General Practitioner, Dr A

Resthome

A Report by the
Health and Disability Commissioner

(Case 01HDC09346)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs C (deceased)	Consumer
Mrs B	Mrs C's Daughter / Complainant
Dr A	General Practitioner / Provider
Resthome / Provider	
Ms D	Registered Nurse / Provider

Complaint

On 17 August 2001 the Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs C. Mrs B's complaint was summarised as follows:

Resthome
Staff at the Resthome failed to exercise reasonable care and skill in caring for Mrs C. In particular:

- *staff did not appropriately investigate the cause of Mrs C's rectal bleeding;*
- *when Mrs C began vomiting on Saturday 10 February 2001, staff failed to arrange a visit from a doctor until Monday lunchtime;*
- *staff failed to put in place an acute care plan once Mrs C became unwell;*
- *On Monday 12 February, staff failed to communicate to Dr A important information about Mrs C's illness, including her previous history of rectal bleeding and the length of time for which she had been vomiting over the previous days.*

Staff at the Resthome failed to provide services to Mrs C in a manner consistent with her needs, in that her specific communication needs were not considered when she was taken to hospital in the ambulance.

Dr A
Dr A failed to provide services to Mrs C with reasonable skill and care. In particular, when Dr A saw Mrs C on Monday 12 February 2001 he failed to:

- *conduct an appropriate physical examination;*
- *appreciate the seriousness of her condition.*

An investigation was commenced on 17 July 2002.

Information reviewed

- Letter of complaint, dated 17 August 2001
- Response from Dr A, dated 22 January 2003
- Response from the Resthome, dated 24 July 2002, including:
  - Mrs C's clinical records
  - Position descriptions for charge nurse, registered nurse, enrolled nurse, and caregiver
  - Procedures for acute health emergencies, admissions and transfers
- Information provided by the District Health Board, including Mrs C's records, dated 19 March 2003
- Report from a doctor at the Public Hospital, dated 8 April 2003

Independent expert advice was obtained from Dr Keith Carey-Smith, general practitioner, and Ms Wendy Rowe, registered nurse.

Information gathered during investigation

Mrs C became a resident at the Resthome on 14 November 2000. The Resthome is sited opposite the house where Mrs C had previously been living with her daughter, Mrs B.

Mrs C, aged 79, was profoundly deaf and suffered from type 2 diabetes. She also had problems with oedema and cellulitis.

On 8 December 2000, the nursing notes record that Mrs C complained that she had been bleeding from the bowel. She was treated for bleeding haemorrhoids, although the bleeding continued.

On the morning of Saturday 10 February 2001, Mrs C began to vomit and complain of abdominal pain. It was also noted that she continued to bleed from the rectum. She was given Mylanta and encouraged to take fluids. She did not vomit again that day, although she did not eat much.

On Sunday 11 February, Mrs C ate a small lunch and dinner. She vomited at around 8.30pm and had an unsettled night.

On Monday 12 February, Mrs C vomited twice in the morning. The second time was at around 11.00am when the nursing notes record that she vomited approximately 1200ml of bile-stained fluid. She was also complaining of nausea, and pain from her sternum to her abdomen. The nursing staff asked Dr A to review Mrs C, and recorded that he did so at around 3.00pm.

Dr A's notes record that he found her with a history of "vomiting x 4". Mrs C's pulse was 68 and regular, her blood pressure was 120/80. She had clear lungs, normal heart sounds and normal bowels, although with increased bowel sounds. Dr A recorded his diagnosis as "gastric virus?". He prescribed Maxolon and noted "LFTs" [liver function tests]. The nursing notes also record that Mrs C was to have liver function tests "when arranged".

In his response to my investigation, Dr A stated that he attended Mrs C during his lunch hour, around 12.00pm. Mrs C was not complaining of any pain, and conveyed to him that she thought her vomiting was due to the mushrooms she had eaten on Friday night. Upon palpation, her abdomen was not tender and Mrs C stated that her bowel motions were normal. Mrs C was not dehydrated or in any distress.

Dr A considered that the most likely diagnosis was gallstones. He ordered liver function tests for the next day, to be followed by an ultrasound to confirm the gallstones. Dr A also ordered two-hourly observations, with instructions to call him if necessary.

At 9.15pm Mrs C vomited approximately 800ml of green vomitus.

At 1.00am on 13 February, Mrs C was found on the floor of her bedroom. She was assessed by the registered nurse on duty, Ms D. Ms D recorded in the nursing notes that Mrs C had no apparent injuries and full movement in her limbs, and had indicated that she was not in pain and had not lost consciousness. She had some mild nausea, and was able to have sips of fluid. Ms D took the following recordings: blood pressure 94/64, pulse 100, respirations 28, blood sugar level 13.2.

At 3.00am, Ms D checked on Mrs C and found her to be cold and clammy and in a profuse sweat. Mrs C indicated that she had no abdominal pain. Her pulse was 80, her blood pressure was unobtainable, respirations 28 and irregular with intermittent apnoea, and her blood sugar level was 9.9.

After assessing Mrs C, Ms D called an ambulance at 3.45am. The ambulance arrived at 3.53am and, after Mrs C had been assessed, left for the Public Hospital at 4.30am. Once Mrs C was in the ambulance, staff at the Resthome contacted Mrs B, who followed the ambulance to hospital.

Upon admission to the Public Hospital, Mrs C was noted to be dehydrated and in acute shock. Her stomach was also badly distended. She was admitted to the intensive care unit and an X-ray was taken, which revealed a small bowel blockage. Mrs C was considered too ill to undergo surgery, but by 4.00pm her condition had deteriorated and she required emergency surgery. The surgery revealed that Mrs C was suffering from gallstone ileus, a rare and diagnostically difficult condition, where a large gallstone erodes the gallbladder, moves down the duodenum and causes a blockage in the small bowel. The gallstone was removed, but Mrs C did not recover from the surgery, and died on the morning of 17 February 2001.

Independent advice to Commissioner

General practitioner advice
The following independent expert advice was obtained from Dr Keith Carey-Smith, a general practitioner:

"**Documents and records reviewed**

- Letter of complaint (17/8/01) and attached documents
- Letter of notification (17/7/02)
- Response from [the Resthome] (24/7/02) with patient records and attached documents
- Response from [Dr A] (22/1/03)
- Report by [the doctor at the public hospital] (7/4/03)
- [Mrs C's] patient records for her admission to [the Public] Hospital from 13/2/01

Advice and comments

Expert advice requested:

1. **Did [Dr A] adequately investigate and respond to [Mrs C's] condition, when he saw her on Monday 12 February 2001? (see under conclusions). In particular did he:**

a. Carry out appropriate physical examination?
b. Carry out and/or order appropriate tests?
c. Communicate appropriately with the staff of [the Resthome]?

Summary of[[Dr A's] management of [Mrs C's] condition:

Information provided on which to base my opinion consists of [Dr A's] letter of response along with medical and nursing notes from [the Resthome] during the period in question. There appear to be no additional available notes held by [Dr A] at his surgery, and the last page of [Dr A's] notes held by [the Resthome] appear to be absent (he is said to have recorded '… Maxolon orally. Liver function tests'). The 'communication book' entries are also not provided. [My staff have reviewed Dr A's notes and confirmed that the comments appear as stated.]

[Mrs C] came under [Dr A's] care when admitted to [the Resthome] in November 2000. She was reviewed regularly by him, including a visit in response to her rectal bleeding on 21/12/00, at which examination revealed internal haemorrhoids and constipation was suspected. Both problems were appropriately treated.

On 11 and 12 February nursing notes record several vomiting episodes, and a request to [Dr A] to visit some time after 11.00am on 12 February. Abdominal pain was also recorded. A note of [Dr A's] visit was made at 3pm, followed by administration of Maxolon (presumably on the advice of [Dr A]). The notes then record [Dr A's] visit at

3.00pm (although [Dr A] states in his letter that he visited at midday), followed by further Maxolon and the instruction for blood tests in the morning (as confirmed in [Dr A's] letter).

The medical note relating to the visit of 12 February records a history of four vomiting episodes, implying communication of this fact either by nursing staff or via the nursing notes. There is no mention of abdominal pain, and [Dr A] in his letter states that she did not complain of pain, and thought that the vomiting was due to mushrooms (this item is not recorded in the notes). The notes include an entry 'bowels normal', apparently referring to bowel motions. The entry details examination of vital signs including blood pressure, and findings from examination of heart and abdomen. Although findings on palpation are not specifically recorded, the recording of 'increased bowel sounds' suggests a full abdominal examination. [Dr A] states in his letter that there was no tenderness, although again this was not documented at the time.

The diagnosis is recorded as '?gastric virus', antiemetics were prescribed, and two-hourly observations apparently ordered (no confirmation of this in records viewed). [Dr A's] differential diagnosis of gall stones led to ordering of blood tests the following day. Although [Dr A] states that he considered gall stones the most likely diagnosis, this is not supported by the diagnosis of 'gastric virus?' in the records made at the time. It would appear that treatment was successful since no further vomiting occurred for a further five hours.

Opinion:

From information available, it is considered that [Dr A] conducted a reasonably full and appropriate examination, and ordered appropriate observations, treatment, and investigations to be carried out the next day. I do not consider that the situation necessitated more urgent investigation or admission.

2. Did [Dr A] receive sufficient information, regarding [Mrs C's] condition, from the staff at [the Resthome]?

Communications recorded are the telephone call to [Dr A] around the middle of the day on 12 February, and the discussion at the time of his visit during the afternoon. It is not known exactly what was said on each occasion, but there is no reason to believe, from the records and information given, that [Dr A] lacked significant information at the time he examined [Mrs C]. The only uncertainty is whether the complaint of abdominal pain was passed on to [Dr A]. His letter implied that he enquired about this and none was present at that time. Abdominal pain is often present for a time after a vomiting episode, and can then resolve. His actions are unlikely to have been altered if he had been made aware of the previous complaint of pain.

Subsequent nursing notes do not indicate any situation requiring contact with a doctor until [Mrs C] was found in shock and pain at 3.00am the next morning.

Conclusion:

It is probable that sufficient information was provided to [Dr A] to allow him to conduct appropriate examination and make provisional diagnoses.

3. Are there any aspects of the care provided by [Dr A] which warrant:

a. Further exploration by the Investigation Officer? or
b. Additional comment?

No further issues in [Dr A's] management of [Mrs C] are considered to constitute cause for further comment. I consider his attendance on [Mrs C] to be prompt and appropriate, and medical notes to be adequate. The condition eventually diagnosed (gall stone ileus) is exceedingly rare, and it is not expected that a general practitioner would diagnose this. As stated by the surgeon, even in hospital the diagnosis of this condition is usually only made at surgery.

The documentation provided to me does not include the 'communications book', and a few words of [Dr A's] notes, both mentioned in [the Resthome] reports. The former may have recorded communication with the doctor as well as the relatives. However it is unlikely that the lack of this information would in any way alter the opinions expressed above."

Nursing advice
The following advice was obtained from Ms Wendy Rowe, a registered nurse:

"Documents Reviewed:
- Letter of complaint, dated 17 August 2001, and attached documents
- Letters of notification, dated 17 July 2002
- Response from [the Resthome], dated 24 July 2002
- Response from [Dr A], dated 19 March 2003
- Report by [a doctor at the public hospital], dated 7 April 2003
- Mrs C's patient notes for her admission to [the Public Hospital], from 13 February 2001

Did the staff at [the Resthome] respond appropriately to [Mrs C's] vomiting? In particular, could the staff reasonably have been expected to:
- **Call a doctor to review [Mrs C] prior to Monday lunchtime?**
- **Instigate an acute care plan for [Mrs C] once she became unwell?**
- **Contact [Mrs B] prior to sending [Mrs C] in the ambulance?**

Clinical notes indicate that [Mrs C] vomited up to 7 times between the dates of the 10 – 12 February.

Clinical entry dates are very hard to read with a photocopied and bound document. Original photocopies would have to be attained to confirm these dates.
Doctor's notes indicate resident vomited 4 x in total.

There seems to be some confusion over the times and amount of vomiting that [Mrs C] was experiencing over the days between 10 – 13 of February 2001.

Since there seems to be a pattern of repeated vomiting of recorded and noted large amounts it would seem appropriate that a fluid balance chart would need to be commenced as [Mrs C] stopped eating and drinking and was known to have Type 2 Diabetes.

[Mrs B] indicates in her letter to the manager of the [Resthome], that on 12 February 2001 at 9.30am her mother vomited about two litres of faecal/bile 'vomitus' into a bowl. (Letter dated 19 March 2001).

[Mrs C's] vomiting began on 10 February 2001, and as no-one witnessed the vomit until 12 February 2001 it is reasonable to believe [Mrs C] had a gastric event as she continued to eat and drink small amounts.

On 12 February 2001, when it is noted that the vomit is bile stained, a doctor was appropriately notified. More action should have been taken by the staff after she had been seen by the doctors as [Mrs C's] vomiting persisted even though she was having IM antiemetics, only drinking and eating small amounts and complaining of abdomen pain. [Mrs C's] vomiting did start four days before her admission to hospital, however the first two days she only vomited three times in total, with no volumes collected.

As [Mrs C] was known to be a diabetic closer monitoring of her blood sugar levels and input output were indicated on 12 February 2001. No blood sugar monitoring is noted until her fall at 1.00am on 13 February 2001 (no date to indicate 13 February 2001 in the clinical notes).

An acute care plan should have been implemented on the 12th of February 2001 when it was ascertained that [Mrs C's] vomiting was persistent and obviously not a virus.

Although the registered nurse did not call the family until [Mrs C] was on her way to hospital, this task could have been delegated to another staff member as [Mrs C's] daughter only lived across the road from [the Resthome].

If the actions taken by the staff were not reasonable in the circumstances, what actions should have been taken, when, and by whom?

The registered nurses should have:

- established an acute care plan on the morning shift of 12 February 2001
- ensured the vomit was kept on the morning of 12 February 2001 when the vomit was identified as bile like in colour
- commenced a fluid balance chart established for 12 February 2001
- conducted 2 hourly monitoring of vital signs as requested by the doctor
- commenced regular monitoring of blood sugar levels from midday onwards (four hourly) on 12 February 2001

- informed the caregivers to notify them of any changes in the resident's condition.
- contacted a doctor at 1.00am to assess [Mrs C] after her fall as her vital signs recorded indicated a considerable drop in blood pressure and her blood sugar level was also increasing
- phoned an ambulance immediately on finding resident at 3.00am experiencing an obvious medical emergency with no vital signs obvious, instead of waiting for 30-40 minutes as stated in registered nurse [Ms D's] report, dated 23 March 2001.

Did the staff at [the Resthome] provide sufficient information to [Dr A] regarding [Mrs C's] condition?

The information provided by the staff was sufficient information. A more accurate assessment would have been made by the doctor if the vomit had of been able to be viewed.

Were the records kept by [the Resthome] of a reasonable standard?

[Dr A] indicates in his correspondence dated 22 January 2003 that 'I ordered the usual two hourly observations, with instructions to call me if needed'. These were not taken or reported from mid day onwards on Monday 12 February 2001.

Documentation on residents is reported in more than one place, resident's notes and a communication book. The communication book is not given as part of evidence. As previously noted, the records collected by the registered nurse and staff were inadequate and sometimes illegible so it is hard to make a decision as to what is written in the clinical notes and who it is written by, dates and times are not always visible.

If the staff did not provide services of a reasonable standard to [Mrs C], please indicate the severity of their departure from the expected standard of care.

The services provided to [Mrs C] on the weekend of 10 and 11 February 2001 were of a reasonable standard. Documentation during these dates is appropriate. Appropriate action was also taken by the staff working on the morning of 12 February 2001 as the doctor was notified when it became obvious that [Mrs C's] condition was not improving. This is a reasonable standard of care.

When [Mrs C] vomited again at 9.15pm on 12 February 2001 no vital signs were recorded and no further action was taken even though she had had IM Maxolon with no effect. The doctor should have been notified at this point by the registered nurse. Further when [Mrs C] fell at 1.00am, although she is not a high risk of falling, no doctor was notified even though her blood pressure was significantly lower than that recorded by the doctor earlier that day. These actions were unreasonable and I would view this conduct with moderate disapproval.

The registered nurse who assessed [Mrs C] following her fall at 1.00am on 13 February 2001 and took 30-40 minutes to assess and phone and ambulance when [Mrs C] was found at 3.00am on 13 February 2001 did not show a reasonable standard of care and I would view this with severe disapproval. Nurse [D] indicates that this was her first experience as a registered nurse dealing with an emergency such as this. [Ms D] should have sought assistance from a more senior nurse if one was on-call for support.

Are there any aspects of the care provided by the staff at [the Resthome] which you consider warrants further exploration by the Investigation Officer?

Poor documentation and a lack of consistent monitoring of [Mrs C] by the registered nurses at [the Resthome] made it difficult to see evidence of efficient and effective monitoring of this acute episode for [Mrs C]. The monitoring in question is of a basic level, and would be expected of a registered nurse in any aged care facility when a resident displays signs of deterioration in their physical condition, with known underlying medical problems. An acute care plan would have assisted the caregivers and registered nurses to more accurately monitor [Mrs C's] deteriorating health and assess her need for medical intervention."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

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

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

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

Opinion: No Breach – Dr A

When Dr A saw Mrs C on 12 February 2001 his examination included taking her pulse and blood pressure and examining her heart, chest and abdomen. He also ordered blood tests, and prescribed antiemetics.

I accept my expert advice that Dr A carried out an adequate examination and that the circumstances did not warrant him undertaking further urgent investigation or having Mrs C admitted to hospital. Gallstone ileus is an exceedingly rare condition, and a general practitioner would not be expected to diagnose it. In my opinion Dr A provided medical services with reasonable care and skill and did not breach Right 4(1) of the Code.

Opinion: Breach – Resthome

Monitoring Mrs C on 12 February
I accept my expert advice that the Resthome staff adequately monitored Mrs C prior to Monday 12 February 2001. However, on 12 February it was clear that Mrs C's vomiting was persistent and not the result of a virus. Given Mrs C's history of type 2 diabetes, the fact that she had not been eating or drinking, and that her vomiting was repeated and of large volumes, Resthome staff should have instituted an acute care plan and fluid balance chart for Mrs C.

I note that Dr A states that, having assessed Mrs C, he ordered two-hourly observations. This is not recorded in the notes. There is no record of any observations being carried out during the afternoon of 12 February, despite the need for an acute care plan and close monitoring of Mrs C's blood sugar level.

I consider that, regardless of Dr A's instructions, staff should have monitored Mrs C during the course of the afternoon, recorded their observations, and been prepared to inform the registered nurses of any changes in Mrs C's condition.

Response to Mrs C's deteriorating condition
At 9.15pm on 12 February 2001 Mrs C vomited about 800ml of green vomitus. There is no record of Resthome staff taking any action at that time. I accept my expert advice that, given Mrs C's continued vomiting, Resthome staff could reasonably have been expected to seek medical assistance from 9.15pm.

I note Dr Carey-Smith's advice that the nursing notes do not "indicate any situation requiring contact with a doctor until [Mrs C] was found in shock and pain at 3.00am the next morning". However, in assessing the actions of nursing staff, it is appropriate for me to rely on the advice of my nursing expert, who as a peer is able to advise in relation to professional nursing standards.

At 1.00am on 13 February 2001, Mrs C was found collapsed in her bedroom. She was placed back in bed and assessed by the registered nurse on duty, Ms D. The incident form and nursing notes record that Mrs C had no apparent injuries, full movement in her limbs, was not in pain and had not lost consciousness. She had some mild nausea, and was able to have sips of fluid.

Her blood pressure was recorded as 94/64 (94/68 on the incident form), pulse 100, respirations 28, and blood sugar level 13.2. The incident form was completed by a caregiver and signed by Ms D as the "person in charge". The form is checked "doctor notified – No", "relatives notified – Yes". Mrs C's daughter, Mrs B, was not in fact notified until approximately 4.30am.

Ms D attributed Mrs C's low blood pressure and increased pulse and respiration rates to her current hydration status. She considered that Mrs C's fall may have resulted from a drop in her blood pressure due to her having been lying down. On the basis of her observations, Ms D decided to return Mrs C to her bed and to take further observations once she had done a round of Resthome's hospital ward. I accept my expert advice that, given Mrs C's significant drop in blood pressure (from 120/80 as recorded by Dr A earlier in the day) and elevated blood sugar level, it would have been appropriate to seek medical assistance at 1.00am.

At around 3.00am, when Ms D returned to assess Mrs C, she found her to be much worse. Ms D noted that Mrs C was cold and clammy and in a profuse sweat, although she had no abdominal pain. Her pulse was 80, her blood pressure was unobtainable, respirations 28 and irregular with intermittent apnoea, and her blood sugar level was 9.9. Having spent around 45 minutes assessing Mrs C, Ms D called an ambulance.

I accept my expert advice that Mrs C was suffering an obvious medical emergency and that Ms D should have sought urgent medical assistance. I note that around 45 minutes passed between Ms D first seeing Mrs C at 3.00am, and the ambulance being called at 3.45am.

I note my expert's comments that Ms D's error, in not seeking medical assistance at 1.00am, was moderately serious. By 3.00am, when Mrs C was suffering a medical emergency, Ms D's delay amounted to a serious departure from the standard of care expected of a registered nurse in the circumstances.

I note that, as time passed and Mrs C's condition worsened, the need for medical assistance became more obvious. It is clear that during Mrs C's acute episode Resthome staff did not respond appropriately to her deteriorating condition. In my opinion this amounts to a failure by the Resthome to provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

Opinion: No Breach – Resthome

Arranging medical review on 12 February
I accept my expert advice that it was appropriate for staff to arrange for Dr A to see Mrs C on 12 February 2001, after she had vomited bile-stained fluid and it had become obvious that her condition was not improving. I also accept my expert advice that staff provided Dr A with adequate information regarding Mrs C's condition, although I note that it would have been helpful if they had also collected some of the vomit for Dr A to examine. Accordingly, the Resthome did not breach Right 4(1) of the Code in relation to this issue.

Arrangements for ambulance transfer
In my opinion staff at the Resthome took reasonable steps to provide services to Mrs C in accordance with her needs, in arranging her ambulance trip on the morning of 13 February 2001. Although Mrs C had specific communication needs, due to her profound deafness, I do not consider that it was necessary for the Resthome to have taken extra time to make special arrangements, given her very serious medical condition and the urgent need to have her transferred to hospital. In my opinion, the Resthome did not breach Right 4(3) of the Code in relation to this issue.

Other comments

Dr A's records
I note that at a late stage in my investigation Dr A provided me with clinical information that was not included in his notes, namely that:

- when he saw Mrs C she was not complaining of any pain and conveyed to him that she thought her vomiting was due to mushrooms she had eaten on 9 February;
- upon palpation, Mrs C's abdomen was not tender;
- Mrs C was not dehydrated or in any distress and had conveyed to him that her bowel motions were normal.

I draw Dr A's attention to the following passage from *Good Medical Practice: A Guide For Doctors* (Medical Council of New Zealand, 2000):

> "3. In providing care you must:
> …
> keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed."

Resthome's records
I note my expert advice that the nursing notes kept by staff at the Resthome were inadequate. I also note that some entries throughout the nursing notes are difficult to read, and some are virtually illegible. In an environment such as a rest home, where care is provided by a number of individuals often over a long period of time, adequate and accurate notes are vital to ensuring that care is co-ordinated and complete.

Actions

- I recommend that the Resthome:

  - apologise to Mrs B and the family for breaching the Code. This apology is to be sent to my Office and will be forwarded to Mrs B;
  - review its procedures for medical review of unwell residents and acute medical emergencies in light of my report;
  - ensure that its staff are aware of their obligations in regard to record keeping.

- A copy of this report will be sent to the Nursing Council of New Zealand, with a recommendation that the Council consider whether any further action should be taken in respect of Ms D.

- A copy of this report, with identifying details removed, will be sent to the Nursing Council and Residential Care NZ, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.
