Crown Health Enterprise

Report on Opinion - Case 97HDC5492

Complaint

The Commissioner received a complaint with respect to the care the complainant's late husband, (the consumer), received in a Hospital over ten days in July 1996. The complaint is as follows:

- *In mid-July 1996, the consumer fell from his bed in a Ward at the Hospital, while unsupervised and in a confused state, and as a result of the fall his essential life support systems became disconnected from his body.*
- *The consumer died three days later as a result of the fall and consequent loss of essential life support.*

Investigation

The Commissioner received details of the ACC claim on behalf of the consumer's wife from the ACC Medical Misadventure Unit on 13 March 1997 and an investigation was undertaken. Information was obtained from:

The Consumer's wife
The Charge Nurse, in the Ward at the Hospital
The Chief Executive Officer, the Crown Health Enterprise

The Commissioner reviewed the ACC Medical Misadventure Unit file.

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Outcome of Investigation

In early July 1996 the consumer was admitted to a Hospital with severe vomiting and diarrhoea. On admission at that Hospital it was noted that he had surgical emphysema (air in the tissues) and mediastinal emphysema (air in the space in the chest between the lungs). This finding was suggestive of a ruptured oesophagus and following confirmation of this by a barium swallow test the consumer was transferred to another Hospital (which is the subject of this opinion), where he underwent emergency surgery for a ruptured oesophagus. The Surgeon who performed the surgery was identified.

The Surgeon prepared a medical report dated mid-August 1996. In the report he stated that the consumer's oesophagus was torn in three places and that during surgery he attempted to repair the tear despite it normally being necessary to wait *"for nature to heal [such a tear] of its own accord"*. Following surgery the consumer experienced drainage of fluid from the right side of his chest. The Surgeon determined that a definitive drainage procedure needed to be performed and in addition that the consumer's long term nutrition requirements would necessitate the insertion of a jejunostomy tube.

Six days later the consumer underwent elective surgery during which the Surgeon replaced a right side intercostal tube and inserted a feeding jejunostomy tube. The Surgeon stated that prior to the elective surgery he had spoken to the consumer's family and explained to his son that the consumer had a *"very serious condition and that there was a distinct possibility he may not survive his stay in hospital because of this"*.

The next day, after an overnight stay in the Cardiothoracic Unit for observation, the consumer was transferred to another Ward. The Surgeon noted that while the consumer's clinical condition was relatively unchanged since the day of his admission, he had developed atrial fibrillation (abnormal action of the heart muscle). He had been seen by the Cardiology Registrar two days after his admission, and had been started on Amiodarone. In addition he had experienced other problems, in particular with pain management.

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Outcome of Investigation, ***continued***

Two days after the elective surgery, the consumer had an epidural catheter inserted and was prescribed Pethidine PCA to relieve the pain. He had also experienced some hallucinations and confusion which the Surgeon noted were probably related to his narcotic pain relief. The consumer was having trouble sleeping and consequently by that time was suffering from progressive sleep deprivation which added to his confusion. He was given Haloperidol 5mg to help him sleep during the night.

On the consumer's return to the Ward on that night, cot sides were placed on his bed to prevent him from getting out. Nursing staff believed this was necessary due to his confused state. A hospital aide was assigned to stay with the consumer during the night to help reduce his tension and so that there would be someone close by if he suddenly became very restless. The Commissioner was advised that restlessness is a feature of progressive sleep deprivation. The report written following the internal review carried out by the Hospital noted that the consumer had a wakeful night.

The next morning a Nurse recorded that the consumer was *"slightly paranoid"*. The consumer continued to hallucinate but also had periods of clarity. The Hospital's internal review confirmed the Surgeon's report that apart from sleep deprivation, it was recognised that the Morphine and Pethidine PCA, given for pain relief, were possibly also contributing to the consumer's hallucinations and confusion. The internal review noted that the consumer was the only patient allocated to one of the nurses for the afternoon shift on that day. This was because the complexity of his care and the knowledge that he was to have an epidural cathether inserted for pain relief meant that he would occupy one nurse for most of the time. However, the internal report reported that this nurse was able to and did leave the consumer from time to time. The nurse recorded that some time after the insertion of the epidural catheter she found the consumer sitting on the edge of the bed saying he wanted to move his bowels. She recorded that following this he settled well and comfortably into bed again.

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Outcome of Investigation, *continued*

The consumer's wife visited him on that day. In a letter to the ACC Medical Misadventure Unit dated 18 October 1996, the consumer's wife stated that:

"I arrived in the early evening to find [my husband] very stressed out. He had had no sleep since he came up from the Cardiothoracic Unit the day before. Although he knew who I was, he was not himself, he was much worse than the previous night, he was hallucinating the whole time, asking that the window curtains be drawn as people were looking in (we were on the 10th floor). He told me that some men in black had come in and attacked the doctors and one of the doctors had run away and now our eldest son was out in the hall fighting them and I needed to call 111 and get the police, this concerned him greatly and several times he asked me to go and phone. I tried to get him to settle down and go to sleep and although he shut his eyes they would only stay shut for a few minutes, his whole body was very tense and he was very anxious about all the things that seemed to be happening around him.

I was very concerned for him and I felt that he needed to rest and perhaps if I left he would find it easier to relax. I didn't just want to leave because of the condition he was in and so went to tell one of the nurses so that they would know there was no-one with him. It took me a few minutes to track down a nurse, there were none on the ward, they were all in the nurses' lounge. I told the nurse who had been looking after him that I was leaving and also told her that [my husband] was hallucinating badly, much worse than the previous evening."

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Outcome of Investigation, ***continued***

The consumer's wife further discussed her visit of that evening in a letter to the ACC Medical Misadventure Unit dated 19 January 1997 as follows:

"I can't understand how the staff came to the conclusion that he did not need someone physically monitoring him. He was very upset at the hallucinations and had already been found sitting on the end of the bed earlier on and while I was there he made two attempts to get out of bed, the first time when I asked he said he was "going to close the door" and the second time was to "get the police". Because I was there I was able to reassure him that the door was closed (in fact, there was no door to close) and that it was okay we didn't need the police. When I left I made sure I notified the staff that I was going as no one had been in the room while I was there and I wanted to make sure that they knew he was not being watched."

There were three nurses in the Ward for the night shift on that night. Two of these were staff nurses permanently employed by the Crown Health Enterprise and one was from a nursing agency. The agency nurse was called in because the Ward was particularly busy. The Charge Nurse in the Ward described the staff nurses as experienced practitioners working permanently on the Ward and the agency nurse as *"inexperienced"*.

The internal report stated that the nurse assigned to the consumer informed the two staff night nurses that the consumer's mental and physical state was serious but stable and that a "special" for the night was therefore not necessary. Accordingly, the night nurses decided to observe the consumer every 15-30 minutes. The nurses on afternoon shift handed over to the night nurses in the ward office. The report noted that at least one person was in the ward while the handover was being carried out.

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Outcome of Investigation, ***continued***

In addition to the checks to be made every 15-30 minutes by the nurses, the consumer's condition was monitored by a device known as a Spacelab console which has a central console in the ward office. The Spacelab console also has an audible alarm that is activated when preset individualised parameters are exceeded. An Incident Report stated that the nurses assumed that if a patient was detached from the Spacelab console without suspension of its functions (as happens for example when a patient gets out of bed to have a shower), the alarm would sound. The internal report noted that the alarm pitch is sufficient to penetrate all parts of the ward. However, no alarm was heard when the consumer became disconnected from the console.

The internal report noted that the condition of patients in the Ward is considered to be stable and that the consumer's room is a *"step down unit"* where continuous monitoring of the information on the central console is not necessary. The value of the Spacelab console relies therefore on the audible alarm.

The internal report stated that *"...the current combination of valuable, immediately available data with frequent visual checks of the patient by a competent nurse is more likely to result in effective treatment and care. Any change in balance of these variables will increase risk. The most sophisticated technology can never replace skilled observation by an experienced nurse but it is a useful support for the provision of appropriate treatment"*.

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Outcome of Investigation, ***continued***

The internal report stated that at 11.30pm on the night the consumer fell, prior to leaving the ward, his nurse checked him and found that he was lying quietly in bed. She reported her observations to the night staff. Between 11.45pm and 11.50pm, another nurse checked the consumer and found him lying on the floor. The central venous line, the jejunostomy tube and two leftsided intercostal tubes had been disconnected. Further, the plug inserted into the Spacelab console had been pulled out. The alarm had not gone off when he became disconnected from the monitor. The Surgeon stated that the consumer had presumably sustained a cardiac arrest. The nurse noted in the Incident Report that the consumer was breathing when she found him but that as she examined his head his breathing ceased. Following CPR, the consumer was transferred to the Intensive Care Unit where he was noted to have generalised fitting indicating that he had sustained a severe anoxic brain assault. Following discussion with the consumer's wife and other family members it was decided that no further attempt at resuscitation would be made. He was transferred back to the ward three days later and died that evening. The Surgeon stated that death was as a result of brain damage secondary to cardiopulmonary arrest.

One of the nurses stated that shortly before checking on the consumer, she had noted that the Spacelab central console showed one display which was normal. The consumer was the only patient in the ward being monitored at the time. The internal report suggests that the possible time lapse between the observation of the console and the check on the consumer was a maximum of two minutes. This is because the nurse had organised pain relief for another patient and had timed the order at 11.35pm and then administered the drugs at 11.40pm. Shortly afterwards that nurse noticed the console. She estimates that she found the consumer between 11.45pm and 11.50pm.

Following the incident, a representative from the company distributing the Spacelab monitors checked the equipment and found that an alarm in the monitor had not been set and that this omission must have happened when the monitor was first set up. The Charge Nurse in the Ward stated in August 1996 that as a result of these findings the alarms had subsequently been set.

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Outcome of Investigation, *continued*

The internal report made the following recommendations:

1. That all staff be provided with regular refresher training in the use of the Spacelab console either by a skilled clinician or the agent's Service Manager.

2. That a programme of planned preventive maintenance be organised by the Hospital with either the Biomedical Engineering Department and/or the Distributors.

3. That the alarm parameter settings be verified at the beginning of each shift, as recommended in the Spacelab Operations Manual.

4. That the process of the nursing handover be reviewed urgently and more effective ways of managing this implemented.

5. That monitoring philosophy and practices in the Ward are compared with a ward with a similar mix of patients and acuity to ensure that speciality norms are maintained.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

...

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

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Report on Opinion - Case 97HDC5492, continued

Opinion: Breach

Rights 4(1), 4(3) and 4(4)

In my opinion the Crown Health Enterprise breached Rights 4(1), 4(3) and 4(4) of the Code of Health and Disability Services Consumers' Rights.

The report written at the conclusion of the internal investigation states that on the evidence available to the nurses in the Ward on the night of the consumer's fall, there was nothing to trigger a concern that the consumer would attempt to climb out of bed or require closer supervision than the usual 15-30 minute checks provided to patients in his room. This is at variance with the consumer's wife's account that her husband attempted to get out of bed twice during her visit and that these attempts were related to the hallucinations he was experiencing and that she told nursing staff about this.

The consumer was assigned a hospital aide to sit with him on the night before his fall because of his condition, yet his condition was similar if not worse the next evening, when he fell.

While I accept that the decision to transfer the consumer from the Intensive Care Unit to the Ward was reasonable in the circumstances, once transferred, close monitoring of the consumer was imperative. The internal report states that in the Ward, *"the emphasis is on visual observation of the patient and the data on the bedside console rather than cultivating a false sense of security and dependence on the data in isolation, or an assumption that if there is no alarm all is well"*. This may be the case. However, it appears that in this instance some reliance was placed on the alarm as a monitoring tool.

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Opinion: Breach, ***continued***

In the circumstances, the failure of the Crown Health Enterprise to check the monitors when they were originally installed in November 1995 and the subsequent failure of nursing staff to provide regular checks on the monitors were inconsistent with the consumer's right to have services provided with reasonable care and skill. Further, services were not provided in a manner which was consistent with the consumer's needs and which minimised the potential harm to him. If the alarm had been checked at the beginning of the shift, the nursing staff would have been alerted much earlier to the consumer's predicament.

While it is uncertain how long the consumer was lying on the floor before he was discovered, or when resuscitation services were made available to him, it is clear that there was at least some minutes' delay. In my opinion this was unacceptable and inconsistent with his right to have services provided with reasonable care and skill. Certainly had the monitoring alarm been checked at the beginning of each shift and had closer supervision been provided to the consumer, this delay could have been avoided.

Actions

The Crown Health Enterprise has advised that as a result of this incident the following steps have been taken:

a) *A complete check of the Spacelab console monitors in use at the Hospital has been carried out and rectified by technical staff;*
b) *The technical staff have undergone extensive training in the use and servicing of the Spacelab console monitors and regular checks are now made;*
c) *It is now nursing policy to check the alarms at the beginning of each shift;*
d) *The supplier of the Spacelab console monitors gives updated training to the clinical staff on a regular basis.*

Other Actions

This opinion will be forwarded to the Health Funding Authority and the Ministry of Health. A copy will be sent to all Health and Hospital Services to reinforce the need to ensure equipment is functioning correctly and that staff are appropriately trained in its use.