable for the nursing staff to ask [Dr D] to write a prescription for [Mr A's] discharge?

Given that [Dr D] was the on call house surgeon that is perfectly reasonable. However, the problem could have been averted had the usual house surgeon or [Dr C] done the prescription when the decision to discharge him was made the day before. In her statement [Dr C] says that had she known that [Mr A] had not required sevredol then she would not have charted it as a discharge medication. This seems counter factual to her remarks about issue 4. above.

7. The adequacy of the discharge process, including:

— Was it reasonable for [Dr D] to write the discharge prescriptions for [Mr A] given that she had never been involved in his care and had not reviewed [Mr A] herself?

[Dr D] was in a sense just 'following orders' — ideally she might have questioned the need for such medication in an elderly patient whose recent pain relief experience would seem to have been favourable without recourse to narcotic analgesia. The delegation of such tasks to on-call staff is by no means unusual but having said that it is incumbent on prescribers to attend to the particular circumstances of the patient who is being discharged. There is also an annotation to the effect that the clinical area was uncharacteristically busy for a Sunday and that there were pressing demands on her time. I am unconvinced that this factor can ameliorate the situation and it is another issue that the DHB may need to address. A review of the deployment of on call RMOs may need review in the light of this event.

— The appropriateness of [Dr D] prescribing Sevredol for discharge.

There are few house surgeons who would question their registrar's decision about pain relief management. However, it seems that as [Mr A] had not required sevredol despite it being charted then the decision to include it in his discharge medication could reasonably be questioned.

— The failure to complete a discharge summary.

Not only was this not completed but the admission to discharge paper work was not attended to either. There seems little point in having such documentation as part of the standing orders of a DHB if they are not going to be attended to. An audit of CCDHB's policies and procedures is long overdue. I have already expressed misgivings about CCDHB's processes generally. This seems another example of having a suite of policies and procedures in place that are not always adhered to.

8. The adequacy of [Dr E's] involvement in [Mr A's] care, including:

— Should [Dr E] have reviewed [Mr A] himself?

[Dr E] would not normally expect to be contacted about a routine discharge. The failure to notify him of the discharge circumstance means that he would have been ignorant of the looming problem of narcotic pain relief in an elderly man. Having performed a successful angioplasty he would assume that all was well unless he heard to the contrary which he patently did not.

— Was it reasonable for [Dr E] to rely on information provided by [Dr C]?

The problem here is that there was no information imparted to [Dr E] so the question of his reliance on that is superfluous. [Dr D] did not speak to [Dr C]. [Dr C] did not speak to [Dr E]. That is the nub of the issue.

9. The adequacy of the policies and procedures in place at CCDHB in relation to:

— Prescribing.

— Patient discharge. I have alluded to the fact that while there are perfectly acceptable policies and procedures in place they are ineffective if staff do not use them properly or as in this case not at all.

Any other comment you wish to make.

Overall the management of this case represents a severe departure from standard practice at least for the reason that a patient died as a result of what happened at CCDHB. Much of the blame should be attributed to imperfect deployment of junior medical staff, the absence of compliance of standing orders within the DHB and particularly, less than satisfactory discharge planning.

[Dr C's] prescription of sevredol is regarded as a moderate departure from standard care. I believe prescribing such medication for future rather than present need and in a patient with reduced cognition is less than ideal.

Poor communication between the levels of resident medical officers (house surgeons and registrars) has been poor. That is partly due to the beliefs and attitudes of the staff concerned and partly because of an imperfect matching between workload and deployment of staff. So the DHB has to share some of the responsibility for blame here but the failure to escalate the concern by the relevant

medical staff is also noteworthy. Collectively this element of the case is a moderate departure from a reasonable standard of care.

I do note the apologies of relevant staff to the family but that is only part of the response that should be made to this unfortunate event. I make a number of recommendations for your consideration.

1. CCDHB should audit the relevant policies and procedures that were found not to be adhered to in this case. In the body of the report I allude to the folly of having such instruments in place if they are not to be followed.

2. If it is the case that medical staff of any level finds difficulty in complying with these processes then the problem either resides with a workforce of insufficient numbers and/or experience to cope with the work load. Or the policies themselves are unworkable for a range of reasons. Complexity, relevance and length spring to mind as potential barriers to compliance.

3. Weekend discharges should be possible in a DHB of this size. If they are not (as this case would seem to indicate) then it may partly be the fault of an imperfect deployment of junior or other medical staff.

4. I do appreciate and acknowledge that the involved junior medical staff must have been very discomforted by these events. My worry is that a repetition can have nothing other than more adverse effect on such staff and therefore a 'systems evaluation' should take place using this case as an example of what went wrong, why and how it can be prevented.

5. I am well aware that CCDHB has both the intellectual and workforce resources to enable this to occur."