Inadequate healthcare provided to patient in prison
16HDC01703, 29 March 2019

Prison healthcare ~ Medical officer ~ Registered nurse ~ Reflux ~ Nausea ~ Symptom history ~ Assessment ~ Examination ~ Right 4(1)

A woman was received into a correctional facility. She reported to staff at the Health Centre that she had been diagnosed with irritable bowel syndrome (IBS).

A few months later, the woman submitted a health chit. She wrote that she had a burning throat and a sore right ear, that she was unable to hold down food, and that she was very light-headed and feeling weak. She consulted with a nurse a few days later and reported having too much gas in her stomach. She also told the nurse that sometimes she woke up with acid in her mouth. This information was relayed to a medical officer, who charted Losec in response. A short time later, the medical officer prescribed Mylanta for the woman for break-through heartburn, and increased her dose of Losec. As with the previous occasion, this was done without reviewing the woman.

The woman submitted another health chit. She wrote that she was still experiencing reflux and constantly felt bloated. She was seen by the medical officer a week later, and was charted ranitidine, which decreases stomach acid production.

The woman made a further request for review and was seen by a nurse. It is documented that the ranitidine was working, and that the woman's reflux was reducing.

Further health chits refer to ongoing reflux symptoms. The woman attended the nursing clinic as a walk-in. She reported that she felt particularly nauseous at night, and felt like vomiting when lying down. The woman was commenced on metoclopramide.

The woman presented again as a walk-in. She stated that she was feeling weak from reflux and vomiting. Her vital signs were normal, and she was asked to return in the afternoon for review. She returned for review later than anticipated, during the dinner medication round. She complained of feeling unwell, and of vomiting and being unable to tolerate food. However, she had normal vital signs, and when the nurse followed up with the woman in the evening, the woman reported that she had not vomited since the afternoon.

The next day, the woman was seen by a locum medical officer, who queried a diagnosis of labyrinthitis and charted prochlorperazine to treat her nausea.

The following evening, the woman informed a registered nurse that she was vomiting frequently, and that the vomitus contained black matter. The nurse scheduled the woman for a review in the nursing clinic the following day. When the woman attended the clinic, she was in a wheelchair and described her pain as "10/10". Her oxygen saturation level was 87%, and her temperature was 35.6°C. She was transferred to the public hospital's Emergency Department for immediate assessment. Further investigations revealed an advanced gastric cancer causing near complete or complete obstruction of the outlet to her stomach. Sadly, the woman died.

Findings

Adverse comment is made about the medical officer's management of the woman on two occasions.

It was found that the locum medical officer did not take adequate account of the woman's symptom history, and did not perform an appropriate clinical examination. Accordingly, the medical officer failed to provide services to the woman with reasonable care and skill, and breached Right 4(1).

The registered nurse's response to the woman's report of black vomitus was seriously deficient, and lacked the required urgency. Accordingly, the nurse failed to provide services to the woman with reasonable care and skill, and breached Right 4(1).

There were a number of deficiencies in the care provided to the woman, including a lack of appropriate assessment and physical examination, inconsistent documentation, and poor coordination of care. This was considered to be indicative of an environment that did not support its staff adequately to do what was required of them. Staff individually and as a team failed to act on the woman's continued discomfort and escalating symptoms. The correctional facility failed in its responsibility to ensure that the woman received services of an appropriate standard and, accordingly, breached Right 4(1).

Recommendations

In accordance with a recommendation made in the provisional opinion, the medical officer provided the woman's family with a written apology for his breach of the Code.

It was recommended that the registered nurse provide the woman's family with a written apology.

In response to the recommendations made in the provisional opinion, the correctional facility provided evidence of staff training, and undertook to contract an independent nursing educator to provide nursing staff with education on commonly presenting health conditions. Additionally, it commissioned an independent review to provide assurance around health services.

It was recommended that the correctional facility provide a written apology to the woman's family, and conduct an audit of staff compliance with the "SOAPIE" (subjective, objective, assessment, plan implementation, evaluation) documentation format.

The correctional facility was referred to the Director of Proceedings, who decided not to issue proceedings.