General Practitioner, Dr H

A Retirement Village

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC00555)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive Summary

Background

1. Mrs D moved to a serviced apartment at a retirement village (the Village) in January 2010 when she was 86 years old. The Village is a residential village comprised of serviced apartments and independent units for independent retirees, and is owned and operated by a company. The Village does not offer rest home or hospital care facilities. At the time of events, general practitioner Dr H held weekly clinics at the Village, and the Village employed two nurses who held daily nurse clinics providing basic services for residents.

2. Mrs D consulted Dr H on 3 June 2010 for a routine check-up. Dr H ordered blood tests, which showed that Mrs D was at high risk of diabetes or glucose intolerance. The pathology report recommended further tests, in particular a fasting glucose test. On 25 June 2010, Dr H ordered a repeat glucose test, which showed a glucose level above normal. The pathology report again recommended further follow-up testing. Dr H did not follow up this result with further testing, and did not inform Mrs D of the result of her tests.

3. Mrs D consulted Dr H in October and November 2010 with pain and swelling in her legs and ankles. She consulted Dr H again in February 2011, and blood tests performed indicated an elevated GGT level[1] on the liver function tests, elevated cholesterol, and an abnormal lipid profile. Mrs D was not informed of the results of these tests.

4. Mrs D's next consultation with Dr H was in December 2011, when she presented to him with fluid retention in her lower legs and shortness of breath. Dr H noted that Mrs D did not have cellulitis, and he prescribed frusemide (a diuretic).

5. In January 2012, Dr H ordered a further blood test for Mrs D, which revealed a high non-fasting glucose level. The pathologist's report recommended further testing to confirm a diagnosis of diabetes mellitus. Mrs D was not informed of the result, and Dr H did not arrange further tests. A further blood test organised on 13 February 2012 showed a high non-fasting glucose level and confirmed a diagnosis of diabetes mellitus.

6. Mrs D underwent a needs assessment on 15 February 2012, following which she was admitted to hospital, where she was diagnosed with diabetes.

Decision summary

7. Dr H's repeated failure to manage Mrs D's elevated glucose levels appropriately, and to ensure that the abnormal tests were appropriately followed up was extremely poor

[1] Gamma-glutamyl transferase (GGT). The GGT test is sometimes used to help detect liver disease and bile duct obstructions. It is usually ordered in conjunction with, or as follow-up to, other liver tests such as ALT, AST, ALP, and bilirubin. Increased GGT levels may indicate in general that the liver is being damaged, but does not specifically point to a condition that may be causing the injury. While elevated GGT levels may be caused by liver disease, they may also be caused by alcohol consumption and/or other conditions, such as congestive heart failure.

care, and a breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

8. Dr H's failure to inform Mrs D of the results of her tests was a breach of Right 6(1)(f)[3] of the Code. Dr H's record-keeping also fell below the expected standard, and was a breach of Right 4(2)[4] of the Code.

9. Dr H was referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

10. The care provided to Mrs D by the Village was consistent with expected standards and, accordingly, the Village did not breach the Code.

Complaint and investigation

11. The Commissioner received a complaint from Mr E about the services provided to his mother, Mrs D, by general practitioner Dr H and by the Village. The following issues were identified for investigation:

- *Whether the Village provided Mrs D with an appropriate standard of care between January 2010 and March 2012.*
- *Whether Dr H provided Mrs D with an appropriate standard of care between January 2010 and March 2012.*

12. An investigation was commenced on 29 April 2013. The parties involved in the investigation were:

Mrs D	Consumer
Mr E	Complainant/Consumer's son
Mrs F	Consumer's daughter
Mrs G	Consumer's daughter
The Village	Retirement village/Owner of the Village/Provider
Dr H	General practitioner/Provider
The practice	General practice
Ms I	Community geriatric nurse
The hospital	Public hospital

[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 6(1)(f) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including … the results of tests."
[4] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

13. Independent expert advice was obtained from the Commissioner's in-house clinical advisor, general practitioner Dr David Maplesden. The advice is **attached** as Appendix A.

Information gathered during investigation

Background

The Village[5]

14. The Village is a residential retirement village housing approximately 240 residents in a mixture of independent residential units and serviced apartments. Residents in the serviced apartments are provided with support services additional to that provided to residents in the independent residential units. All residents of the Village must be able to live independently, because the Village does not provide rest-home level care.

15. Emergency on-call nursing care is provided at the Village. In 2010 there were two nurses available for 240 residents. The nurses held a daily clinic for residents, providing basic services such as dressing changes, injections, and blood pressure checks. The Village's marketing material, supplied to prospective residents, includes the statement:

> "The on-site nurse provides emergency medical care as well as regular nurse clinics, and doctors hold regular surgeries in the village. On-going care, in the form of additional support or nursing services, is available to residents on a user-pays basis."

16. Prospective residents attend a "meet and greet" discussion with the Nurse Manager and Village Manager, where it is made clear that residents must be able to live independently, and that ongoing nursing care is not provided by the Village. Prospective residents are also informed that, where a resident's health declines below a certain level, the resident is required to move to a facility better suited to his or her needs.

17. Mrs D visited the Village with her family in November 2009 as a prospective resident. The Village explained to HDC that, following her application to reside at the Village, Mrs D and her daughters attended the "meet and greet" discussion and, as such, would have understood the limitations of the nursing care at the Village.

Mrs D

18. In January 2010 Mrs D moved in to a serviced apartment at the Village. At this time Mrs D was 86 years old, and had a history of vitamin D deficiency and breast cancer (which had been treated in 2002 by local excision). She was in the early stages of dementia. Mrs D has three adult children, two of whom lived nearby.

[5] The Village is owned and operated by a company, which in turn is owned by another company. For simplicity, the owner is collectively referred to as "the Village" in this report.

Dr H

19. Dr H is a vocationally registered general practitioner (GP) and a fellow of the Royal New Zealand College of General Practitioners. Dr H operates out of his private general practice, (the practice).

20. In 2006 Dr H purchased the practice and took over the practice's existing obligations with the Village. Dr H told HDC that there was no contractual relationship between himself and the Village, and the Village described the relationship as "an informal arrangement through the goodness of Dr H making himself available for our residents". The arrangement involved Dr H holding a weekly clinic at the Village, which usually took place on a Thursday morning. If a resident required medical attention at a time outside the weekly clinic, he or she could make an appointment at the practice, so long as the Village organised transport and sent the resident's files with the resident. Generally, the Village residents enrolled with the practice before they were seen by Dr H.

21. However, Dr H provided HDC with a document titled "Protocol for the Village Patients under [Dr H]" (the agreement). The agreement states that all patients are to be seen at least once every three months, and are to have blood and urine tests once every three months. Diabetic patients are to be closely monitored, with three-monthly blood tests and weekly glucose monitoring. Dr H told HDC that he also had a policy that repeat prescriptions were to be given only once within a six-month period — any further repeats required a medical review and medication review. Dr H also told HDC that he had an understanding with the Village that all residents enrolled with his practice had to be reviewed by him at least once every six months.

22. Residents could make appointments to see Dr H at the weekly clinic through the Village receptionist or through Village nurses. If Dr H needed to cancel the weekly clinic, Village nurses would notify the residents affected, assess the urgency of their issues, and make arrangements accordingly. However, the nurses were not usually directly involved in the care provided to residents by Dr H.

23. Dr H told HDC that clinical notes taken at the weekly clinic were kept in hard copy on site at the Village. Dr H explained that he did not take any of these notes back to the practice, and he did not transfer them to the practice's electronic records. However, clinical notes taken when Dr H saw a resident at the practice were recorded in electronic form and kept on the practice's computer system. This meant that, when Mrs D consulted Dr H, some of her clinical notes were handwritten and kept at the Village, and some were in electronic form and kept at the practice. The Village informed HDC that in the event that the nurses became aware that a resident had booked an appointment with Dr H at the practice, they would ensure that the resident took his or her handwritten file to the practice.

24. The results of laboratory tests ordered by Dr H were received and processed at the practice, and were not automatically copied to the Village. Dr H explained that, if a result was abnormal, he would ask his practice nurse to advise the patient and to organise appropriate follow-up. If the Village nurses were aware that a blood test had been ordered for a resident, they would ring the practice for the results and add them to the resident's weekly clinic medical file. The Village noted that test results were

not automatically sent to them, and the nurses were often not involved directly in the care Dr H provided, and were therefore unaware of when blood tests had been ordered.

Dr H's care of Mrs D

Early 2010

25. On 8 March 2010 Mrs D enrolled with Dr H's practice. Her first consultation with Dr H was on 11 March 2010, at the weekly clinic. Dr H recorded in the handwritten clinical notes that Mrs D had a history of breast cancer and vitamin D deficiency. He also recorded that Mrs D had elevated lipids, increased blood sugar, hypertension, and cardiomegaly,[6] and was in the early stages of "senile dementia". Dr H undertook a physical examination and recorded that Mrs D's blood pressure was normal, that her lungs were clear, and that she reported feeling well and had no concerns.

26. On 7 April 2010 Mrs D had a fall, which was recorded in the Village nursing notes.[7] This was the first fall recorded in Mrs D's nursing notes.

June 2010 — first blood tests

27. On 3 June 2010, Dr H saw Mrs D again at the weekly clinic for a routine check-up. During that consultation Dr H performed a physical examination and recorded in the handwritten clinical notes that Mrs D's blood pressure was normal, her resting pulse was 78bpm, and that she had a clear chest on examination. The clinical notes also record that Mrs D was reportedly well and had no concerns. Although it is not recorded in the notes, it appears that Dr H ordered blood tests at this consultation, as results were sent to his practice on 4 June 2010.

28. The blood test results showed that Mrs D's non-fasting glucose test measured 10.5mmol/L.[8] The pathology report stated that there was "a high risk of diabetes or glucose intolerance" and recommended further tests. The report specifically recommended undertaking a fasting glucose test.

29. On 25 June 2010, Dr H arranged for follow-up glucose tests, but for reasons not stated, Dr H did not arrange for a fasting glucose test to be performed. The results of the 25 June glucose tests showed a non-fasting glucose level of 7.9mmol/L. Though lower than the previous test, this glucose level was still above normal. The pathology report again stated that further follow-up testing was recommended.

30. Dr H told HDC that, after he received the second elevated glucose test result, he asked his practice nurse to arrange a follow-up appointment with Mrs D. There is no record

[6] Enlarged heart.

[7] The Village's nursing notes recorded the interactions between the resident and the Village nurses.

[8] A fasting glucose test measures blood glucose after the patient has not eaten for at least 8 hours, and was the preferred screening test for diabetes at the time of the events in question. A non-fasting glucose test is a random glucose test that measures blood glucose regardless of when food has been consumed. A non-fasting result of > 11.1mmol/L is diagnostic for a person with symptoms of diabetes (2 results of > 11.1 are required for an asymptomatic person). Non-fasting glucose results between 5.5 and 11.1 mmol/L are more difficult to interpret, although the threshold for performing a fasting blood glucose (or oral glucose tolerance test (OGTT)) would get lower as the fasting glucose result gets closer to 11.1 mmol/L (BPAC guidelines, "Detecting Diabetes: Tools for better care", 2008).

of this request in either the handwritten or electronic notes of Dr H's appointments with Mrs D, and no follow-up appointment was arranged. Dr H explained that, had the appointment been arranged, he would have ordered a fasting glucose test. If this test had revealed a high result, Dr H said he would have followed up with a glucose tolerance test (a diagnostic test for diabetes).

Late 2010 — leg swelling and other deterioration

31. On 5 August 2010 the Village nursing notes record that Mrs D had a fall from her bed, and was found on the floor by a nurse. The Village nursing diary records that Mrs D was seen by a Village nurse on at least nine other occasions during August 2010. Mrs D appeared to be confused and forgetful and reported feeling dizzy. Because of her dizzy spells, Mrs D was having difficulty showering. The nursing records indicate that, during August, Village nurses helped Mrs D's daughter to organise showering assistance for Mrs D.

32. On 26 August 2010 a Village nurse arranged for Dr H to issue a repeat prescription for Mrs D's various medications. Dr H did not see Mrs D before issuing this repeat prescription, and there is no indication that Dr H reviewed Mrs D's notes and blood test results at that time. Dr H did not tell the Village nurse who requested the repeat prescription about Mrs D's elevated glucose results, and did not arrange a follow-up consultation with Mrs D.

33. The Village nursing notes from October 2010 show that Mrs D was having difficulty with swelling in her leg, and with continence, and that a nurse had had a discussion with Mrs D's daughter, Mrs F, regarding these issues.

34. On Tuesday 12 October 2010 Dr H saw Mrs D. This consultation is recorded in the handwritten notes, which would usually indicate that the appointment took place at a weekly clinic at the Village. However, the Village told HDC that this consultation did not occur at the weekly clinic, but at the practice. The Village explained that the notes for this consultation are recorded in the handwritten notes because the Village nurses sent the notes with Mrs D to the appointment at the practice.

35. Dr H recorded in the handwritten notes for this consultation that Mrs D had experienced a "couple of falls and occasional dizziness". On examination, Mrs D did not have chest pain, shortness of breath or palpitations. Her blood pressure was 150/80mmHg when sitting and 130/80mmHg standing.[9] Dr H also listened to Mrs D's heart, which he recorded as sounding normal with no carotid bruits.[10] Dr H recorded in the clinical notes that his plan was for Mrs D to increase her fluid intake, and that he would review her as necessary. There is no indication in the clinical notes that Dr H discussed the June blood test results with Mrs D, or that he took any action to follow up those results with further blood tests at the time of this consultation.

36. On Friday 29 October 2010 Mrs D saw Dr H again, this time with symptoms of pain and swelling in her right leg and ankle. This consultation is recorded in the

[9] The sitting measurement indicates high blood pressure; the standing measurement indicates high–normal blood pressure.
[10] A carotid bruit is a murmur heard in the carotid artery area.

handwritten notes; however, the Village told HDC that this consultation also did not occur at the weekly clinic, but at the practice.

37. The clinical notes for this consultation record that Mrs D had some shortness of breath but that this resolved when lying flat. Dr H measured Mrs D's calf circumference as 31cm and noted no calf tenderness. He recorded his impression that Mrs D was suffering from fluid retention in her feet and lower limbs. He noted that deep vein thrombosis was unlikely and that he planned to review Mrs D in one week.

38. Two weeks later, on Friday 12 November 2010, Dr H reviewed Mrs D again. He recorded in the handwritten notes that the consultation was a routine three-monthly check-up, and noted that Mrs D was well but had swelling in her left foot. Mrs D was still experiencing shortness of breath and had high blood pressure when sitting.[11] Dr H wrote that the plan was to "continue same". It is unclear where this consultation took place.

39. Dr H did not inform Mrs D of the elevated glucose results from the 3 June and 25 June tests.

2011 — further appointments with Dr H

40. On 23 February 2011 Dr H saw Mrs D at the weekly clinic. Dr H recorded in the handwritten clinical notes that Mrs D's pulse was 82bpm and her blood pressure was 140/80mmHg. Dr H also noted that Mrs D had shortness of breath and was feeling tired. Although it is not recorded in the notes, it appears that Dr H ordered blood tests at this consultation, as results were sent to his practice two days later, on 25 February. The blood tests were for liver function, renal function, lipids, and serum B_{12} and folate. Dr H did not order glucose tests. The 23 February blood test results indicated an elevated GGT level on the liver function tests, elevated cholesterol levels, and an abnormal lipid profile. These results were not communicated to Mrs D.

41. Mrs D did not see Dr H again until 16 December 2011, when she saw him at the practice. The electronic notes for this consultation record that Mrs D presented with fluid retention in her lower legs, and shortness of breath. Mrs D's blood pressure was 130/80mmHg. Dr H noted the absence of infection such as cellulitis. Dr H prescribed an increase in Mrs D's dose of frusemide (a diuretic), and noted his plan to review her again in one week. Dr H informed HDC that he did not consider testing for diabetes at this consultation. Dr H did not review the previous blood test results and did not discuss those results with Mrs D at this consultation.

42. On 23 December 2011 Mrs D saw Dr H at the practice. Dr H noted in the electronic notes that the fluid retention in Mrs D's lower legs and feet was less but still present. On examination, Mrs D had no shortness of breath, and her chest was clear.

16 January 2012 — further blood tests

43. On Monday 16 January 2012, Mrs D and her daughter, Mrs G, attended a consultation with Dr H at his practice, regarding the swelling in Mrs D's legs. Mrs D was also having difficulty managing her personal cares, and had worsening incontinence. The

[11] Recorded at 140/80mmHg at this consultation.

clinical notes record that Dr H ordered blood tests for Mrs D, and the results were sent to the practice that same day. The blood tests revealed a non-fasting glucose level of 13.5mmol/L. The pathologist's comment was:

> "Result indicates diabetes mellitus if there are supporting symptoms/signs. Without symptoms a further random glucose higher than 11.0 mmol/L, a true fasting glucose higher than 6.9mmol/L or HbA1c > 49 mmol/L is needed to confirm the diagnosis."

44. Dr H did not organise or carry out any follow-up of these results, and did not diagnose Mrs D with diabetes at that time. He explained that his failure to organise follow-up of the results promptly was because he had missed his weekly clinics at the Village on 19 and 26 January 2012 because of illness.

45. The Village informed HDC that, at this time, Mrs D had not displayed any of the classic symptoms of diabetes such as weight loss, polydipsia,[12] blurred vision, acetonic breath,[13] rapid deep breathing, nausea or abdominal pain. The fluid retention in Mrs D's legs (a further symptom of diabetes) had been present prior to her arrival at the Village, although it had become worse during her time there.

31 January 2012 — respite care and referral for needs assessment

46. On 31 January 2012 Dr H recorded in the electronic clinical notes that a Village nurse had telephoned him. The nurse informed him that Mrs D was having difficulty mobilising and required full-time assistance in the form of rehabilitation and rest home care. The Village nursing notes for that day record that Mrs D had been found on the floor, and that urgent geriatric assessment was needed. That afternoon, Mrs D was moved to a local rest home facility for three days of respite care.[14]

47. That day Dr H wrote a referral to the hospital for a needs assessment in order to establish whether rest-home care was appropriate for Mrs D. In the referral letter Dr H noted that Mrs D had been having difficulty managing, had a poor memory, and was falling frequently. There is no mention in the referral letter of Mrs D's elevated glucose levels.

Early February 2012 — cancelled appointments

48. On 2 February 2012 Mrs D's daughter, Mrs F, met with Dr H to discuss Mrs D's need for admission to hospital. At this stage Mrs D was still in respite care, but had only one day remaining on her stay there. Dr H telephoned the hospital and discovered that it had not received his referral of 31 January. Accordingly, Dr H re-sent the referral and arranged to visit Mrs D the following day.

49. Dr H arranged for Mrs D to remain in respite care until 7 February, as he was unable to see her as planned on 3 February owing to commitments at the practice. On 7 February 2012 Mrs D was taken back to the Village. A Village nurse asked Dr H to review Mrs D at the weekly clinic on 9 February 2012. Dr H was again unable to

[12] Abnormally increased thirst.
[13] The patient's breath smells of acetone (acetone has a distinctive "fruity" smell).
[14] This facility is a residential rest home that provides a higher level of assisted living than the Village, and includes a dementia unit and a hospital.

attend the weekly clinic that day because of commitments at his practice. At this time the nurses at the Village felt that Mrs D was managing after her stay in respite care, and therefore did not press Dr H for another appointment.

13 February 2012 — further blood tests

50. On 13 February 2012 Mrs D had a blood test (ordered by Dr H). The results, which were sent to the practice, showed a non-fasting glucose level of 17.3mmol/L. The pathologist commented that "[t]aken with the previous high glucose result, this result confirms the diagnosis of diabetes mellitus".

51. Village nurses requested a copy of the results, as they were aware they had been ordered.

15 February 2012 — geriatric assessment

52. On 15 February 2012 a community geriatric nurse, Ms I, visited Mrs D at the Village to assess her need for rest-home or hospital care.

53. In Ms I's written report, sent to Dr H on 16 February 2012, she advised that Mrs D was to be admitted to hospital for a full medical review and rehabilitation. Ms I noted that "[Mrs F] refers to her mum just being perpetually tired. She is concerned that the swelling in her mum's legs, noticeable over the last nine months, has worsened over the last six months and developing lumps with the left being the worst." Ms I further commented:

> "Today the upper aspect of her left leg appears blistered and leaking clear fluid. The skin is pink and slightly warmer than the right leg. Some skin appears possible macerated.
>
> …
>
> Her observations today were temperature 36.2°C, pulse regular at 77bpm, oxygen saturation 97% with a BP of 130/64. She denied any dizziness on standing. As she was clearly tiring I did not complete any formal memory tests. Of Concern: her BSL at 23mmol/L which I retook at 19.9mmol/L at 10.15hours. Recent bloods taken refer to a non fasting blood glucose of 13.5 at 11.23 hours on 16th February 2012, and 17.3 at 15.45 hours on 13th February 2012. There is no supporting diagnosis of diabetes. I also note her haemoglobin had fallen from 134 on 16th January 2012 to 118 on 13th February 2012. Her liver function and ferritin levels had also changed and were beyond normal. As all of these require investigating and are obviously having an impact on her welfare I discussed the value of her coming into AT & R[15] for this purpose. Her daughter [Mrs F] was thrilled at the prospect saying she had asked for something like this when her mum fell and was [put into respite care]. [Mrs D] agreed hoping she will regain some energy and be able to continue living in her unit."

[15] Assessment, treatment & rehabilitation service.

16 February 2012 — hospital admission

54. On 16 February 2012 Mrs D was admitted to hospital, where she was diagnosed with diabetes and lipodermatosclerosis.[16] She was treated for a urinary tract infection, diabetes, and hyponatraemia[17] during her stay at hospital.

5 March 2012 — discharge

55. On 5 March 2012 Mrs D was discharged from hospital. Despite rehabilitation provided during her stay at hospital, Mrs D had been assessed as requiring rest-home level care. Accordingly, she was discharged to a facility that provided services suitable for her needs. In the hospital's "Transfer of Care to GP" form, which was sent to Dr H, it was noted that Mrs D's diabetes had not been adequately managed in the community.

Diagnosing diabetes

56. In July 2008 BPAC[18] issued to New Zealand GPs a guidance publication on the diagnosis of diabetes, titled "Detecting Diabetes: Tools for better care". The following factors are identified as being diagnostic of diabetes:

- In people with symptoms typical of diabetes, a single fasting plasma glucose level of ≥7.0 mmol/L or a random glucose ≥11.1 mmol/L.
- In people without symptoms of diabetes, a fasting plasma glucose result ≥7 mmol/L on two different days and/or a random result of ≥11.1 mmol/L on two different days.
- Following a glucose tolerance test a fasting glucose ≥7 mmol/L and/or a 2 hour glucose of ≥11.1 mmol/L.

Dr H's response to the complaint

57. In his response to HDC, Dr H outlined his workload while he was working with the Village, which he stated had eventually become too much for him. Since this incident, Dr H has stopped working at the Village. He told HDC that he made this decision "because I do not wish ever to make such a mistake again; I always strive to provide a high standard of care to my patients".

58. Dr H advised HDC that, after he received the complaint, he had meetings with the Village nurses and put in place protocols and procedures to avoid any such mistakes in the future. He advised that the practice's standards and workloads were reviewed, and procedures put in place to ensure appropriate follow-up of blood test results. Dr H also advised that he has now changed his consultation style, in that before he sees a patient he goes through his or her medical record and looks at any previous blood tests or any other investigations that are in the inbox, and makes sure that appropriate action has been taken. He also looks at all incoming blood tests several times on a

[16] Chronic thickening, redness and discomfort in the lower leg tissues secondary to venous insufficiency.
[17] Lower than normal sodium concentration in the blood.
[18] An organisation that provides evidence-based educational guidance for primary healthcare professionals in New Zealand through publications.

daily basis, and any urgent action required is done straightaway, by either him or his practice nurse contacting the patient immediately. All other abnormal blood tests are forwarded to the nurse inbox with appropriate instructions as to the action to be taken. The nurse is required to document any action in the patient notes.

59. Dr H concluded that it was human error, on his part, to have failed to follow up Mrs D's blood test results. He stated, "For this I really feel very sorry and sincerely apologise to [Mrs D] and her family." Dr H also advised HDC that he:

1. reviewed the BPAC publication on current recommendations for blood testing in the diagnosis of diabetes;
2. intended to review the BPAC publication "A Primary Care Approach to Sodium and Potassium Imbalance"; and
3. intended to undertake a clinical audit on detecting Type 2 diabetes.

The Village's response to the complaint

60. The Village explained to HDC that, when a diagnosis of diabetes is made for a resident, it is usual practice for the nurses to keep a log of regular three-monthly blood sugar results. As the Village was unaware of Mrs D's raised glucose levels until mid-February 2012, and no diagnosis of diabetes had been made by Dr H, regular monitoring of Mrs D's blood sugar levels did not occur.

61. The Village did not receive copies of Mrs D's blood test results, as all blood test results were sent from the laboratory directly to Dr H. The Village advised that, since receiving the complaint, it has made changes to its system for receiving and recording blood test results and other laboratory test results. The Village now requests from the doctor a hard copy of any results, and has put in place a register that records the date on which residents have blood tests performed, and whether the results have been received.

62. The Village noted that their nursing records demonstrate that Mrs D's ability to live independently deteriorated over her time there. Mrs D had numerous falls and, on many occasions, suffered from both urinary and faecal incontinence. Village nurses provided Mrs D with care that the Village submitted was above and beyond that of their normal role. This included helping with showering, cleaning her unit, assisting when she was confused, liaising with her caregiver (who was arranged following a needs assessment in August 2010), and giving her breakfast when she felt unwell. The nurses liaised closely with Mrs F about their concerns.

63. The Village explained that the nursing staff would always assist families to transition a resident to a higher level of care in another facility or private hospital. However, the Village stated that this process can be difficult, as residents do not always agree that they need a higher level of care, or do not want to move from the Village.

Response to provisional opinion

64. In response to the provisional opinion, Dr H advised as follows:

> "I sincerely regret that I failed to manage [Mrs D's] elevated glucose levels appropriately and to ensure that the abnormal test results were appropriately followed up. I also failed to inform [Mrs D] of the results of her tests and my record keeping fell below expected standards. I have apologised sincerely to [Mrs D] and all her family."

65. Dr H went on to state that he does not believe that the oversights that occurred in relation to Mrs D could happen again, "… due to the insights that [he has] in relation to this complaint and the resultant changes [he has] made to [his] practice".

Opinion: Dr H

Follow-up of test results — Breach

66. The first blood test result indicating elevated levels of glucose was received by Dr H on 4 June 2010. My expert advisor, general practitioner Dr David Maplesden, advised that, in response to that test, it would have been appropriate for Dr H to order either a fasting glucose test or a glucose tolerance test. These tests would have enabled a diagnosis of diabetes to be confirmed or excluded. Dr H did arrange follow-up blood tests, but instead of ordering a fasting glucose test he repeated the non-fasting glucose test.

67. The second blood test result, received by Dr H on 25 June 2010, also revealed elevated glucose levels. Dr H acknowledged that at that point prompt follow-up was required, which did not occur. Dr H said that he had attempted to follow up on the second result by asking his practice nurse to arrange a follow-up consultation. However, there is no record of Dr H's request to his practice nurse to follow up the test results with Mrs D, and there is no record that any follow-up occurred.

68. As the prescribing doctor, it was Dr H's responsibility to ensure that the test was appropriately followed up, and he failed to do so. As this Office has previously stated:

> "Doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal results. The primary responsibility for following up abnormal results rests with the clinician who ordered the tests …"[19]

69. Dr H's failure to follow up the 4 June 2010 test results appropriately, and to follow up the 25 June 2010 test results at all, was sub-optimal care.

[19] See Opinion 10HDC01419, available at www.hdc.org.nz.

70. Dr H next had an opportunity to review Mrs D's blood results on 26 August 2010, when he was telephoned by a Village nurse with a request for a repeat prescription for Mrs D. While it was not unreasonable to provide Mrs D with this repeat prescription, the telephone call was a missed opportunity for Dr H to review Mrs D's patient notes and ensure appropriate follow-up arrangements were made.

71. Dr H saw Mrs D three further times in 2010. Dr H explained that these consultations were mainly related to Mrs D's swollen legs, and some shortness of breath. Dr H was treating the swelling in Mrs D's legs with frusemide, a diuretic.

72. While I accept Dr Maplesden's advice that Dr H's treatment of Mrs D's swollen legs was appropriate given the overall clinical picture, I remain concerned that Dr H took no action to arrange appropriate follow-up care during those three consultations in late 2010. I consider that at these appointments Dr H missed yet another opportunity to identify and respond to Mrs D's concerning blood test results.

73. Dr H saw Mrs D again on 23 February 2011, at his weekly clinic on site at the Village. Dr H ordered further blood tests for Mrs D, which were reported on 25 February. The blood test results indicated an elevated GGT level on the liver function tests, elevated cholesterol levels, and an abnormal lipid profile. Dr Maplesden advised that the results of the blood test indicated some cardiovascular risk; however, management of such findings in an elderly person who is asymptomatic and has no past history of cardiovascular disease is debatable. A further blood test for liver function should have been undertaken within the next 6–12 months.

74. Dr H did not see Mrs D again for a further nine and a half months. Mrs D presented at Dr H's clinic on 16 December 2011 with fluid retention in her lower legs and shortness of breath. Dr H conducted appropriate physical examinations and followed up Mrs D one week later on 23 December 2011. Dr H informed HDC that he did not consider testing Mrs D for diabetes at these consultations.

75. One month later, on 16 January 2012, Mrs D again attended Dr H's practice, this time with her daughter, Mrs G. Dr H ordered further blood tests, including glucose tests. The results indicated the probability of diabetes mellitus, should supporting symptoms be present. In the absence of symptoms of diabetes, further tests for fasting glucose levels were recommended. The Village informed HDC that Mrs D did not develop obvious symptoms of diabetes, such as weight loss, increased hunger and/or thirst, or polyuria. However, Mrs D was noted to be increasingly tired and lethargic, and was experiencing significant fluid retention in her legs, which was impacting on her ability to be mobile.

76. Dr H said that he did not organise or carry out any follow-up on Mrs D's test results of 16 January 2012 as he was unable to attend the following two scheduled visits at the Village. Dr H did not arrange to see Mrs D at his clinic to review the results, or arrange for further testing. In my view, Dr H's response is not an adequate reason for his failure to follow up appropriately on Mrs D's abnormal test results. Dr H should have ensured that Mrs D was informed of the result and, if he was unable to attend his Thursday clinics at the Village, that Mrs D presented to the practice for further testing and diagnosis.

77. On 31 January 2012 Dr H wrote a referral to the hospital for a needs assessment for Mrs D. There is no mention in the referral letter of Mrs D's elevated glucose levels. The writing of the referral letter was another missed opportunity for Dr H to identify that Mrs D required follow-up tests.

78. Dr H's overall management of Mrs D's blood test results led to a significant delay in her diagnosis of diabetes and, therefore, a delay in her access to appropriate treatment. Dr H had multiple opportunities over the course of the two years he treated Mrs D to follow up her test results and take appropriate steps to reach a diagnosis of diabetes, after which treatment could have been commenced. Dr H's repeated failure to manage Mrs D's elevated glucose levels appropriately, and to ensure that the abnormal test results were appropriately followed up was extremely poor care. Dr H failed to provide services to Mrs D with reasonable care and skill and, accordingly, he breached Right 4(1) of the Code.

Communication of test results — Breach

79. In addition to failing to follow up Mrs D's test results adequately, on multiple occasions Dr H also failed to inform Mrs D of the results of her tests. In particular, there is no evidence that Dr H advised Mrs D of the results of the blood tests taken in June 2010, February 2011, and January 2012. As a result, Mrs D was unable to be a partner in her own healthcare or make lifestyle decisions that may have improved her health.

80. As the clinician who ordered the tests, it was Dr H's responsibility to ensure that Mrs D was informed of the results. By failing to do so, Dr H breached Right 6(1)(f) of the Code.

Documentation — Breach

81. Professional and legal standards for clinical documentation are very clearly established, and the importance of such cannot be overstated. The Medical Council of New Zealand publication "The maintenance and retention of patient records" (August 2008)[20] notes the importance of clinical records for ensuring good care for patients, and requires doctors to keep "clear and accurate patient records that report: relevant clinical findings; decisions made; information given to patients; any drugs or other treatment prescribed". A detailed and clear record of a patient's history, assessment, and management plan is one of the cornerstones of good care, and the primary tool for continuity of care and patient management.[21]

82. Dr H explained that all medical notes for patients who were resident at the Village were kept in paper files at the Village. Those notes were not taken back to the practice, and were not recorded in the electronic notes kept at the practice.

83. In my view, keeping two separate sets of notes in different locations makes appropriate review of those notes at each consultation difficult. It is clear from Mrs D's clinical records that the results of blood tests and the electronic notes recorded for

[20] Available at: http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf.
[21] See also Opinion 10HDC00610, available at www.hdc.org.nz.

visits at the practice were not at any stage consolidated with the handwritten notes taken by Dr H on his visits to the Village (and when she took those notes to the practice). This was inadequate. As has previously been stated by this Office, to ensure continuity of care, handwritten and computerised notes need to be appropriately integrated.[22]

84. Dr H needed to ensure that his handwritten and computerised notes were consolidated so that the notes were readily accessible for appropriate review, and that at any consultation he had a full clinical picture in relation to his patient. Dr H's record-keeping fell below the expected standard, and was a breach of Right 4(2) of the Code.

Referral for needs assessment — Adverse comment

85. The Village nursing records demonstrate a progressive deterioration in Mrs D's ability to cope with independent living. Mrs D suffered numerous falls and was increasingly incontinent of both urine and faeces. I note that marked deterioration in Mrs D's independence was evident from December 2011. Although there was a gap of nine and a half months between when Mrs D consulted Dr H in February 2011 and December 2011, Mrs D consulted Dr H twice in December 2011 and once in January 2012 before a Village nurse contacted him on 31 January 2012 and requested an urgent geriatric assessment.

86. In my view, Dr H should have taken a more proactive approach to Mrs D's identified increasing needs and dependence. The possibility of undergoing a needs assessment review and finding alternative placement could have been raised by Dr H with Mrs D and her family at a much earlier stage. Dr Maplesden advised that earlier intervention in terms of assessment of Mrs D's incontinence, cognitive and behavioural difficulties, and physical symptoms may have prolonged her overall independence.

Opinion: No Breach — The Village

Follow-up of blood test results and management of diabetes

87. The Village is an independent living retirement village. As such, the Village does not provide full-time rest home level care, but rather has two emergency nurses available for the 240 residents in the retirement village. The Village explained that residents would usually either make their own medical appointments or would attend an appointment with Dr H at his weekly clinic at the Village.

88. As all residents are required to live independently, the nurses were most often not involved in the care Dr H provided, and were therefore not always aware when a resident had a blood test or other laboratory test. The Village did not receive copies of blood test results or other laboratory test results ordered by Dr H. The Village informed HDC that the nurses first became aware of Mrs D's raised glucose levels on 14 February 2012.

[22] See Opinion 09HDC01765, available at www.hdc.org.nz.

89. The agreement between the Village and Dr H required nurses to monitor diabetic patients closely by conducting blood tests three monthly, and assisting with weekly patient self-monitoring of fasting glucose. However, as the Village was unaware of Mrs D's raised glucose levels until mid-February 2012, and no diagnosis of diabetes had been made by Dr H, regular monitoring of Mrs D's blood sugar levels did not occur.

90. My in-house clinical advisor, Dr David Maplesden, advised that in an independent living retirement village such as the Village, it is the sole responsibility of the treating doctor to ensure that he or she acts on blood test results efficiently. I do not consider that the Village can be held accountable for Dr H's management of Mrs D's raised glucose levels, and I am satisfied that the Village had appropriate policies and procedures in place for the management of diabetic residents once a diagnosis had been made. For these reasons I am satisfied that the Village did not breach the Code with regard to follow-up of Mrs D's blood test results.

Management of Mrs D's increasing dependence

91. The Village informed HDC that its nursing records demonstrate that Mrs D's ability to live independently deteriorated over her time there. Mrs D had numerous falls and, on many occasions, she suffered from both urine and faecal incontinence. The Village also explained that all prospective residents to the Village attend a "meet and greet" discussion with the Nurse Manager and the Village Manager. At that interview the Nurse Manager clarifies that the Village does not offer ongoing nursing care and, therefore, if a resident's health declines, requiring nursing care, it is necessary for the resident to move to a facility better suited to cater for his or her needs.

92. In August 2010 a referral was made by a Village nurse for a needs assessment of Mrs D with respect to assistance with showering, and caregiver assistance was arranged in that regard. The Village said that the nurses liaised closely with Mrs F about their concerns, which included Mrs D's deteriorating mobility, social withdrawal, refusal to have showers, and her increasing incontinence.

93. I have taken note of the Village's liaison with Mrs D's family, and the service Mrs D was provided with by the Village nurses when managing her incontinence and mobility difficulties. Overall, I am satisfied that the care provided to Mrs D by the Village was consistent with expected standards and, therefore, the Village did not breach the Code.

Recommendations

94. Dr H has provided a written apology to Mrs D and her family, which has been forwarded.

95. In the provisional opinion, I recommended that Dr H:

1. Advise HDC of the outcome of his June 2013 clinical audit on detecting Type 2 diabetes, and any proposed follow-up action he intends to take in response to that audit, within **one month** of the date of the final opinion.
2. Review his practice, including his documentation practices.
3. Arrange an audit in relation to documentation, systems for following up referrals, and continuity of care at his practice, and report to HDC on the results, within **three months** of the date of the final opinion.

96. In relation to recommendation (1), Dr H advised of the outcome of his clinical audit on detecting Type 2 diabetes, and provided a copy of the audit documentation. The audit results assessed Dr H at "Level B (reasonably good support for diabetes management)". Dr H advised that, as follow-up, he intends to retake the audit in 12 months' time and achieve "Level A (fully developed diabetes management)".

97. In relation to recommendation (2), Dr H advised that he has reviewed his practice in light of the care he provided to Mrs D, including in relation to his documentation practices.

98. In relation to recommendation (3), I ask that this occur within the requested timeframe.

99. I recommend that the Medical Council of New Zealand review Dr H's competence.

Follow-up actions

100.
- Dr H will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, and the District Health Board, and they will be advised of Dr H's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

101. The Director of Proceedings laid a charge before the Health Practitioners Disciplinary Tribunal. Professional misconduct was not made out.

Appendix A — Independent clinical advice to the Commissioner

The following expert advice was obtained from general practitioner Dr David Maplesden:

"1. [Mr E], son of [Mrs D] complains about the care his mother received at [the Village] by nursing staff there and by the attending GP, [Dr H]. The complaint related mainly to a delay in the diagnosis and appropriate management of his mother's diabetes and chronically swollen legs, difficulty getting [Dr H] to attend his mother, and delays in organising requested assistance for incontinence care and rest home level care assessment. [Mr E] was critical of the level of care offered by [the Village] staff with respect to organising medical reviews for his mother, including reviews prior to repeat prescribing of her regular medications, and their failure to bring [Dr H's] attention to [Mrs D's] abnormal blood tests.

2. [The Village] is a residential independent living retirement village. [Mrs D] was evidently living in a serviced apartment, having shifted there in January 2010. The brochures supplied to me (and to prospective buyers) include the statement *The on-site nurse provides emergency medical care as well as regular nurse clinics, and doctors hold regular surgeries in the village. Ongoing care, in the form of additional support or nursing services, is available to residents on a user-pays basis.* The [Village] response emphasises the nature of the nursing care provided is predominantly emergency, and is quite different to the level of care provided in a rest home. There are two nurses available for 240 residents. There is a daily nurse clinic for the purposes of dressing changes, injections, blood pressure checks etc.

3. [Dr H] states he has been working at [the Village] for six years, attending one day a week (mainly on Thursday mornings). However, at times he was unable to attend due to personal ill-health or the absence of his work colleague, implying commitments to his practice took precedence over commitments to [the Village] on these latter occasions. There were two occasions on which [Dr H] was unable to attend scheduled appointments with [Mrs D]. If a patient required medical attention outside the scheduled Thursdays, it was agreed they would be brought to [Dr H's] practice. Alternatively, the local accident and medical GP service could be accessed, or [the hospital] for emergencies. [Dr H] states that patients at [the Village] would either make their own appointments to see him via the [the Village] receptionist, or nurses might make an appointment on behalf of the patient. The [Village] response notes that if [Dr H] had to cancel his clinic, facility nurses would notify patients and assess the urgency of the problem, making an appointment at the surgery on the patient's behalf if indicated.

4. [Dr H's] response indicates that medical notes for attendances at [the Village] are kept there (handwritten) and not incorporated into his surgery PMS. Laboratory results are received and processed at his surgery. If a result is abnormal, [Dr H] sends a message to his practice nurse to advise the patient and organise appropriate follow-up. The [Village] response notes that due to the independent status of their clients, they were not always aware when blood tests had been ordered, and did not automatically receive copies of results. If results

were received, they were placed in the patient's [Village] file ready for the doctor's visit. Since the complaint, [the Village] has developed a results register to ensure a hard copy of all blood tests ordered by the doctor is received at the facility for review by the doctor. All patients at [the Village] were supposed to be reviewed at least six-monthly but, if stable, one repeat prescription could be supplied within this period.

5. Diagnosis of diabetes and general clinical management

(i) The [Village] response notes that at no stage did [Mrs D] develop obvious symptoms of diabetes such as loss of weight, polydipsia (she had to be reminded to drink fluids) and was frequently incontinent so polyuria was not able to be assessed. I note [Mrs D] complained of chronic lethargy prior to her admission to [hospital] (see below).

(ii) Blood test results received by [Dr H] are tabulated below:

Date	Non-fasting glucose[23] (mmol/L)	Sodium[24] (mmol/L)	Pathologist comment
4 June 2010	10.5	–	High risk of diabetes or glucose intolerance … follow-up fasting glucose and/or oral GTT is required
25 June 2010	7.9		Comment as above
25 Feb 2011	13.5	136	If diabetes … not known to be present, the result indicates diabetes … if there are supporting symptoms/signs. Without symptoms a further random glucose higher than 11.0mmol/L, a true fasting glucose higher than 6.9mmol/L or HbA1c>49mmol/mol is needed to confirm the diagnosis
16 Jan 12	13.5	128	Diabetes comment as above. Sodium comment includes *moderate hyponatraemia* and advises consideration of possible causes, and follow-up/further investigation

[23] Acceptable range 3.5–7.7 mmol/L
[24] Normal range 135–145 mmol/L

13 Feb 12	17.3	131	Taken with the previous high glucose result, this result confirms the diagnosis of diabetes mellitus.

(iii) From the BPAC Publication Detecting Diabetes: Tools for better care (July 2008)

a. The following are diagnostic of diabetes

- In people with symptoms typical of diabetes, a single fasting plasma glucose level of ≥7.0 mmol/L or a random glucose ≥11.1 mmol/L.
- In people without symptoms of diabetes, a fasting plasma glucose result ≥7 mmol/L on two different days and/or a random result of ≥11.1 mmol/L on two different days.
- Following a glucose tolerance test a fasting glucose ≥7 mmol/L and/or a 2 hour glucose of ≥11.1 mmol/L.

b. Role of other tests for diagnosis ...

- Non fasting blood glucose: limited role in opportunistic testing.
- Urine glucose: non-sensitive and non-specific, not recommended.
- HbA1C: best test for monitoring, currently not recommended for diagnosis.

c. HbA1C

HbA1c is the best test of glycaemic control in diabetes. Test six monthly in stable diabetics, and three monthly following changes in treatment. The goal is to achieve an HbA1c as low as possible, preferably less than 7.0%, without causing unacceptable hypoglycaemia.

d. Self-monitoring blood glucose (SMBG)

- For people with non-insulin treated type 2 diabetes, self-monitoring of blood glucose (SMBG) appears to have little or no effect on glycaemic control.
- SMBG is associated with higher costs and lower quality of life.
- HbA1c remains the most useful tool for assessing glycaemic control in people with non-insulin treated type 2 diabetes.

(iv) Review of GP notes

a. General standard of clinical documentation is adequate. The first assessment following admission to [the Village] was 13 June 2010. In total, there were seven consultations at [the Village] and three at the surgery between June 2010 and February 2012 — approximately one consultation per quarter. Swollen legs were noted from October 2010 and treated with diuretics on the basis of a diagnosis of heart failure. Such treatment was reasonable given the overall clinical picture (including shortness of breath and positive lung auscultation on occasions). Diuretics

were increased in May 2011 and again on 16 December 2011 in response to the persistent oedema. On review on 23 December 2011 the oedema was noted to have decreased a little but was still present. There is no reference to blister formation or weeping. Last recorded consultation is 16 January 2012 when blood tests were arranged and referral organised for needs assessment. The medication being prescribed was generally appropriate to [Mrs D's] conditions, and I note most of the medication was continued following discharge from [the hospital]. The exception was the prescribing of the NSAID meloxicam which should be used with caution in the elderly, particularly those with an increased risk of cardiovascular disease or heart failure, and this was stopped on admission to [the hospital]. The indication for continued use of meloxicam, in the absence of first line analgesics such as paracetamol, is not clear from the clinical records.

b. There is no reference in the clinical notes to [Mrs D's] abnormal blood test results in terms of follow-up or treatment, or any recorded comments from the practice nurse regarding messages to telephone [Mrs D] regarding the results. In his response, [Dr H] states that on receipt of the result of 4 June 2010 another test was ordered. *On receipt of the second result (25 June 2010) I sent a message to my practice nurse for further follow-up but I have now learned that this did not happen.*

(v) Comments:

a. The overall clinical management of [Mrs D] by [Dr H], excluding management of her blood results discussed further below, was reasonable in many respects although I am mildly critical that he was not more proactive in providing timely assessments on those occasions when he was unable to attend scheduled visits to [the Village]. However, I note there was a process in place whereby nursing staff at the facility would check on the needs of those patients whose visits had been deferred, and ensure alternative arrangements were appropriate. While [Mrs D] had chronic medical problems (both overt and undetected) there was no apparent medical urgency for review on those occasions when visits were deferred. [Dr H's] management of [Mrs D's] chronic lower leg oedema was active and clinically reasonable, although provision of lower limb compression stockings might have been considered, but balanced with the difficulty many patients have in applying these devices. It is evident there was more rapid deterioration in the degree of oedema in the days following [Dr H's] last assessment of [Mrs D], and by that stage a specialist assessment had been arranged which was a logical next step. I am mildly critical that [Dr H] was not more proactive in organising a needs assessment somewhat earlier than he did and this is discussed further below.

b. [Dr H] has acknowledged there were deficiencies in his detection and management of [Mrs D's] diabetes, and has attributed these oversights in part to excessive workload and also a failure of his normal process for following up abnormal results. I am critical of [Dr H's] management in

this regard in several respects: he did not specify a fasting glucose or OGTT as follow-up of the initial abnormal blood test — either of these would have enabled a diagnosis of diabetes to be confirmed or excluded, but instead another non-fasting test was undertaken; the second abnormal test was not followed up in accordance with expected standards (this may have been the result of a process failure but the lack of an acknowledgement in the notes of the first abnormal result meant an additional prompt was not present); the abnormal result of February 2011 was not acknowledged or followed up when results to date were highly suspicious for a diagnosis of diabetes or at least impaired glucose tolerance; results of January 2012 were not acknowledged when they were diagnostic of diabetes (see section 5(iii) above); results of 13 February 2012 were not acknowledged when they were diagnostic of diabetes (although medical review was imminent). As a separate issue the significantly low sodium level detected in January 2012 (a new finding) was also not apparently acknowledged (in terms of clinical record or urgent patient/medication review) although follow-up bloods were evidently ordered. A mild mitigating factor is that [Mrs D] was not exhibiting classic hyperglycaemic symptoms over this period. I think [Dr H's] overall management of [Mrs D's] blood results, which resulted in a significant delay in her diagnosis of diabetes and access to appropriate treatment for this was a moderate to severe departure from expected standards taking into account the mitigating factors he has presented. A referral to the Medical Council may be appropriate in this instance to determine whether the working conditions described by [Dr H] are interfering with his ability to provide competent and safe care.

6. Leg oedema

(i) The [Village] response notes that [Mrs D] had a degree of leg oedema when she first arrived at the facility, but this worsened during her stay. [Mrs D] had five visits to the Doctor since 09/10/10 regarding the bilateral pitting oedema … there was no report of [Mrs D's] legs weeping by either the nurse who gave [Mrs D] her medication on the morning of 14 February 2012 or the caregiver who showered [Mrs D] that morning.

(ii) [Dr H's] role in the treatment of [Mrs D's] leg oedema has been discussed above. While chronic oedema can be difficult to treat, it appears [Mrs D] was caught in the cycle of oedema contributing to immobility, which in turn exacerbated the oedema. Whether [the Village] staff took a sufficiently active role in addressing this problem is addressed further in section 8, but from a clinical perspective I think management was primarily the responsibility of [Dr H].

7. Repeat prescriptions

(i) The [Village] response notes that nurses do not decide whether or not a patient should be reviewed prior to a repeat prescription, but they do notify the doctor when a repeat prescription is due. If the doctor is happy

to provide a repeat prescription prior to seeing the patient, an appointment is made at the next available doctor's clinic for routine review.

(ii) Whether or not a repeat prescription is to be provided without the patient being seen is the responsibility of the prescriber — in this case [Dr H]. It is not uncommon for patients with very stable medical conditions, as there would be in the population at [the Village], for six-monthly reviews to be undertaken. In this case, it is expected the patient would contact the doctor if there was a need for earlier review because of new symptoms or a deterioration in existing symptoms.

8. Referral for needs assessment

(i) The [Village] response states The Nurses' Report outlines a deteriorating ability by [Mrs D] to cope with independent living at the village. She had numerous falls and removed her pendant alarm. On many occasions she was both urinary and faecally incontinent … the response describes the on-going support, beyond emergency care, given by the facility nurses and caregiver, and that staff liaised closely and regularly with [Mrs D's daughter] about their concerns which included [Mrs D's] deteriorating mobility, social withdrawal, refusing to have showers and her incontinence. An outline of the Nurses Report is contained in the response. There were increasing problems with [Mrs D's] dependence as outlined above culminating in the action of 31 January 2012 — Nurse phoned Doctor for urgent geriatric assessment. Further examination of the nursing notes shows a referral was made for a needs assessment (with respect to assistance for showering) in August 2010 and caregiver assistance was provided for this. Marked deterioration in [Mrs D's] independence is evident from December 2011 with more frequent faecal incontinence, increasing difficulties with mobilising, and poor motivation. A referral was made on 5 December 2011 ([Dr H's] practice nurse) for assessment by the community incontinence service. She was admitted to [respite care] for respite care on 31 January 2012 and arrangements made for [Dr H] to visit prior to making the referral for geriatric assessment (although it appears the referral was made in any case). For various reasons [Dr H] was unable to visit [Mrs D] while she was in [respite care] (stay extended to 7 February 2012) and he was not notified by staff there of any concerns at her condition. A scheduled review back at [the Village] for 9 February 2012 also did not occur and this was rescheduled for 16 February 2012. On 15 February 2012 the geriatric nurse specialist reviewed [Mrs D] at [the Village] and arranged her admission to [the hospital] for the following day.

(ii) The geriatric nurse specialist ([RN I]) assessment report dated 16 February 2012 is on file. The reason for assessment is recorded as GP request ... 'has been living independently at [the Village] and has been having difficulty managing, has poor memory and frequent falls. Family members would like her assessed for rest home care as she has been needing a lot of support from them' [presumably from GP referral note].

> The report notes concerns expressed by [Mrs D's] daughter at her mum just being perpetually tired. She is concerned that the swelling in her Mum's legs, noticeable over the last nine months, has worsened over the last six months … worried, she took her mum to the doctor before Christmas. [Ms I] notes the presence of blisters leaking fluid on the upper aspect of [Mrs D's] left leg, and slight leakage in a similar area on the right. [Mrs D] did not appear concerned by her legs. Vital signs were normal but capillary blood glucose was elevated at 23 mmol/L, still elevated at 19.3 mmol/L when repeated some time later. [Ms I] evidently had access to recent blood results (January and February 2012) and noted a number of abnormalities which she felt required inpatient assessment. In discussion with [the geriatrician] it is agreed that with the concerns listed above [Mrs D] be offered admission into AT&R for a full medical review and MDT input around supporting her to achieve her goal of being able to remain in her unit. In hospital [Mrs D] was treated for urinary tract infection (IV antibiotics), diabetes (insulin and oral hypoglycaemics), hyponatraemia (conservative management). A diagnosis of lipodermatosclerosis is recorded (chronic thickening, redness and discomfort in the lower leg tissues secondary to venous insufficiency). Admission medications were continued except for meloxicam and bendrofluazide. There is reference in discharge documentation to patient's diabetes was not managed in the community. Despite rehabilitation [Mrs D] required rest home level care and was discharged to a suitable facility on 5 March 2012.

(iii) Leaving aside the issue of the delayed diagnosis of diabetes, I am mildly critical that neither [the Village] staff nor [Dr H] took a more proactive approach to [Mrs D's] identified increasing needs and dependence (probably from at least early December 2011 if not before) by broaching the subject of needs assessment review and the possibility of alternative placement with her and her family. While I understand the 'delicacy' required to approach such matters when perceived loss of independence is a major issue for many elderly, earlier intervention in terms of assessment of [Mrs D's] incontinence, cognitive and behavioural difficulties, and physical symptoms (taking an holistic rather than fragmented approach) might have prolonged her overall independence.

9. Remedial measures

(i) The changes made by [the Village], in terms of handling of results, are appropriate and should serve as a useful 'backup' to the processes currently in place at the doctor's surgery. However, it should be clear that nurses at [the Village] are not identifying abnormal results on behalf of the doctor (and I would not see this as their function in the residential care setting described at [the Village], unlike a rest home or doctor's surgery), and that the doctor requesting the test holds sole responsibility for ensuring his or her processes for assessing and acting on results is effective and efficient.

(ii) [Dr H] has enclosed a list of proposed changes to processes at [the Village] for patients under his care. While most of these have merit, others I think require further thought. It may not be a wise use of resources for all patients to have 3-monthly blood and urine tests — such testing should be based on the individual clinical needs of the patient, and be evidence-based. Self-monitoring of blood glucose is not routinely required or recommended for all patients (see 5(iiid)). He also indicates nurses at [the Village] will have an active role in identifying and following up abnormal test results for patients at [the Village]. This may be a duplication of the surgery processes and could lead to confusion over roles of the practice nurse versus [the Village] nurse and certainly required further thought (see above). If such a role is agreed by [the Village] staff, the processes for such handling or results including roles and responsibilities should be explicit and embodied in a process document.

(iii) [Dr H] should be asked to provide a copy of his practice policy for handling of test results to ensure the current policy is robust.

(iv) [Dr H] has evidently apologised to [Mrs D] and some family members for the distress caused by the delayed diagnosis of her diabetes, and I think this is appropriate.

(v) As discussed in section 5(vb) referral of [Dr H] to the Medical Council may be appropriate in this instance to determine whether the working conditions he describes are interfering with his ability to provide competent and safe care."

Dr Maplesden provided the following further clinical advice:

"I have reviewed the additional responses received concerning this file. Subsequent comments should be read in conjunction with my original advice provided on 8 November 2012.

1. [The Village's] response dated 6 December 2012

(i) Dates of visits undertaken by [Dr H] at [the Village] have been clarified.

(ii) Efforts made by [Village] staff to organise a needs assessment for [Mrs D] have been clarified, including [Dr H] cancelling a scheduled visit required to facilitate the assessment.

(iii) A revised service provision document is being developed with [Dr H] to ensure clinical task delegation and management expectations are explicitly defined. A copy of this document should be provided for the Commissioner once finalised.

(iv) [Village] staff should be reminded of the importance of clear and timely communication with family and medical providers when there is a perceived change in the needs or condition of a resident. Timely intervention and appropriate rehabilitation before a resident becomes 'deconditioned' can prolong independence.

(v) I have no further comments or recommendations regarding the role of [Village] staff in [Mrs D's] management.

2. [Dr H] response dated 14 February 2013

(i) [Dr H] has outlined changes to his practice processes with respect to handling of blood test requests and results. These changes are appropriate and the associated policy documents are generally robust and include use of PMS reminder systems where appropriate.

(ii) [Dr H] has outlined changes undertaken to his working hours and structure. My initial concerns that referral to the Medical Council might be required to ensure [Dr H's] work regime was not negatively impacting on his ability to provide competent clinical care appear to have been addressed in a satisfactory manner, but [Dr H] should maintain an awareness of the need to maintain a healthy work-life balance to facilitate optimum functioning in both spheres.

(iii) [Dr H] has provided the family of [Mrs D] with a written apology for any oversights that impacted negatively on her standard of care. This is appropriate.

(iv) While I remain of the view that [Dr H's] management of [Mrs D] departed from expected standards to a moderate to severe degree (primarily with respect to his handling of her abnormal blood test results and failure to diagnose diabetes) I feel the remedial actions he has undertaken are appropriate and that further investigation of this case is unlikely to add significant information. However, I feel some educational interventions are warranted with respect to management of elevated glucose and hyponatraemia and I make the following additional recommendations:

a. [Dr H] review the BPAC publication on current recommendations for blood testing in the diagnosis of diabetes available at:

http://www.bpac.org.nz/magazine/2012/february/hba1c.asp

b. [Dr H] undertake a clinical audit on detecting Type 2 diabetes — see BPAC audits approved for MOPS available at:

http://www.bpac.org.nz/Public/admin.asp?type=publication&pub=Audit&page=1

This audit should also record whether patients meeting the criteria for a diagnosis of type-2 diabetes have been appropriately coded and managed. A copy of the first-pass of the audit, including self-assessment comments, should be provided to the Commissioner for review.

c. [Dr H] review the BPAC publication 'A primary care approach to sodium and potassium imbalance' available at:

http://www.bpac.org.nz/resources/bt/2011/09_imbalance.asp?page=1