Department of Corrections

Medical Officer, Dr C

Registered Nurse, RN D

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01703)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. Ms A was received into a corrections facility on 16 Month1[1] 2016. Ms A reported to staff at the Health Centre that she had been diagnosed with irritable bowel syndrome (IBS).

2. On 14 Month5, Ms A submitted a health chit. She wrote that she had a burning throat and a sore right ear, that she was unable to hold down food, and that she was very light-headed and feeling weak. She consulted with a nurse on 18 Month5, and reported having too much gas in her stomach. She also stated that sometimes she woke up with acid in her mouth. This information was relayed to the corrections facility's medical officer, Dr E, who charted Losec in response.

3. On 5 Month6, Dr E prescribed Mylanta for Ms A for break-through heartburn, and increased her dose of Losec. As with the previous occasion, this was done without reviewing Ms A.

4. Ms A submitted another health chit on 8 Month6. She wrote that she was still experiencing reflux and constantly felt bloated. She was seen by Dr E on 15 Month6 and was charted ranitidine, which decreases stomach acid production.

5. On 17 Month6, Ms A made a further request for review. She was seen by a nurse on 19 Month6. It is documented that the ranitidine was working, and that Ms A's reflux was reducing.

6. Health chits from Ms A on 22 and 25 Month6 refer to ongoing reflux symptoms. On 30 Month6, Ms A attended the nurses clinic as a walk-in. She reported feeling particularly nauseous at night and that she felt like vomiting when lying down. Ms A was commenced on metoclopramide.

7. On the morning of 2 Month7, Ms A presented again as a walk-in. She stated that she was feeling weak from reflux and vomiting. Her vital signs were normal, and she was asked to return in the afternoon for review.

8. Ms A returned for review later than anticipated, during the dinner medication round. She complained of feeling unwell, and of vomiting and being unable to tolerate food. However, she had normal vital signs, and when the nurse followed up with Ms A in the evening, Ms A reported that she had not vomited since the afternoon.

9. Ms A was seen by Dr C on 3 Month7. Dr C queried a diagnosis of labyrinthitis and charted prochlorperazine to treat her nausea.

10. On the evening of 4 Month7, Ms A informed RN D that she was vomiting frequently and that the vomitus contained black matter. RN D scheduled Ms A for a review in the nurses clinic the following day.

11. When Ms A attended the nurses clinic on 5 Month7, she was in a wheelchair and described her pain as "10/10". Her oxygen saturation level was 87%, and her temperature was 35.6°C. She was transferred to the Emergency Department at the public hospital for

[1] Relevant months are referred to as Months 1–8 to protect privacy.

immediate assessment. Further investigations revealed an advanced gastric cancer causing near complete or complete obstruction of the outlet to her stomach. Sadly, Ms A passed away in 2017.

Findings

12. Adverse comment is made about Dr E's management of Ms A on 5 Month6 and 15 Month6.

13. It was found that Dr C did not take adequate account of Ms A's symptom history, and did not perform an appropriate clinical examination. Accordingly, Dr C failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

14. RN D's response to Ms A's report of black vomitus was seriously deficient and lacked the required urgency. Accordingly, RN D failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

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

Recommendations

16. In accordance with a recommendation made in the provisional opinion, Dr C provided Ms A's family with a written apology for his breach of the Code.

17. The Deputy Commissioner recommended that RN D provide Ms A's family with a written apology.

18. In response to the recommendations made in the provisional opinion, Corrections provided evidence of staff training, and undertook to contract an independent nursing educator to provide nursing staff at the corrections facility with education on commonly presenting health conditions. Additionally, Corrections told HDC that it has commissioned an independent review to provide assurance around the corrections facility's health services.

19. The Deputy Commissioner recommended that Corrections provide a written apology to Ms A's family, and conduct an audit of the corrections facility's staff compliance with the "SOAPIE" (subjective, objective, assessment, plan implementation, evaluation) documentation format.

20. Corrections was referred to the Director of Proceedings.

Complaint and investigation

21. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her daughter, Ms A, by the Department of Corrections. The following issues were identified for investigation:

- *Whether the Department of Corrections provided Ms A with an appropriate standard of care in 2016.*
- *Whether Dr C provided Ms A with an appropriate standard of care on 3 Month7 2016.*
- *Whether RN D provided Ms A with an appropriate standard of care on 4 Month7 2016.*

22. This report is the opinion of Deputy Commissioner Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

23. The parties directly involved in the investigation were:

Ms A	Consumer (dec)
Mrs B	Complainant/consumer's mother
Department of Corrections	Provider
Dr C	Provider/locum medical officer
RN D	Provider/registered nurse

24. Information was also reviewed from:

Medical centre	Community medical practice
District Health Board	Provider
Dr E	Provider/medical officer
RN F	Provider/registered nurse
RN G	Provider/registered nurse
RN H	Provider/registered nurse
RN I	Provider/registered nurse

Also mentioned in this report:

RN J	Registered nurse

25. In-house clinical advice was obtained from general practitioner Dr David Maplesden (Appendix A). Independent expert advice was obtained from RN Kim Carter (Appendix B).

Information gathered during investigation

Introduction

26. The Department of Corrections (Corrections) has a duty to provide prisoners with primary health care, including general practitioner services, nursing, and basic dentistry. Prisoners are entitled to receive "reasonably necessary" medical treatment,[2] and the standard of health care must be "reasonably equivalent" to the standard of health care available to the public.[3]

27. This report relates to the care provided to Ms A (35 years old at the time of these events), at a corrections facility from her arrival at the facility until her hospitalisation in Month7.

The corrections facility's medical service

28. The corrections facility's Health Centre is run by registered nurses, who are on site from 7am until 10pm daily. Outside of these times, a nurse is available on call. At the time of these events, Dr E was contracted to provide general practitioner services to the corrections facility for 16 hours each week, spread over four days.

29. All new arrivals at the corrections facility undergo an initial medical assessment. Following the initial assessment, prisoners can request access to non-urgent health services verbally or by submitting a Health Request Form (also known as a "health chit"). Corrections' policy requires health chits to be cleared daily and actioned according to clinical need. The health chits are triaged by a registered nurse, and the prisoner is either booked in for the nurses clinic or referred to the medical officer. If a patient is triaged as non-urgent, the patient is required to be seen within seven days. While it is possible to be seen at the nurses clinic without an appointment, as a "walk-in", one of the registered nurses told HDC that "[i]n general clinics were always fully booked and extra walk ins were not accommodated unless presenting as unwell".

30. If a prisoner is acutely unwell and the nurse is not able to assist, the medical officer is called for advice or asked to attend. Alternatively, prisoners can be referred to the public hospital.

Initial assessment

31. Ms A was received into the corrections facility on 16 Month1. The health triage form noted that Ms A reported that she had been diagnosed with irritable bowel syndrome (IBS) four to five months previously. She was scheduled to undergo an initial health assessment with a registered nurse on 23 Month1, but this was postponed because of staffing shortages. Ms A had her initial health assessment on 26 Month1. RN I documented that Ms A weighed 90kg.

[2] Section 75(1) of the Corrections Act 2004.
[3] Section 75(2) of the Corrections Act 2004.

32. Four days after the initial health assessment, RN J reviewed Ms A in response to her complaint of stomach cramps and diarrhoea. RN J provided Ms A with Buscopan[4] in accordance with a standing order.[5]

33. On 31 Month1, Ms A attended her initial medical assessment with Dr E. The notes from this consultation state that Ms A had been prescribed Colofac[6] for IBS, and that there was no family history of note.

34. Ms A's notes from the medical centre were received by the corrections facility on 11 Month2. The notes indicate that in the months prior to her incarceration, Ms A had had a possible weight loss of 4–5kg.[7] The notes also show that Ms A had experienced epigastric pain and reflux symptoms between June and October 2015, and that she had developed abdominal pain and loose bowel motions in the six weeks prior to her incarceration. They further indicate that Ms A did not have a confirmed diagnosis of IBS, and detail a plan for further investigation.

Health chit — 14 Month5

35. On 14 Month5, Ms A submitted a health chit. She wrote that she had a burning throat and a sore right ear, that she was unable to hold down food, and that she was very light-headed and feeling weak. She documented that she had had these symptoms for seven days. A nurse triage appointment was booked for 18 Month5. According to the consultation notes, Ms A complained of having too much gas in her stomach, and sometimes woke up with acid in her mouth. Ms A was referred to Dr E for an assessment.

36. On 25 Month5, Dr E charted Losec[8] 20mg twice daily in response to communication from a nurse regarding Ms A's complaint of heartburn. Dr E told HDC:

> "It is only in certain situations that I chart medications to prisoners without seeing them. In this situation [Ms A] had requested [via the nurse] the medication by name, had a known condition, and I saw from her GP notes that she had taken it previously with good effect."

37. Dr E also noted that Losec is available over the counter.

[4] Used to ease stomach and bowel cramps.
[5] A written instruction issued by a medical practitioner, dentist, nurse practitioner, or optometrist. It authorises a specified person or class of people (eg, paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs. The intention is for standing orders to be used to improve patients' timely access to medicines — for example, by authorising a paramedic in an emergency or a registered nurse in a primary healthcare setting.
[6] Used to alleviate some of the symptoms of irritable bowel syndrome by relaxing the muscles in and around the gut.
[7] Her weight was recorded as 95.7kg on 8 Month1, and she had reported on that occasion that a few months previously she had weighed approximately 100kg.
[8] Slows or prevents the production of acid within the stomach.

38. Dr E stated that on 5 Month6 she was asked by a nurse to chart Mylanta[9] for Ms A, as she was experiencing break-through heartburn. Dr E charted Mylanta 30ml four times a day as required, and increased Ms A's dose of Losec to 40mg. As with the previous occasion, this was done without reviewing Ms A. Dr E explained that she did so because Mylanta is available over the counter, and heartburn is a common issue. She also noted that Ms A had IBS, which "goes hand in hand with heartburn".

39. Dr E stated:

> "It was not uncommon to deal with a patient's problem without seeing them, relying on nurses to monitor progress and report back. There was no option in many cases when it was impossible to physically see a patient. Though hardly ideal, it was preferable to doing nothing about a situation."

Health chit — 8 Month6

40. Ms A submitted another health chit on 8 Month6. She wrote:

> "Current medication is OK. Still experiencing reflux and stomach constantly feels bloated affecting my eating. I've kept away from certain foods but [it is] still not working. Can I please see [a] doctor."

41. RN G reviewed the health chit, and noted that Ms A was booked in for an appointment with a nurse for a smear on 10 Month6. A review of Ms A's reflux issues was added to that appointment. Ms A told HDC that when she attended the appointment, it was confirmed that she did not require a smear. Ms A said that there was no mention of her reflux. The notes for this consultation state only that the smear was declined.

42. On 15 Month6, Ms A consulted with Dr E regarding her ongoing heartburn. Dr E stated: "She did not complain of pain or vomiting, it was simply acid reflux. Acid reflux co-exists with IBS as both relate to the gut, and are known to be exacerbated by stress." Dr E ordered a blood test to exclude a bacterial infection, and charted ranitidine.[10] Her notes record an intention to review Ms A in a week's time.

Health chit — 17 Month6

43. On 17 Month6, Ms A made a further request for review. She wrote on the health chit that the ranitidine was causing more burping and reflux, which was burning her throat. Ms A also wrote that she had had no sleep and no food.

44. Ms A was seen by RN I on 19 Month6. RN I documented that the ranitidine was working, and that Ms A's reflux was reducing. Dr E told HDC that she assumed from this information that the reflux was under control, and as the blood test had returned normal, she considered that there was no need for a further review unless specifically requested by Ms A .

[9] Provides relief from heartburn, acid indigestion, or gas.
[10] Used to reduce the amount of acid in the stomach.

Health chits — 22 and 25 Month6

45. On 22 Month6, Ms A requested medical attention for ongoing reflux. She wrote: "Current pills have taken away bloatedness but still experiencing reflux and burning throat. Still uncomfortable when sleeping." The chit was received on 24 Month6, and an appointment was booked for nurse triage on 27 Month6.

46. On 25 Month6, Ms A submitted a further health chit, which stated: "Please I need to see the doctor ASAP as I'm unable to still eat much and my reflux is getting worse." It was noted that Ms A was already booked into the nurses clinic on 27 Month6.

47. Corrections told HDC that Ms A was not able to be seen on 27 Month6 owing to time constraints, and the appointment was deferred until 31 Month6. Corrections explained that time constraints are usually caused by issues such as overbooking, a lack of custodial support, or incidents requiring immediate response. The cause of the time constraint on this occasion is not known.

48. On 30 Month6, the Health Centre Manager, RN F, documented a request from Ms A's relative for Ms A to be seen by a doctor rather than a nurse. RN F noted that Ms A would be seen by a doctor as she had been prescribed medication and required a review. An appointment with the doctor was booked for 1 Month7. RN F stated that she prioritised the patient on the medical officer's appointment list by writing "URGENT" on the booking.

49. Later that day, Ms A was seen by RN G as a walk-in. Ms A complained that her medications were not working and that she was still vomiting. She reported feeling particularly nauseous at night, and that she was having difficulty sleeping as she felt like vomiting when lying down. RN G commenced Ms A on metoclopramide[11] in accordance with a standing order. RN G stated:

> "I should have documented her vital signs, such as blood pressure and [temperature, pulse, and respiration] and undertaken a physical examination that would have captured more objective data and undertaken a more comprehensive clinical assessment. I accept that I only addressed her presenting issue instead of getting a more holistic picture of what was happening around her case. I was influenced by the fact that [Ms A] would be having a full medical review of presentation and medication by the doctor the next day."

50. Ms A was seen again in the nurses clinic on 31 Month6. Ms A spoke of having sleep disturbance due to reflux, and mentioned that she had lost her appetite. RN K documented a plan for Ms A to continue with her prescribed medication until her doctor's review the following day.

51. However, Ms A was not seen by the doctor on 1 Month7, and her appointment was rebooked for 6 Month7. RN F stated that it was standard practice for the clinic nurse who

[11] Used to relieve nausea and vomiting.

rebooked a patient to annotate the reason why the patient was not seen, and the reason for rebooking, but in this case it was not done. RN F stated:

> "The medical review did not occur, and the appointment was rebooked to 6 [Month7] without a reason given for the rebook … the nurse would have gone in retrospectively through the computer list and rebooked anyone who the doctor did not see. At that time the rebooking nurses have no detail other than what is in the system or handed over to them by the GP or custodial officer organising the movements."

52. At 9.23am on 2 Month7, Ms A presented as a walk in. She said that she had not been eating or drinking, that she was feeling weak from reflux and vomiting, and that she had not been getting any sleep. An RN recorded Ms A's vital signs as normal, and advised Ms A to return for review at 3pm. The RN also completed an "Advice of Prisoner Health Status Form", requesting that custodial officers observe Ms A for any signs of illness or any other concerns. Ms A was booked to see the doctor on 3 Month7.

53. RN H, who was on the afternoon shift for the low security area, stated that a verbal handover occurred between 1.30pm and 2pm. RN H told HDC that she was asked to review Ms A and check her vital signs on the night medication rounds, which is "routine for patient follow-up between the [two] shifts".

54. RN H said that she had started to administer dinner medications when Ms A presented for review at 3.45pm (rather than the 3pm time as organised). RN H stated: "Currently, consultation during medication is highly discouraged to avoid delays on administration, avoid medication errors and to utilise medical chits to the maximum to emphasise consistency of approach with all patients requesting to be seen." RN H also stated that the medication administration dinner round needed to be completed by 4pm, as it could be done only in the presence of a custodial officer. RN H said:

> "I still did my best to carry out the verbal handover by the morning clinic nurse, to see [Ms A] for repeat vital signs follow-up through the night rounds. I sat with her, recorded her vital signs, asked her concerns and documented all that she expressed."

55. According to the notes, Ms A complained of feeling unwell, vomiting, and being unable to tolerate food. RN H recorded that Ms A looked "unwell and sluggish", but had normal vital signs.

56. RN H told HDC that she did not carry out an abdominal examination (inspection, auscultation, palpation, and percussion) because she saw that Ms A's condition was the same as it had been in the morning, and she noted that Ms A had walked to the clinic unaccompanied and did not appear to be in pain. RN H further stated that she was under time pressure to complete the dinner medication round, and that a rushed abdominal examination would risk not revealing accurate information. She said that auscultation alone would take at least five minutes. RN H stated:

> "I was aware she had IBS based on the Reception Health Triage (RHT) and Initial Health Assessment (IHA) record. The current presenting symptoms based on the daily notes and classification suggested IBS."

57. RN H asked Ms A to continue taking metoclopramide, and followed up with Ms A at 7.30pm, during the night medication round. The notes state that Ms A reported that she had not vomited since that afternoon. RN H told HDC that this was reassuring information, and she noted that Ms A was already booked in to see the doctor the following day.

Dr C's review

58. Ms A was seen by Dr C, a general registrant whom Dr E had engaged as her locum,[12] on 3 Month7. Dr C recorded the following:

> "Nausea and vomiting when she lies down for the past five weeks
> … Difficult keeping food and fluids down
> [Diagnosis] ? Inner ear issue/infection
>
> Plan
> Check bloods
> Add stemetil[13] (prochlorperazine) regularly."

59. Dr C noted that Ms A did not have great weight loss, and no mass or abdominal pain. Dr C stated that he was aware of Dr E's working diagnosis, and considered labyrinthitis[14] as a differential diagnosis. He told HDC:

> "I did not exclude gastroesophageal reflux and my differential diagnosis was an additional possibility pending further investigations which I ordered. I regret that my documentation did not reflect this clearly."

60. Dr C also said that he recommended regular nursing review and monitoring of Ms A's physical state. There is no written record of these instructions.

4 Month7

61. During the night medication round on 4 Month7, RN D administered Ms A her first dose of prochlorperazine. Ms A informed RN D that she had been vomiting frequently, and that it was worse when lying down. RN D documented that Ms A reported no particular pain, but had nausea and associated discomfort in her lower abdominal muscles. RN D also wrote: "[D]escribes the vomitus as being 'black' suggesting it contains blood."

62. RN D told HDC:

[12] A person who temporarily fulfils the duties of another.
[13] Used to treat nausea.
[14] Inflammation of the labyrinth of the inner ear.

> "In order to perform a physical examination on [Ms A] I would have to obtain permission from the Prison Director or her Deputy to formally unlock the cell for purposes other than medication administration and bring her to the Health Unit. This is something that is done when the patient's condition is assessed as being acute, for example, chest pain, acute abdominal pain, labour, or severe difficulty breathing …
>
> With [Ms A], meeting her for the first time, I did not feel that her report of previous vomiting was immediately life threatening, judging from her calm demeanour and absence of any dark stained vomitus for me to observe. I decided to review her notes back in the Health Unit before deciding on a course of action … had [Ms A's] overall presentation appeared any more acute, e.g. actual evidence of dark-stained vomiting which may have suggested haematemesis,[15] or more acute abdominal pain, then most certainly I would have gone back to the Health Unit to obtain equipment to record her temperature, blood pressure, pulse, respirations, O_2 saturations."

63. RN D scheduled Ms A for review in the nurses clinic the following day. RN D advised Ms A to raise her pillow with rolled-up clothes to avoid lying flat, and to sip water with some salt and sugar added.

Transfer to hospital

64. On 5 Month7, Ms A presented to the nurses clinic in a wheelchair. RN I documented that Ms A appeared unwell, was crying intermittently, and described her pain as "10/10". Of note, Ms A's oxygen saturation level was 87%,[16] and she had a temperature of 35.6°C.[17] RN I further documented that Ms A had waves of pain and constriction in her chest. RN I told HDC that she contacted the public hospital and made the necessary arrangements for Ms A to be transferred to the Emergency Department for immediate assessment.

65. Further investigations at the public hospital revealed an advanced gastric cancer causing near complete or complete obstruction of the outlet to Ms A's stomach. Surgery was undertaken on 9 Month7 but, unfortunately, complete resection of the cancer was not possible, and Ms A was commenced on a palliative chemotherapy regimen.

66. Sadly, Ms A passed away in 2017.

Further information

Dr E

67. Dr E stated:

> "On both occasions that I met with [Ms A] she did not present with any symptoms that alerted me to anything more sinister that would have been suggestive of gastric cancer. She did not at any stage present with epigastric [pain], early satiety, feeling of fullness, vomiting or vomiting blood, all of which are symptoms of gastric cancer."

[15] Vomiting of blood.
[16] Normal blood oxygen levels range from 95% to 100%.
[17] Normal body temperature is around 37°C.

Dr C

68. Dr C told HDC that he has reviewed his practice and sought peer review and collegial support within the service, and has taken steps to improve his documentation.

RN H

69. RN H stated that the daily bulk of health chits results in overbooking, rebookings, and delays in seeing the person owing to time constraints. Additionally, there is the difficulty of managing prisoners who present to health clinics as "walk ins".

70. RN H further stated that delays in seeing patients can arise for a number of reasons, such as code blue break calls for emergencies, and difficult movements brought about by complex situations, e.g., remand prisoners not being permitted to go together with sentenced prisoners, or patients who need maximum security requiring three escorts to go to medical.

RN D

71. RN D told HDC that she regrets not mentioning her concern for Ms A to her nurse colleague who was based in the high security section that afternoon/evening, as it is possible that she may have been familiar with Ms A and noticed deterioration in her condition. RN D stated that this experience has heightened her awareness of the importance of comprehensive patient assessment and detailed history-taking. She reflected:

> "Reliance on subjective appearances and lack of immediate evidence of haematemesis is not sufficient information on which to base a decision as to the urgency of the patient's condition and the appropriate care response, regardless of the perceived environmental or clinical constraints. Urgent medical advice and referral must always be sought and made in the patient's best interests."

Corrections

72. Corrections acknowledged that Ms A's medical records from her community medical centre were not reviewed in a timely manner, and that it is best practice for comprehensive assessments, including physical examinations, to be undertaken when clinically indicated.

73. RN F told HDC that since the events in question, a number of changes have been made to the corrections facility's health service, including the following:

- There is an updated process for new arrivals and for requesting and reviewing GP notes. There is a form for Health Administrators to use to follow up on GP notes to ensure it is done in a timely manner. Compliance is audited weekly.

- The nursing team leader now reviews the nurses' clinical documentation prior to booking from the medical officer booking spreadsheet onto the medical officer's appointment tab.

- An assessment and documentation audit of each nurse on site was completed in August 2017 with a 12-week documentation coaching plan initiated for nursing staff who did not meet expected standards for documentation.

- The Medicines Management Policy has been updated to reflect changes to the Standing Orders Policy, with education and competence requirements for registered nurses for each standing order, and regular audits to ensure compliance with regulations and expected standards of practice. At this time, only emergency standing orders are utilised, with a plan to introduce approved standing orders once nurses are deemed competent to administer them. Audits have been undertaken for nurses who administered standing orders in the six months prior to the change in standing order policy.

- Along with ongoing training, nurses are prompted to use the SOAPIE (subjective, objective, assessment, plan, implementation, evaluation) format for clinical documentation, and the PQRST (provocation/palliation, quality, region/radiation, severity, time) format for pain assessment through reminders in the nursing consultation rooms.

- A daily clinical discussion format has been implemented to discuss patients at handover and follow them through until they no longer require oversight. The minutes are typed up daily and forwarded to all health staff at the corrections facility. The complex cases are then reflected in the Health Centre Manager's report to be escalated to the Prison Director and Regional Governance Team.

- There are now two contracted medical officers providing 20 hours of service over three days a week.

- Other staff increases include two additional nurses and the appointment of another Clinical Quality Assurance Advisor, and administrative support for the senior advisor of health to assist with weekly reporting of targeted practice improvement initiatives. Approval has been obtained to recruit an assistant Health Centre Manager, and a nurse practitioner.

- Corrections has a contract with a community medical facility where patients are sent for urgent but non-emergency medical concerns.

- The medical officer and the doctor's clinic nurse now review the patient list prior to commencing the clinic so that urgent patients are prioritised. The nursing team leader or delegated nurse reviews the doctor's clinic appointment tab as well as the wait list for the doctor through the week, to ensure that patients are prioritised and booked appropriately, reflecting their urgency and their wait times.

74. Dr E and Dr C are no longer contracted by Corrections to provide medical services.

75. RN D, RN J, RN K, and RN I are no longer employees of Corrections.

Responses to provisional opinion

76. Mrs B was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. Mrs B expressed her concerns that staff at the corrections facility did not respond to Ms A's ongoing symptoms adequately, and detailed the impact this has had on Ms A's family. Mrs B stated: "Whether a prisoner or not, no one in this modern day and age of advanced medicine, should endure and suffer the trauma and consequence that [Ms A] did."

77. Dr E, Dr C, RN D, and Corrections were provided with the opportunity to comment on relevant parts of the provisional opinion. Their responses have been incorporated into the report as appropriate.

78. Corrections told HDC that it accepts the provisional findings and has commissioned an independent review to provide assurance around the corrections facility's health services. Corrections also told HDC that all Health Centres in the North Region are now able to access a clinical information sharing service that collates results from district health boards, community laboratories, community radiology providers, and community pharmacists. The clinical information sharing service is accessible to all approved Corrections Health Services staff nationwide, which includes all nursing staff at the corrections facility. Health information is therefore more readily available to staff at the corrections facility.

Opinion: Dr E — adverse comment

79. Dr E was the medical officer contracted to provide general practitioner services to prisoners at the corrections facility.

80. On 25 Month5, a nurse alerted Dr E to Ms A's two-week history of heartburn, and Dr E prescribed Losec 20mg twice daily in response. Ms A continued to report her reflux symptoms to nursing staff. On 5 Month6, Dr E prescribed Mylanta to Ms A and increased the dose of Losec to 40mg twice daily. Dr E did not review Ms A on either of these occasions. On 15 Month6, Dr E saw Ms A regarding the persistence of her reflux symptoms, and added ranitidine to her anti-reflux therapy. Dr E also ordered a blood test and planned to review Ms A in a week's time. The review did not occur, as nursing notes gave Dr E the impression that Ms A's symptoms were responding to ranitidine.

81. My in-house clinical advisor, Dr David Maplesden (a general practitioner), advised that best practice would have been to examine Ms A before prescribing Losec on 25 Month5. However, Dr Maplesden commented that he was "not particularly critical" of Dr E's management on this date, having regard to the nature and short duration of Ms A's reflux

symptoms, their known association with IBS, the fact that she was being reviewed regularly by nursing staff, and the fact that she had been prescribed the same medication previously. Dr Maplesden noted that Ms A did not report any red flag symptoms, such as vomiting, haematemesis, unintentional weight loss, rectal bleeding, nocturnal symptoms, a family history of gastrointestinal cancer, inflammatory bowel disease, or coeliac disease.

82. Dr Maplesden advised that even though there were no obvious additional red flags evident on 5 Month6, he still considers that a review ought to have occurred. He noted that Ms A had not been reviewed since the development of her reflux symptoms, and she had experienced three weeks of reflux symptoms that had failed to respond to "a reasonable dose" of Losec. He advised that he would have also expected the decision to increase the dose of Losec and its rationale to be recorded in the notes. Dr Maplesden concluded that he was mildly critical of Dr E's management on this occasion.

83. With regard to Dr E's review on 15 Month6, Dr Maplesden noted that Dr E reported that Ms A complained only of reflux symptoms (no abdominal pain or vomiting). Dr Maplesden stated:

> "I feel a more thorough clinical assessment (check of weight, abdominal palpation) was also warranted given the atypical situation of a patient with recent onset dyspepsia requiring such rapid escalation of therapy because standard treatment was ineffective."

84. Dr Maplesden viewed the standard of assessment as a mild to moderate departure from the accepted standard of care.

85. I accept Dr Maplesden's advice, and am critical that Dr E did not review Ms A on 5 Month6, given that she had not been reviewed since the development of her reflux symptoms, and her symptoms had failed to respond to a reasonable dose of Losec. I am also critical that Dr E did not undertake a more thorough clinical assessment of Ms A on 15 Month6. However, I note that Ms A did not appear to have raised any known "red flag symptoms", and I consider this to be a mitigating factor. I also note that Dr E planned to review Ms A for signs of improvement following the 15 Month6 review, but that this was considered unnecessary given reports of her improvement with ranitidine.

Opinion: Dr C — breach

86. Dr C was providing locum cover for Dr E when he reviewed Ms A on 3 Month7, seven weeks after the reported onset of her reflux symptoms at the corrections facility. Dr C documented that Ms A had a five-week history of nausea and vomiting on lying down. He also noted that Ms A had difficulty keeping down food and fluids. Dr C made a differential diagnosis of labyrinthitis and ordered a blood test. He also prescribed Ms A

prochlorperazine. Dr C told HDC that he also took into account the absence of abdominal pain or "great weight loss".

87. Dr Maplesden advised:

> "The history recorded by nurses, [Dr E] and on [Ms A's] health chits referred to symptoms clearly suggestive of persistent gastro-oesophageal reflux which was worsening despite maximal therapy. I could find no reference to symptoms of dizziness, vertigo, loss of balance, hearing distortion or tinnitus to suggest inner ear pathology. It was noted that [Ms A's] nausea, vomiting and throat burning were worse when she was lying flat, but when the overall symptom history is considered … it was not reasonable to consider a diagnosis of inner ear pathology above that of persistent treatment-resistant gastro-oesophageal reflux. [Dr C] does not describe what physical findings supported his diagnosis, and there are no physical assessment findings documented in his notes of 3 [Month7]."

88. Dr Maplesden noted that Dr C appropriately ordered further investigations and prescribed symptomatic treatment, which he considers are mitigating factors. However, Dr Maplesden remains of the view that there was insufficient justification for the diagnosis reached by Dr C. Dr Maplesden concluded that Dr C's care departed from accepted standards to a moderate degree.

89. I accept Dr Maplesden's advice that it was not reasonable to diagnose an inner ear pathology above that of persistent treatment-resistant gastro-oesophagael reflux. There is no indication from the clinical notes or in Dr C's responses to HDC that his suspicions were supported by a physical assessment, and it appears that the diagnosis of labyrinthitis was largely based on Ms A's report that her symptoms became worse on lying down. Based on the evidence before me, I find that Dr C did not adequately take into account Ms A's symptom history, and did not perform an appropriate clinical examination. Accordingly, I find that Dr C failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[18]

Opinion: RN D — breach

90. On the evening of 4 Month7, RN D administered Ms A her first dose of prochlorperazine. Ms A informed RN D that she had frequent vomiting that worsened on lying down. RN D documented that Ms A reported no particular pain, but had nausea and also discomfort in her lower abdominal muscles. RN D recorded that Ms A described having black vomitus, which was suggestive of containing blood. RN D did not perform a physical examination or take any observations. She told HDC that she would have had to obtain permission to unlock the cell for purposes other than medication administration, and she did not

[18] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

consider that Ms A's vomiting was immediately life-threatening. RN D stated that she did not observe any dark-stained vomitus at the time. She acknowledged in retrospect that this was not sufficient information to form a view about the urgency of Ms A's condition.

91. Expert advice was obtained from RN Kim Carter. RN Carter advised:

> "In any clinical setting, it would be expected that an RN would identify haematemesis (or suspected haematemesis) as a red flag — an urgent and potentially life threatening situation. Any RN would be expected to be able to assess at a minimum, the frequency, volume and nature of the vomiting. Any RN would be expected to complete at a minimum, important relevant basic observations, for example blood pressure and a heart rate. Whilst in general, detailed and diagnostic abdominal examination may fall outside the scope or abilities of RNs, I would expect a primary health care RN to be able to palpate and auscultate a patient's abdomen to assess for signs of pain, bowel sounds, rebound or guarding which provides critical information to assist decision making about the urgency and the response required. Throughout this episode, a distinct lack of urgency was displayed by the RN in their response to suspected haematemesis, particularly within the context in this case and [Ms A's] history.
>
> The lack of adequate assessment, physical examination and urgent response is an extremely significant departure, and falls well below accepted practice standards."

92. I find it unacceptable that despite appearing to recognise the possibility of haematemesis, RN D did not take appropriate steps to exclude a potentially life-threatening condition. I agree with RN Carter's advice that RN D's response to Ms A's report of black vomitus was seriously deficient and was lacking in urgency. Accordingly, I find that RN D failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: Department of Corrections — breach

93. Under section 75 of the Corrections Act 2004, prisoners are entitled to receive medical treatment that is "reasonably necessary", which must be "reasonably equivalent" to the standard of health care available to the public. The Code also requires Corrections, as a healthcare provider, to operate its health service in a way that provides consumers with services of an appropriate standard.

94. As detailed below, there were a number of deficiencies in the care provided to Ms A following her arrival at the corrections facility. These relate to a lack of appropriate assessment and physical examination, inconsistent documentation, and poor coordination of care. This is particularly concerning given that Ms A, as a prisoner, did not have the same choices or ability to access health services as a person living in the community, and

was entirely reliant on staff at the health centre for adequate monitoring, treatment, and escalation of her health concerns.

95. Staff at the corrections facility individually and as a team failed to act on Ms A's continued discomfort and escalating symptoms. While individual providers are responsible for their deficiencies in care, in my view the pattern of failures by multiple nurses involved in Ms A's care is indicative of broader systems issues at the corrections facility.

96. My expert advisor, RN Carter, advised that a physical examination ought to have occurred on each of the following occasions:

- At the initial health assessment on 26 Month1, once it was identified that Ms A had a long-term condition (IBS). A basic physical assessment in the context of IBS would include abdominal palpation and auscultation. RN Carter considers this to have been a moderately significant departure from accepted practice.

- Prior to the supply of Buscopan under a standing order on 30 Month1. This is also viewed as a moderately significant departure from accepted practice.

- When Ms A repeatedly reported a range of symptoms over the period between 14 Month5 and 3 Month7. The only documented observations over this period are two blood pressure readings and one weight on 2 Month7. RN Carter advised that it would be usual practice for registered nurses to perform a basic examination of at least an abdominal palpation and auscultation of bowel sounds. Additionally, the notes provide minimal evidence of Ms A being asked specific questions about her symptoms, such as frequency and onset, specific food/fluid intake, urine output, bowel motions, and the presence of other symptoms such as pain, discomfort, fevers, chills, nausea, vomiting, and dark-coloured stools. RN Carter stated: "The lack of assessments and physical examinations is a highly significant departure from accepted practice."

- On the evening of 4 Month7, when Ms A complained of having black vomitus. RN Carter viewed the failure to follow this up appropriately as an extremely significant departure.

97. Additionally, RN Carter advised:

- When consulted by Ms A regarding her IBS symptoms, RN J ought to have made attempts to obtain more information about Ms A's regular medications. This information could then have been utilised by Dr E when she saw Ms A the following day. At this point, the corrections facility had yet to receive Ms A's notes from her community medical practice. RN Carter stated:

> "In primary health care, it is not unusual that new patients may present for care before their previous records are received. However, it is usual practice for a

clinician to recognise this and attempt to establish what the regular medications are as appropriate to the presenting symptoms."

RN Carter views the lack of follow-up about regular medications as a moderately significant departure from accepted practice.

- On 11 Month2, Ms A's notes were received from her previous practice. The notes were scanned into the practice management system but there is no evidence that they were reviewed. RN Carter noted that the very first page of the notes states that Ms A's IBS symptoms were not controlled, and that a confirmed diagnosis of IBS had yet to be made. The notes outline a plan to continue further investigations of Ms A's longstanding weight loss, pain, and diarrhoea. RN Carter commented that this ought to have alerted staff that a more complex plan of care was required. RN Carter views the lack of formal review of the records as a highly significant departure from accepted practice.

- The notes show an inconsistent approach to nursing documentation. It is standard practice for consultation notes to follow a format such as SOAP (subjective, objective, assessment, and plan). This is a minor departure from the standard of care.

- Entries made by registered nurses contain little, if any, reference to consultations or issues documented by colleagues, suggesting that there was little interaction between the team. There appears to have been no awareness from individual registered nurses that Ms A had requested assistance nine times in seven weeks, that treatment had had little effect, and that Ms A's symptoms had escalated. RN Carter views this lack of a "helicopter view" as a highly significant departure from accepted practice. RN Carter is also critical that Ms A's appointment with the medical officer on 1 Month7 was cancelled, given the length of time Ms A had been waiting for review, and the fact that registered nurses had deferred further actions in light of that appointment.

98. RN Carter commented:

"[I]t would be almost impossible for multiple RNs, at the same time, to all demonstrate the same lack of awareness, consistently poor health assessment and physical examination skills, and inadequate care coordination. The actions and inactions of the staff involved evidence in this situation a faulty system at work as well as individual failings."

99. As further indications of system faults at the corrections facility, RN Carter also pointed to the inconsistent documentation format, poor new patient process, lack of care coordination processes, and missed opportunities to provide appropriate interventions.

100. I share RN Carter's concerns regarding the nursing care provided to Ms A. It is unacceptable that nursing staff consistently omitted to carry out appropriate and timely assessments (including physical examinations), particularly when Ms A reported a range of gastrointestinal symptoms that increased in frequency and severity over time. I agree that

further information should have been obtained from Ms A during nursing reviews, and that no registered nurse appears to have looked at the overall picture, despite Ms A raising health concerns on a number of occasions. I am concerned at the lack of critical thinking by staff in this respect.

101. RN Carter's impression of the corrections facility's Health Centre as a "sometimes chaotic appearing under-resourced health service" is supported by the time pressures and staffing shortages described by nursing staff in their responses to HDC, and the cancellations of Ms A's scheduled nursing and medical reviews on 23 Month1, 27 Month6, and 1 Month7.

102. It is clear to me that Corrections did not provide medical treatment that was "reasonably necessary", and that the standard of health care at the corrections facility was not "reasonably equivalent" to the standard of health care available to the public. Given the factors outlined above, I consider that there was an overarching service failure in this case. I also consider that the number of failings in the care provided to Ms A is indicative of an environment that did not adequately support its nursing staff to do what was required of them.

103. For the reasons above, I am of the view that Corrections failed in its responsibility to ensure that Ms A received services of an appropriate standard. Accordingly, I find that Corrections breached Right 4(1) of the Code.

Recommendations

104. In response to a recommendation in my provisional report, Dr C provided Ms A's family with a written apology for his breach of the Code.

105. I recommend that RN D provide Ms A's family with a written apology for her breach of the Code. The apology should be sent to HDC within three weeks of the date of this report, for forwarding.

106. I note that the Nursing Council of New Zealand has undertaken a competence review of RN D.

107. In response to recommendations made in my provisional opinion, Corrections has:

a) Provided evidence of staff training in relation to comprehensive history taking, health assessment, and physical examinations.
b) Undertaken to contract an independent nursing educator to provide nursing staff at the corrections facility with case-study based education on a range of commonly presenting health conditions, with a focus on providing further structure and format for identifying presenting signs and red flags.

108. Following consideration of the remedial actions undertaken by Corrections, I recommend that it undertake the following additional actions:

a) Provide a written apology to Ms A's family for the failures identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding.
b) Conduct an audit of the corrections facility's staff compliance with the "SOAPIE" (subjective, objective, assessment, plan, implementation, evaluation) documentation format. The results are to be provided to HDC within three months of the date of this report.
c) Report back to HDC on the outcome of its education programme referred to above, within three months of the date of this report.

Follow-up actions

109. The Department of Corrections 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.

110. A copy of this report with details identifying the parties removed, except the corrections facility, the Department of Corrections and the experts who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN D's name.

111. A copy of this report with details identifying the parties removed, except the corrections facility, the Department of Corrections and the experts who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name.

112. A copy of this report with details identifying the parties removed, except the Department of Corrections and the experts who advised on this case, will be sent to the Office of the Ombudsman, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

113. The Director of Proceedings decided not to issue proceedings.

Appendix A: Independent GP advice to the Commissioner

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

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs B] about the care provided to her daughter, [Ms A], by staff of the health facility at [the corrections facility]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file including: complaint from [Mrs B] per NH&DAS; response from Department of Corrections and [the corrections facility]; comment from [the DHB]; clinical notes [the corrections facility]; [DHB clinical notes]; clinical notes [the medical centre].

2. [Mrs B] complains about delays in the diagnosis of her daughter's gastric cancer. She states her daughter experienced distressing symptoms associated with the cancer for about seven weeks prior to finally being referred to hospital for appropriate investigation. [Ms A] was in [the corrections facility] at the time and frequently reported her symptoms to nursing staff there, and was reviewed by GPs who failed to consider the diagnosis. On 5 [Month7] [Ms A] was transferred urgently to [the public hospital] with abdominal pain and vomiting, including recent haematemesis. [The DHB] comments include: *Investigations revealed an advanced gastric cancer causing near complete or complete obstruction of the outlet to her stomach. She had a strong family history of gastric cancer.* Surgery was undertaken on 9 [Month7] but unfortunately complete resection of the cancer was impossible and [Ms A] was commenced on a palliative chemotherapy regime with prognosis expected to be in the region of six months. The surgeon completing the DHB comments felt it was likely the cancer had been present for a number of months, with symptoms related to impairment of gastric emptying likely to have been present *for perhaps a couple of months. It is, however, unlikely that surgery in the last six months would have been able to treat the disease at a point which would allow cure. Unfortunately gastric cancer, by the time it causes symptoms, generally is at a stage which is incurable by surgery or chemotherapy.*

3. Response Department of Corrections

(i) In response to policy reasons for refusing [Ms A] access to her own general practitioner, there is nil record of such a request being made to Health staff prior to patient's hospitalisation.

(ii) In response to the reference of a two-day delay in transferring [Ms A] to the public hospital, the summary of events has been provided from 03 [Month7] to 05 [Month7] which indicate all actions that were taken in response to presenting symptoms (see table below).

(iii) In response to what is now being done to ensure [Ms A] receiving timely, appropriate healthcare, [Ms A] was looked after by a multi agency team which included [the corrections facility] Health and Custodial staff, [the] Hospice, [the DHB] and [another] DHB. Additional agency staff had been placed to cover night shifts for Controlled Medication administration as well as a Health Care Assistant in the mornings to assist as required.

(iv) [Ms A] was reviewed by registered nurses daily during morning and afternoon medication rounds as well as when called by [Ms A] which is reflected in the daily record provided. Any concerns regarding [Ms A] [were] discussed with the GP and/or [the] Hospice nurse. Medications were reviewed by the site GP and [the] Hospice nurse as symptoms progressed. During the night, an agency nurse was based in the House where [Ms A] resided to be at hand for any medical concerns. An End of Life Care plan was developed and updated with any changes to patient care and this is included in the documents provided. Regular monitoring was done on [Ms A] which is evidenced in the medical notes provided.

(v) [The corrections facility] medical Team consists of 1 GP and 15 registered nurses of which 1 is the nursing Team Leader and 1 is the Health Centre Manager. All of the nurses hold current NZ practising certificates. We have cared for two terminally ill patients in the past one of which was in 2013 and the other in 2014. Our nurses have ongoing professional development mainly focusing on Primary Care Health needs such as pharmacology, nursing assessment, diabetes management, asthma management, Mental Health, Pre Hospital Emergency Care etc. Some of our nurses have also completed Post Graduate Nursing qualifications including one who completed her Masters. While we mainly focus on Primary Health Care needs of our population, we have access to external providers that come on site and attend to our patients receiving palliative care as would happen in a community setting.

4. Timeline provided by [the corrections facility] (my comments as italics or footnotes following review of notes, and content of timeline verified against clinical notes).

Date	**Task**	**Action**	**Outcome/Comment**
16 [Month1]	[RN]	Received on site at 1615hrs [Ms A] reported that she had been diagnosed with Irritable Bowel Syndrome (IBS) 4–5 months prior and had been on medications (Norpress and 'another one for stomach'). She reported that she did not	— RN triaged her as a priority 3 (Routine followup) — [Ms A] booked for an Initial Health Assessment on the nurse clinic on 22 [Month1] and an Initial Medical Assessment with the doctor on 31 [Month1]. — Diet recommendation was to be sent on confirmation of IBS on

		tolerate bread due to her IBS.	receipt of [Ms A's] GP notes.
22 [Month1]	[RN]	Initial Health Assessment with the nurse cancelled due to staffing shortages.	Appointment rebooked to 26 [Month1].
23 [Month1]	[RN]	— Medical chit received[1] where [Ms A] reported that she had IBS and she needed Norpress and a special diet as she was unable to eat certain food.	Booked appointment on 26 [Month1] updated to reflect additional issues.
26 [Month1]	[RN]	[Ms A] was seen for an Initial Health Assessment, IBS and medications. She reported that she took Norpress for IBS. On assessment, [Ms A's] **weight was 90kg**, BMI of 28.41 and BP of 92 systolic and 63 Diastolic.	RN followed up with a request for GP notes.
30 [Month1]	[RN]	[Ms A] assessed for complaint of IBS overnight due to eating bread. [Ms A] reported to have experienced diarrhoea and stomach cramps overnight.	RN noted that [Ms A] was booked for the GP the following day and commenced Buscopan as per standing order and gave an off work certificate for a day.
31 [Month1]	[RN]	[Ms A] was assessed by the GP *(see section 6)*.	— Commenced on Colofac for IBS. — Diet recommendation sent to the kitchen for exclusion of bread from [Ms A's] diet — It was noted by the GP that the Norpress was for sleep issues. Nil other concerns reported to GP.
7 [Month2]	[RN]	It was noted by RN that [Ms A]	

[1] 23 Month1: Request for Health Appointment (RHA) — *I mentioned to [initials] that I have IBS* [irritable bowel syndrome] *and need Norpress pills + that there were certain foods I am unable to eat. I need my medication and a special diet to help with IBS and need Norpress pills + that there were certain foods I am unable to eat. I need my medication and a special diet to help with IBS.* Symptom duration is recorded as *6 months +* but the nature of the symptoms is not otherwise specified.

		had not reported for her medication for 3 nights.	
11 [Month2]	[RN]	[Ms A] signed a refusal form stating that she did not need Colofac.	External GP notes received and forwarded to GP for review. The refusal form referred to the GP and Colofac discontinued.
14 [Month5]	[RN]	Medical chit received from [Ms A] requesting an appointment for 'burning throat and sore right ear. Unable to hold food. Very light headed + feeling weak[2].'	Nurse triage appointment booked for 18 [Month5]
18 [Month5]	[RN]	Seen for throat and ear pain in nurse clinic. [Ms A] complained of 'too much gas in her tummy, sometimes waking up full of acid in her mouth.' Patient reported to RN of being on omeprazole in the community.	Plan to refer patient to the site GP for advice. Nil other concerns were voiced by patient as per daily record.
21 [Month5]	[RN]	— [Ms A] booked in nurse clinic for blood tests (followed up for routine Hep B, Hep C, HIV screening as per plan following Initial Health Assessment).	[Ms A] declined screening.
25 [Month5]	[RN]	No clinical entry other than prescription which is for 2x20mg omeprazole BD although initial prescription in prescribing notes is for 20mg BD.	Omeprazole commenced by the GP.

[2] 14 [Month5]: RHA — *Burning throat and sore right ear. Unable to hold down food. Very light-headed and feeling weak.* Duration is recorded as *7 days, thought I'd get better but haven't.*

5 [Month6]	[RN]	Patient booked for GP clinic for reflux that was not resolving. Patient not seen by GP and no clinical notes completed other than prescription for Mylanta. Omeprazole dose was increased on this date to 40mg BD.	Mylanta Oral suspension was commenced by the GP.
8 [Month6]	[RN]	Medical chit received from [Ms A] reporting the following 'current medication is o.k but still experiencing reflux and stomach felt constantly bloated affecting my eating. I've kept away from certain foods but still not working — can I please see doctor.'	RN noted that patient had an appointment with a nurse for smear and a review of reflux issues was also added to that appointment.
9 [Month6]	[RN]	[Ms A] assessed to self-medicate.	Paperwork completed.
10 [Month6]	[RNs]	[Ms A] was booked for Smear with […] and a review of reflux as per appointment.	Noted in clinical notes by [RN] that patient had verbally declined appointment.
15 [Month6]	[GP] [RN]	[Ms A] reviewed by GP.	Blood test for H. Pylori ordered by GP and Ranitidine commenced with a plan to review in 1 week. Bloods done on same day by [RN].
17 [Month6]	[RN]	Medical chit received[3] reporting that 'new medication, Ranitidine, causing more burping, really sore throat.'	Booked for nurse clinic on 19 [Month6].
19 [Month6]	[RN]	Reviewed by RN where [Ms A] presented for medication issues.	Noted by RN that at the time of consult, [Ms A] was feeling better in comparison to the time when she had written her chit and the

[3] 17 Month6: RHA — *New medication Ranitidine causing more burping + reflux, really burning my throat — no sleep & no food … 4 x weeks.*

			reflux was reducing.
24 [Month6]	[RN]	Medical chit received with [Ms A] requesting appointment for 'current pills have taken away bloating but still experiencing reflux and burning throat. Still uncomfortable when sleeping.'	Appointment was booked for nurse triage on 27 [Month6].
25 [Month6]	[RN]	Medical chit received with [Ms A] requesting appointment 'I need to see doctor ASAP as I'm unable to still eat much and my reflux is getting worse.' *Duration of symptoms recorded by [Ms A] as 5 weeks.*	Noted by the RN that an appointment for nurse triage had been booked for 27 [Month6].
27 [Month6]	[RN]	Unable to be seen due to time constraints.	Nurse triage appointment rebooked to 31 [Month6].
30 [Month6]	[RN]	1343hrs Call received from [Ms A's] relative with concerns that medications were not working for patient and she wished for [Ms A] to be seen by the doctor and to bypass the nurses.	Caller advised that patient's condition could not be discussed over the phone without patient consent but her concerns were taken on board. Noted in the daily record that patient would be booked for the doctor directly as had been prescribed medication and required a review. Urgent appointment made with the doctor on his next clinic on 01 [Month7] (GP covering [Dr E] on leave).
30 [Month6]	[RN]	[Ms A] seen as a walk in with complaint that her medications were not working. Patient reported to be 'still spewing' and feels nauseous especially at night — unable to sleep much because when she lies down she feels like	It was noted that [Ms A] only ate cereals as 'fat makes her sick'. Dietary advice given by nurse, commenced on metoclopramide as per standing orders and booked for review by GP.

		throwing up.	
31 [Month6]	[RN]	1050hrs Seen in nurse clinic as per booked appointment where [Ms A] complained of sleep disturbance due to reflux. Patient also reported loss of appetite and having to force herself to eat.	Plan to continue with prescribed medication until doctors review booked on 01 [Month7].
1 [Month7]	[RN]	Unable to be seen by the GP.	Appointment rebooked by RN.
2 [Month7]	[RN]	0923hrs [Ms A] presented as a walk-in complaining of not eating or drinking, feeling weak due to reflux and vomiting. She stated that the medications were not working and that she was not getting any sleep.	Vitals done (BP 103/77, oxygen saturation 100% in room air, pulse 74, temp 36.7, respiration rate 12 and blood sugar level of 4.6. [Ms A] advised to return for medical review at 1500hrs. Health advice sent to residential unit to monitor patient and inform medical if any concerns with patient.
2 [Month7]	[RN]	1000hrs — received call from family member who was calling from [the corrections facility]. Visits Reception area requesting to meet face to face to discuss patient concerns.	Advised caller that a doctor's appointment which had been booked for 01 [Month7] wasn't able to be facilitated but she was booked for the doctor on 03 [Month7]. Declined request to meet face-to-face. Referred request to Custodial management as concerns about patient privacy in relation to request.
2 [Month7]	[RN]	1545hrs — Reviewed by RN and patient reported that she still felt unwell and unable to tolerate food due to vomiting. [Ms A] also reported that she had been bloated for years.	RN observed that [Ms A] looked unwell and sluggish. Vital signs were normal (**Weight 86kg**, BP 114/77, pulse 65, oxygen saturation of 99% in room air, respiration rate 18). RN documented that [Ms A] was on Metamide and would take it with a glass of juice later. Plan to follow-up during medication

			rounds.
2 [Month7]	[RN]	1930hrs — Reviewed in her cell during medication rounds.	[Ms A] was seated on the lower bunk and reported that she had not vomited since she returned from medical that afternoon. — Nil concerns were voiced and [Ms A] was advised that she was booked for the GP the following day.
3 [Month7]	Dr C	Reviewed by GP *(see section 7)*	Prescribed Stemetil and for blood tests (FBC, U&E, LFT, TFT). — Booked for bloods on 05 [Month7].
4 [Month7]	[RN]	1900hrs Reviewed in her cell during night medication rounds where [Ms A] complained of continued frequent vomiting which worsens when she lies down. On assessment [Ms A] reported that she had no particular pain, just associated discomfort in her lower abdominal muscles (possibly from retching). She also had nausea. It is noted in the clinical notes that patient describes vomitus as being 'black' suggesting it contains blood.	New medication, Stemetil/Prochlorperazine administered. Advised to raise her pillow with rolled up clothes to stop lying flat. Advised to add some salt and sugar to water and to sip. [Ms A] reported that she was already doing the latter. Booked for a review on 05 [Month7] in nurse clinic. No vital signs recorded.
5 [Month7]	[RN]	[Ms A] presented in a wheelchair appearing unwell and crying intermittently. Pain was described as 10/10 with waves of pain and constriction in the chest.	Vital signs done (BP 109/76, Pulse 85, oxygen saturation 87% in room air and temperature of 35.6. Phone call made to registrar at [the public hospital] and patient sent to [public hospital] Emergency Department for immediate assessment.

5. Previous GP notes [medical centre]

(i) On review of previous GP notes I see [Ms A] reported symptoms of epigastric pain and *reflux/burning in lower chest* most days since early June 2015 when she had been seen in ED and commenced on omeprazole. There was no family history of stomach ulcer (although I note later hospital notes indicate a strong family history of gastric cancer) and no recent use of NSAIDs. Abdominal examination showed mild epigastric tenderness only and differential diagnosis was *?gastritis/GORD ?ulcer ?biliary colic.* [Ms A] was referred for blood tests (form provided but no results on file), advised to reduce her caffeine intake and increase omeprazole from 20mg to 40mg per day. Follow up was: *may need USS to exclude gallstones — she will phone us if not improving 2wks for me to refer USS.*

(ii) [Ms A] returned for review in 15 October 2015 and was seen initially by a medical student under the supervision of a GP. Notes include: *3/12 hx of epigastric pain now worsening and felt in back, now more constant but pain level the same, on omeprazole morning and night but no real improvement.* Some pain was noted in [Ms A's] mid back on palpation but good spinal movements. Impression was *poss msk pain* and a trial of PRN NSAID was provided with review to be undertaken on an as needed basis. Blood tests taken that day were unremarkable.

(iii) [Ms A] evidently attended ED again on 19 October 2015. What I assume to be practice nurse notes on that date are: *Seen by ED today for epigastric pain. Pt informs was asked to stop Naproxen by ED dr. Sent for USS — POAC. If comes back negative, needs to be referred for gastroscopy. Informed pt — ED discharge letter received. Will contact pt if GJ would like to review. Pt happy with plan.*

(iv) The next GP consultation was 5 February 2016 when [Ms A] presented with *abd pains — central griping and loose motions for 2 weeks, no blood seen … abdo vague tenderness in places.* It was noted [Ms A] was under considerable stress awaiting sentencing. The GP concluded: *Dx need to consider infectious diarrhoea but I think IBS most likely, advised re this and some dietary modifications — less milk and wheat and greasy foods mainly. Nortrip may help with sleep/anxiety and slowing the bowel a little, review in 2 weeks.* Nortriptyline 25mg nocte was prescribed.

(v) The final GP review prior to [Ms A's] incarceration was 8 [Month1]: ongoing abd pains and loose motions for 2/12 now, stool tests neg … erratic sleep … wt 95.7 — was 100kg a few months ago she says. IBS likely but need to rule out other causes still, for further tests and increase dose of Nortrip and review in a month. Colofac was prescribed at this stage in addition to an increased dose of nortriptyline (50mg nocte). [Ms A] was incarcerated eight days later.

(vi) I could not find copies on file of the ED discharge summaries from early June 2015 and [Month8] 2016. There was no ultrasound result on file and no further mention of a gastroscopy referral. […]

6. Response [Dr E]

(i) [Dr E] outlined the process followed at [the corrections facility] for routine medical assessment of new prisoners, and request for GP notes which is usually done following this assessment. [Dr E's] initial assessment of [Ms A] was undertaken on 31 [Month1]. [Ms A] mentioned she had been prescribed Colofac by her GP for IBS *and that it was helping her symptoms … There were no other issues mentioned, in particular, she did not mention pain, vomiting or heartburn.* Colofac was charted by [Dr E]. [Ms A] had also recently commenced Norpress and it is a policy at the prison not to prescribe sedatives unless there is a major psychiatric disorder. This medication was therefore not prescribed initially.

The GP notes indicate there was a possible 4–5kg weight loss in the months prior to incarceration (weight 95.7kg immediately prior to incarceration and approximately 100kg a few months before this) and that [Ms A] had been treated for persistent epigastric pain and reflux symptoms between June and October 2015 with apparent development of new abdominal pain and loose bowels in the six weeks prior to incarceration.

(iii) On 25 [Month5] [Dr E] was notified by prison health centre nurse that [Ms A] had requested omeprazole for heartburn symptoms. She states she reviewed the GP notes and saw [Ms A] had been prescribed the medication previously with good effect. A further supply was prescribed (at 20mg BD) on the understanding [Ms A] was adequately triaged and monitored by prison nursing staff. On 5 [Month6] [Dr E] was asked to prescribe [Ms A] Mylanta for 'breakthrough' heartburn and a prescription was provided for Mylanta 30ml QID PRN. At the same time [Ms A's] omeprazole was increased to 40mg BD.

(iv) On 15 [Month6] [Dr E] saw [Ms A] with a complaint of persistent heartburn. She did not complain of pain or vomiting. It was simply acid reflux. Acid reflux co-exists with IBS as both relate to the gut, and are known to be exacerbated by stress. Blood tests were ordered for H pylori antibody and were negative. I charted Ranitidine and suggested she be reviewed in a week or so if that did not help. Ranitidine 300mg daily was added to the current regime of omeprazole 40mg BD and Mylanta QID PRN. On 19 [Month6] [Dr E] noted a nurse report that [Ms A's] reflux appeared to be reducing. At that point, and in view of the normal antibodies, I decided that the reflux was under control and a further review was not necessary unless requested.

(v) [Dr E] states that at no time did [Ms A] present to her symptoms suggestive of gastric cancer such as *epigastric pain, early satiety, feeling of fullness, vomiting or vomiting blood …* She states the drop in [Ms A's] weight (in prison) of around 4kg prior to her diagnosis was not uncommon, often due to the change in diet (reduction in junk food and absence of alcohol) associated with incarceration. [Dr E] went on three weeks' leave on 24 [Month6] and did not see [Ms A] again prior to her diagnosis of cancer.

7. Response [Dr C]

[Dr C] saw [Ms A] on one occasion only on 3 [Month7]. His notes include: nausea and vomiting when she lies down for the past five weeks. In prison for the past six months … difficulty keeping food and fluids down. A diagnosis of possible inner ear disturbance was considered given the positional nature of the symptoms and the absence of abdominal pain or 'great weight loss'. A trial of prochlorperazine was provided, blood tests ordered and verbal advice given for regular nurse review. There are no assessment findings documented although vital signs had been recorded the previous day and were unremarkable. There are no follow-up plans or instructions documented.

8. The diagnosis of likely IBS was made about five weeks prior to [Ms A's] incarceration. The apparent basis for the diagnosis was a recent history of griping abdominal pain and diarrhoea which may have been related to current major stressors. A trial of nortriptyline had no apparent impact on the gut symptoms and the dose of this was increased, together with introduction of an antispasmodic agent (mebeverine) shortly before [Ms A] entered [the corrections facility]. Faeces samples were negative for infection. [Ms A] had presented with symptoms suggestive of persistent gastroesophageal reflux disease (GORD) between June and October 2015, and investigation of this remains unclear (see section 5). However, there is no reference to persistence of the GORD symptoms in [Month1 and the previous month] when [Ms A] attended the medical centre, although such symptoms certainly became apparent following her incarceration and were attributed by [Dr E] to [Ms A's] IBS.

9. Brief background on IBS[4]

(i) People with irritable bowel syndrome (IBS) experience recurrent bouts of abdominal discomfort and pain, which may be accompanied by bloating, and a changeable bowel habit. Between bouts of symptoms, people with IBS usually feel well. However, some people may also have non-gastrointestinal symptoms such as fatigue, nausea and backache and feelings of anxiety or depression. IBS is not, however, associated with structural damage to the bowel, as it is in people with inflammatory bowel disease, and weight loss is usually not a feature of IBS. People with IBS are more likely to be: female — approximately 70% of people with IBS are female; younger than age 50 years ([Ms A] was 35 years of age); from a lower socioeconomic group. IBS is the most common gastrointestinal diagnosis in primary care.

(ii) The three key factors that appear to most influence the symptoms of patients with IBS are: altered gastrointestinal motility; altered sensation within the gastrointestinal tract; psychosocial factors, e.g. stress, upbringing, coping strategies. Psychosocial factors play a significant role in patients with IBS, tending to increase the frequency and severity of symptoms such as abdominal pain and diarrhoea.

[4] Extracts from: BPAC. Irritable bowel syndrome in adults: Not just a gut feeling. Best Practice Journal. 2014; Issue 58

(iii) A diagnosis of IBS should be considered if a patient presents with a history of six months or more of any of the following symptoms:

- Abdominal pain or discomfort — the abdominal pain or discomfort experienced by people with IBS varies widely — not only between individuals but also for each person. Symptoms are often made worse by eating and the patient may already be aware of particular foods that aggravate their symptoms.
- Bloating
- Change in bowel habit — An altered bowel habit is the most consistent symptom for patients with IBS. The change in bowel habit may include altered stool consistency (either firm or loose), changes in frequency of bowel motions, urgency, straining, incomplete evacuation or faecal incontinence (usually as a result of urgency). Patients may also describe the passage of mucus with bowel motions. Patients often report the need to urgently pass a bowel movement after eating a meal — referred to as an exaggerated gastric-colic reflex. This can occur in response to specific trigger foods but it may be the act of eating itself which initiates the postprandial symptoms. Diarrhoea or constipation may predominate, or the patient may alternate between symptoms. In addition, patients may have other symptoms including nausea, dyspepsia, early satiety, lethargy, low back ache and bladder symptoms such as frequency and urgency.

(iv) The presence of red flag symptoms should raise the possibility of an alternative diagnosis and referral to secondary care is recommended. Red flags from the history include:

- Unintentional or unexplained weight loss
- Rectal bleeding that is not due to haemorrhoids
- Nocturnal symptoms, e.g. waking from sleep with pain or the need to defaecate
- Onset of symptoms in patients aged greater than 50 years (over 60 years in the NICE guideline)
- A family history of gastrointestinal cancer, inflammatory bowel disease or coeliac disease

Additional red flags may be detected on clinical assessment or with targeted laboratory testing. These include:

- Abdominal mass
- Rectal mass
- Iron deficiency anaemia

- Raised inflammatory markers

10. The relatively recent onset of [Ms A's] symptoms of cramping abdominal pain and diarrhoea was not consistent with the time frames referred to in diagnostic criteria for IBS, while the symptoms referred to in 2015 were more consistent with GORD rather than IBS. Nevertheless, the clinical picture portrayed by the GP notes of [early 2016] had some features consistent with a diagnosis of IBS apart from the short time frame, particularly in regard to the association with stress and [Ms A's] young age. However, there were potential red flags evident: the possibility of unexplained weight loss of 4–5kg in the previous few months and, established in retrospect, a strong family history of gastric cancer. There was no iron deficiency anaemia or history of GI blood loss. It does appear that the community GP had an intention to follow-up [Ms A] in early [Month2] but she entered [the corrections facility] in the interim. I am unable to predict whether [Ms A's] usual GP would have referred her for further investigations or effected an earlier diagnosis of her cancer had she remained in the community.

11. On 26 [Month1] [Ms A's] weight was recorded as 90kg which was a decrease of 5–6kg from that recorded in the community early the same month, acknowledging different scales had been used for the measurements. It is not evident that [Ms A] complained to staff of weight loss and her BMI remained in the overweight range. When reviewed by [Dr E] on 31 [Month1] it does not appear to me that there was any reason for the diagnosis of IBS to be questioned as [Ms A] was apparently gaining relief of her symptoms with Colofac (mebeverine) and did not describe any new or persistently bothersome symptoms. There was no record in the community GP notes of a family history of gastric cancer. I would normally expect such significant history to be present in the relevant module of the file. Noting that the community GP had, in early [Month1], raised the issue of possible unintentional weight loss and had intended to review [Ms A] about the time [Dr E's] review took place, it might have been prudent for [Dr E] to have specifically enquired about any further weight loss (now approaching 10kg over several months). However, as noted [Ms A] remained in the overweight range and a degree of weight loss might not have been regarded as suspicious in the context of stress associated with [Ms A's] impending sentencing, and then the dietary changes associated with incarceration. I feel the weight loss issue should perhaps have been regarded more critically (as a potential 'red flag') and more closely monitored once [Ms A] began complaining of persistent upper GI symptoms (reflux sometimes waking her at night, unable to eat) from mid-[Month5] even if such GI symptoms can be associated with IBS.

12. The symptoms reported by [Ms A] from mid-[Month5] did appear to be more characteristic of GORD than IBS, and she had stopped using mebeverine although it is not clear whether she made this decision because the drug was no longer effective or

her symptoms had resolved temporarily. Local guidance on management of GORD[5] includes the following:

(i) The characteristic features of GORD are heartburn and regurgitation. Heartburn is a burning feeling that rises from the stomach or lower chest towards the neck and frequently occurs after eating. It may also be associated with bending, lying down or straining. Upper abdominal pain or discomfort are reported by approximately two-thirds of people with GORD. Regurgitated food is generally swallowed, but can sometimes be of sufficient quantity to be mistaken as vomit. Several other conditions can cause gastrointestinal symptoms that may be mistaken for GORD. These include gastric ulcer disease, functional dyspepsia (dyspepsia without an obvious cause), and approximately 40% of patients with irritable bowel syndrome will have regurgitation. Helicobacter pylori infection should be considered in patients who present with dyspepsia.

(ii) The complications of GORD are more likely in patients with red flags; these patients should be referred promptly for endoscopy. Empirical treatment with a PPI can be initiated for symptom control but should not delay the timing of referral. Red flags for patients with GORD requiring endoscopy include:

- Dysphagia (difficulty with swallowing); which may be caused by inflammation, abnormal peristalsis or oesophageal hypersensitivity. If dysphagia and globus pharyngeus (the sensation of a 'lump in the throat') are present then peptic stricture should be suspected.
- Odynophagia (pain with swallowing); which is generally associated with severe oesophagitis
- Haematemesis
- Weight loss with no obvious explanation
- Patients aged 55 years or older with unexplained and persistent dyspepsia of recent onset; these patients are at increased risk of gastric and oesophageal cancer

(iii) Endoscopic assessment is indicated:

- Promptly in patients with red flags whether or not empiric treatment is initiated
- Where there is diagnostic uncertainty, e.g. non-specific or atypical symptoms, or when other diagnoses are being considered, e.g. infective or medicine-induced oesophagitis or malignancy

[5] BPAC. Managing gastro-oesophageal reflux disease (GORD) in adults: an update. Best Practice Journal. 2014; Issue 61

- When the patient's symptoms do not respond to PPI treatment, or worsen despite treatment
- Prior to surgical intervention for GORD, e.g. fundoplication

Endoscopy may also be appropriate for patients with GORD who have multiple risk factors for oesophageal adenocarcinoma, e.g. chronic GORD, frequent symptoms, age over 55 years (local guidelines may vary), males, European ethnicity, a history of smoking, hiatus hernia, increased body mass index and intra-abdominal distribution of fat.

(iv) The management of GORD is determined by the severity of the patient's symptoms and the likelihood of complications. If the patient's symptoms are mild, lifestyle changes and antacids may provide benefit before a diagnostic trial with PPIs is tried. Begin PPI treatment with 20 mg omeprazole, once daily, for four to six weeks. For patients who have had an incomplete response to a diagnostic trial with a PPI consider increasing the dose. Antacids can be prescribed as 'rescue' medication for rebound acid secretion. H2-receptor antagonists (such as ranitidine) are second-line for patients with GORD. H2-receptor antagonists are occasionally used as an adjunctive treatment to PPIs (usually after discussion with a specialist). For example, patients with nocturnal symptoms that have not improved following morning dosing with a PPI and lifestyle interventions may gain benefit from the addition of a H2-receptor antagonist at bedtime, e.g. ranitidine, 300 mg, at night, for up to eight weeks.

13. [Ms A] was eventually diagnosed with a gastric cancer (rather than oesophageal cancer). Local guidance on referral for patients with suspected oesophageal or gastric cancer[6] includes:

(i) Gastric and oesophageal cancer: urgent referral (within two weeks): A person of *any age* with dyspepsia should be referred urgently for endoscopy or to a specialist if they have *any* of the following:

- gastrointestinal bleeding
- dysphagia
- progressive unexplained weight loss
- persistent vomiting
- iron deficiency anaemia
- epigastric mass

(ii) A person aged 55 years or older with unexplained and persistent recent-onset dyspepsia solely, should be referred urgently for endoscopy.

[6] New Zealand Guidelines Group. Suspected cancer in primary care: guidelines for investigation, referral and reducing ethnic disparities. Wellington: New Zealand Guidelines Group; 2009.

(iii) A person with dysphagia (specifically, interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process) should be referred urgently.

(iv) For a person with unexplained weight loss or iron deficiency anaemia, without dyspepsia, the possibility of upper gastrointestinal cancer and need for urgent referral for investigation should be considered.

(v) For a person with persistent vomiting and weight loss, without dyspepsia, the possibility of upper gastrointestinal cancer and need for urgent referral for investigation should be considered.

(vi) For a person with unexplained worsening of their dyspepsia, the need for urgent referral to a specialist should be considered if they have any of the following known risk factors:

- Barrett's oesophagus
- known dysplasia, atrophic gastritis or intestinal metaplasia
- peptic ulcer surgery more than 20 years ago

(vii) A person of any age with dyspepsia and a family history of gastric cancer (onset <50 years) should be referred urgently for endoscopy or to a specialist.

(viii) A practitioner should make the decision to refer a person with suspected upper gastrointestinal cancer to a specialist, irrespective of the person's *Helicobacter pylori* status.

(ix) For a person where the decision to refer to a specialist has been made, a complete blood count may be undertaken to assist specialist assessment.

(x) For a person with new onset dyspepsia the need for a complete blood count to detect iron deficiency anaemia should be considered.

(xi) For a person of Māori, Pacific Island or Asian origin, the practitioner should consider the possibility of gastric cancer at a younger age (approximately 10 years earlier) than the general population. (The incidence of gastric cancer in Māori during 1996–2001 was more than three times higher than for non-Māori. Furthermore, the mortality:incidence ratio was 85% for Māori and 72% for non-Māori. Māori when compared to non-Māori, were more likely to be diagnosed with gastric cancer and after diagnosis, were 50% more likely to die as a result of it. In contrast to some cancers, Māori were more likely to be diagnosed at an early disease stage.)

13. On 25 [Month5] [Dr E] prescribed [Ms A] omeprazole 20mg BD in response to her reporting of reflux symptoms in the previous two weeks. There was no report of vomiting, haematemesis or other 'red-flag' symptoms and [Dr E] established [Ms A]

had been previously prescribed the medication apparently with good effect (the medical centre notes indicate [Ms A] was last taking the medication in October 2015). Best practice would have been to examine the patient prior to prescribing, but noting the nature and short duration of [Ms A's] reported GORD symptoms, their known association with IBS, the fact [Ms A] was being regularly reviewed by nursing staff and the fact she had been previously prescribed the same medication I am not particularly critical of her management on this occasion. Although nursing notes referred to [Ms A's] GORD symptoms, best practice would have been for [Dr E] to have recorded in her notes the rationale for her prescribing on this occasion and any intended follow-up.

14. [Ms A] continued to report her reflux symptoms to nursing staff. There is no reference to complaint of actual vomiting (as opposed to reflux of acid or food into her mouth), haematemesis or weight loss. On 5 [Month6] [Dr E] noted a prescription for Mylanta but at the same time increased the dose of omeprazole to 40mg BD (noted only on the prescription chart). At this stage [Ms A] had persistent reflux symptoms for three weeks which had failed to respond to a dose of omeprazole of 40mg daily. Even though there were no obvious additional red flags evident on the basis of the reported symptoms (weight loss evidently not reported, issue of family history has been discussed previously), I believe [Ms A] should have been reviewed by [Dr E] before the dose of omeprazole was increased further noting she had not been reviewed since development of the reflux symptoms and the lack of response to the reasonable starting dose of omeprazole was somewhat atypical. Such review might have included more detailed exploration of her symptoms to specifically exclude 'red flags' and to revisit the issue of weight loss. I would also expect any decision to increase the dose of omeprazole, and the rationale for this decision, to have been recorded in the clinical notes. However, I note a review was undertaken 10 days later when [Ms A's] symptoms persisted. I am mildly critical of [Ms A's] management by [Dr E] on this occasion.

15. [Ms A's] reflux symptoms (as reported) persisted and she was reviewed by [Dr E] on 15 [Month6]. [Dr E] reports that [Ms A] complained only of reflux symptoms at this stage (no abdominal pain, no vomiting) and her anti-reflux therapy was intensified to include ranitidine, with follow-up planned in a week. H pylori serology was ordered (negative). I think it was reasonable on this occasion to intensify [Ms A's] therapy to gain relief of her symptoms (adding in ranitidine) and to check H pylori serology. However, I feel a more through clinical assessment (check of weight, abdominal palpation) was also warranted given the atypical situation of a patient with recent onset dyspepsia requiring such rapid escalation of therapy because standard treatment was ineffective. I cannot say that [Ms A's] management would have changed had a more thorough assessment been undertaken on this date and her prognosis would certainly not have altered. I believe the failure by [Dr E] to undertake a more through physical assessment of [Ms A] on this occasion, despite her reported/recorded symptoms still being consistent with GORD (albeit resistant to

standard treatment) was a mild to moderate departure from expected standards of care. I note an intention to follow-up the patient in one week which was appropriate. Had there been reassuring findings on physical examination (no epigastric mass (see 12 (iv)) and no progressive weight loss), I think it was reasonable to defer follow-up for a longer period if [Ms A's] symptoms responded well to the change in therapy as they apparently did initially, but consideration should certainly have been given to referral for endoscopy if [Ms A] continued to require such intensive therapy for symptom control or had recurrence of symptoms, and once it became evident she had progressive weight loss and had developed persistent vomiting. [Dr E] was away on leave once these factors became apparent.

16. [Ms A's] symptoms progressed from about 24 [Month6] despite therapy, disturbing her sleep and resulting in poor food intake. On 30 [Month6] is the first report of her vomiting as 'still spewing' and it is unclear for how long this symptom had been present (not recorded in notes previously). [Ms A] was eventually seen by [Dr C] on 3 [Month7] and diagnosed with an inner ear disturbance. It appears this diagnosis was made on one aspect of the history (that [Ms A's] nausea and vomiting was worse when she lay flat) and there are no physical assessment findings documented. The previous day nurses had recorded [Ms A's] vital signs which were unremarkable. She had lost a further 4kg since her first recorded weight in [the corrections facility] five months previously which did not appear excessive, although when compared with the weight recorded in her community GP notes this represented a progressive weight loss of about 10kg in the previous six months. Looking back over [Ms A's] history while in [the corrections facility], I find it difficult to determine how a diagnosis of inner ear pathology was given precedence over the working diagnosis of GORD. Apart from the worsening of [Ms A's] nausea/reflux/vomiting symptom with lying flat (which is consistent with reflux in any case) there do not appear to be any additional historical factors (such as vertigo or tinnitus) or findings on physical assessment (no findings documented) to support a diagnosis of inner ear pathology. Nevertheless, my main criticism is the absence of any documented physical assessment on this occasion as well as the failure by [Dr C] to consider progressive GI pathology in his diagnostic formulation (which relates to the lack of physical assessment). I think it was reasonable for him to arrange blood tests in the first instance, and a trial of anti-nausea agent (prochlorperazine) was probably not unreasonable while awaiting blood results. There did not appear to be any indication on 3 [Month7] for immediate hospital admission for [Ms A] (no history of haematemesis at this point and, apparently, no symptoms/signs of an acute abdomen) but the symptoms she was now presenting in the context of a GORD diagnosis warranted urgent referral for specialist review (see 13(i)). I feel [Dr C's] management of [Ms A] on this occasion represents a moderate departure from expected standards of care, mainly in relation to his failure to undertake a physical assessment appropriate to the clinical situation. While [Dr C] states he gave verbal advice to nursing staff regarding monitoring and follow-up of [Ms A], such advice should have been documented.

17. The absence of a recorded family history of gastric cancer is relevant to this case but I am unable to establish from the available information the precise nature of the family history. As stated previously, I would expect relevant family history to be available in the community GP notes and then to subsequent providers but it is good practice to enquire after relevant family history when seeing a patient for the first time. […]"

Dr Maplesden provided the following further advice:

"1. The following comments should be read in conjunction with my original advice provided on 10 January 2017. I have reviewed the response to my original advice from [Dr C] (received 19 January 2018). [Dr C] includes the following comments in his response:

(i) *I was providing locum cover for [Dr E] who was her treating GP whilst in prison. I noted her impression, investigations and treatment for gastro-oesophageal reflux prior to my consultation. A labyrinthitis had been considered in the differential diagnosis in addition to [Dr E's] diagnosis of gastro-oesophageal reflux when I reviewed her.*

(ii) *The positional vertigo and nausea were her presenting symptoms at the time of my consultation. I considered labyrinthitis as a possible differential diagnosis. I made a provisional diagnosis on the basis of the history and physical findings on the one occasion I saw [Ms A]. Her symptoms were of nausea/dizziness and intermittent vomiting when I saw her without great weight loss, mass or abdominal pain. Her physical observations were unremarkable.*

(iii) *I recommended regular nursing review and monitoring of her physical state. This was a one off assessment and follow up would naturally have been with her regular medical officer whom I was providing cover for on this occasion. There was no note that I could see of weight loss or a family history of stomach cancer. These were important findings that were not apparent at the time of my consultation. There was no indication of a mass, haematemesis, rectal bleeding which would have warranted immediate referral.*

(iv) *I ordered bloods to be done urgently although the consultation was on a Saturday [and] the tests were not immediately done. There may have been indicators in the blood tests such as iron deficient anaemia and raised inflammatory markers that would have warranted further investigation.*

2. I cannot see any reference in the clinical notes to labyrinthitis being considered in the differential diagnosis of [Ms A's] symptoms prior to [Dr C's] review on 3 [Month7], and he has confirmed he was the first clinician to consider this diagnosis. The history recorded by nurses, [Dr E] and on [Ms A's] health chits referred to symptoms clearly suggestive of persistent gastro-oesophageal reflux which was worsening despite maximal therapy. I could find no reference to symptoms of dizziness, vertigo, loss of

balance, hearing distortion or tinnitus to suggest inner ear pathology. It was noted that [Ms A's] nausea, vomiting and throat burning were worse when she was lying flat, but when the overall symptom history is considered, rather than isolating a single aspect of the history, I remain of the view that it was not reasonable to consider a diagnosis of inner ear pathology above that of persistent treatment-resistant gastro-oesophageal reflux. [Dr C] does not describe what physical findings supported his diagnosis, and there are no physical assessment findings documented in his notes of 3 [Month7]. Vital signs had been recorded by nursing staff the previous day but there were none documented on 3 [Month7]. I note [Dr C] did order further investigations (blood tests) and prescribed symptomatic treatment (prochlorperazine). He states he requested nursing staff to regularly monitor [Ms A's] condition. While these are mitigating factors, I remain of the view that [Dr C] failed to appropriately and adequately consider [Ms A's] symptom history when concluding she was suffering from inner ear pathology, and there is nothing in his response or clinical documentation enabling me to confirm an appropriate clinical examination was undertaken on 3 [Month7]. I remain of the view these are moderate departures from expected standards of care."

Appendix B: Independent nursing advice to the Commissioner

The following expert advice was obtained from Kim Carter, a registered nurse:

> "Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs B] regarding the care provided to [Ms A]. The complaint concerns care received between the dates of 16th [Month1] to 5th [Month7] while [Ms A] was at [the corrections facility]. In preparing the advice on this case, to the best of my knowledge, I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. My advice is limited to the nursing care provided to [Ms A].
>
> I have been a New Zealand Registered Nurse (RN) since 1990, the last 11 years of which has been spent working in primary health care within the general practice setting. I am a current member of the Executive Committee of the NZ College of Primary Health Care Nurses and a Fellow of the College of Nurses Aotearoa (NZ). I have a Post Graduate Certificate in Advanced Nursing and am currently undertaking further study to complete a post graduate diploma this year. I have been professionally accredited at Expert level of practice as part of the New Zealand Nursing Council and South Canterbury District Health Board's Professional Development Recognition Programme.
>
> I have reviewed the following documentation: Complaint from [Mrs B], response from the Department of Corrections, timeline document, clinical records from the Health Services at [the corrections facility] which includes copies of hospital records, and the response from [Ms A].
>
> I have been asked to provide advice about the nursing care provided at [the corrections facility] particularly the management of the episode on the 4th [Month7]. I have been asked to provide advice as to what the standard of practice or care is, if there has been a departure from the accepted standard of practice or care, and if so, how significant that departure is. I have also been asked to provide, as appropriate, recommendations for improvement that may help prevent a similar occurrence in the future.
>
> In preparing my advice, I have reviewed and referred to the New Zealand Nursing Council's Scope of Practice and Competencies for Registered Nurses, the New Zealand Nurses Organisation's 'Documentation' and 'Standards of Professional Nursing' Practice Guidelines and the Ministry of Health Standing Order Guidelines and Regulations (2002).
>
> [Ms A] was assessed on admission to [the corrections facility] on 16th [Month1] and this is recorded using the Reception Health Triage Form. In addition to the standard questions, the RN has noted some additional comments related to general issues including that [Ms A] had a recent history of a diagnosis of Irritable Bowel Syndrome

(IBS). It was noted that the IBS was controlled at that time. The records indicate further assessment would be planned related to [Ms A's] IBS including a diet recommendation when [Ms A's] clinical records arrived from her previous general practice. The RN records the intention to send dietary recommendations for 'no bread'. The scope of the triage assessment form is appropriate for the purposes of triage.

As a triage process this meets an acceptable standard of practice.

On 23rd [Month1] [Ms A] completed a medical chit. The record shows [Ms A] said she required a special diet and medication to help with her IBS. [Ms A] had been at [the corrections facility] for 7 days without medication however there is evidence dietary arrangements had been planned. It is not clear from the notes when the original routine health assessment had been planned for following triage, however an appointment was booked for the nurse clinic when the medical chit was presented.

There can be a short delay between when clinicians first meet with a new patient and are subsequently able to implement a plan of care including ongoing medications. Delays occur because previous clinical records and information are not always immediately available, as was the situation in this case. Clinicians will consider the requirement for these records and the disruption to ongoing treatment. When chronic or long term conditions are stable (as was documented on the triage assessment 16th [Month1]), it would not be inappropriate to wait until further information was available, so that care plans could reflect more accurately the ongoing treatment.

This meets accepted standards of practice.

On 26th [Month1] [Ms A] was seen by an RN for a further assessment using the Initial Health Assessment Form. A weight of 90kg, height, body mass index and blood pressure were recorded. I have reviewed the Health Services Policy # 3–5, Health Services Health Care Pathway. Section 5.8–5.12 of this policy outline the definitions and standards expected for Plans of Care and Treatment Plans and what factors should be considered in determining which of these are to be developed. Treatment Plans are to be developed for patients that have chronic and complex health needs amongst other criteria. A Plan of care is for patients with less complex or chronic health needs however there are no limitations on the scope and range of interventions that can be identified. Plans of Care 'should reflect the needs of a patient'.

The assessment process in this case was guided by the prescribed format of the Initial Health Assessment Form. There are no narrative notes recorded at this assessment. There is no evidence that a more comprehensive IBS history, dietary or medication review was completed. There is no evidence that any physical health assessment was undertaken. This falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 7.5.

I cannot find evidence in the documentation that a Treatment Plan was developed for [Ms A]. However, the notes outline a care plan to determine the medication [Ms A] was taking prior to arrival at [the corrections facility] for her IBS and a request for notes transfer was done to [Ms A's] previous general practice. It is reasonable that staff did not feel [Ms A] required a Treatment Plan.

It is an accepted standard of practice that a Plan of Care was completed.

Within the general practice setting, it is usual for practices to have a 'new patient' enrolment process. Such processes would normally include a review of previous clinical records and on an initial consultation(s), a general physical examination as relevant, detailed discussion about past and current health status, and medication review. It is not unusual that this new patient process may occur over multiple visits and that there can be delays in receiving previous records and other relevant information. However, RNs have a responsibility to consider the priority and significance of information as received, and adapt their approach accordingly. When patients have a long-term condition, in the context of a health assessment process rather than a triage process, it would be expected practice that a relevant basic history and physical examination is completed. In the case of IBS, it is important to review past and current symptoms, pain/discomfort, bowel and dietary history. A basic physical assessment should include abdominal palpation and auscultation. There are no records that reflect this was done. This also falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 7.5.

The lack of physical examination is a moderately significant departure from expected practice.

[Ms A] was seen by an RN on 30th [Month1] following an episode of stomach cramps and diarrhoea. This was 4 days after the Initial Health Assessment (see paragraph 8). The RN supplied Buscopan under Standing Orders. Standing Orders are utilised within a collaborative prescribing arrangement between authorised prescribers and RNs. There are national guidelines that outline the requirements for use of standing orders to ensure they conform to the Medicines (Standing Order) Regulations 2002. The regulations require that persons using standing orders are responsible for the assessment and decision making related to their use. This includes the documentation of the assessment and decision to supply medicines under the standing order. There is no record of any physical examination and minimal narrative notes related to presenting symptoms and history.

The lack of assessments and documentation related to the use of standing orders is a moderately significant departure from expected standards of practice.

On the 30th [Month1] the RN noted [Ms A] was due to see the GP the following day. However, there is no evidence that the RN identified the fact [Ms A's] records had not arrived from the previous practice, or that they recognised [Ms A] had reported she

had been taking regular medication prior to her arrival at [the corrections facility]. In primary health care, it is not unusual that new patients may present for care before their previous records are received. However, it is usual practice for a clinician to recognise this and attempt to establish what the regular medications are as appropriate to the presenting symptoms. This can be achieved by contacting the previous practice or the dispensing pharmacy for clarification. Whilst in paragraph 7, I comment that the lack of information related to ongoing treatment was not necessarily an issue then, by now on [Month1] 30th [Ms A] was reporting symptoms. I would expect that an RN would attempt to obtain more information relevant to the previous treatment. This also falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 8.3.

The medication may not have been able to be prescribed until [Ms A] saw the GP the next day, but the GP would at least have had access to this information, especially given the fact the previous notes did not arrived to [the corrections facility] until 2 weeks later.

The lack of follow up about regular medications is a moderately significant departure from accepted practice.

On the 11th [Month2], [Ms A's] notes were received from her previous practice. On the 14th [Month2], the records confirm these notes were scanned into the practice management system (PMS). There are no records that indicate these notes were reviewed by an RN. There are no records that indicate the previous plans to obtain specific information related to medications or [Ms A's] history of IBS or special dietary requirements were completed. In fact, the next record entry is some weeks later in [Month5]. This falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 8.

Of concern is that on the very first page of the notes from the previous practice, including the most recent consultation from the 8th [Month1] (which was just the week prior to [Ms A's] arrival at [the corrections facility]), it is clearly documented that [Ms A's] IBS symptoms were not controlled or that a confirmed diagnosis of IBS had yet been made. In fact, these notes outline a plan to continue further investigations given [Ms A's] symptoms which included long standing weight loss, pain and diarrhoea. Even a brief review of this first page should have alerted staff to the requirement for a more complex plan of care. Perhaps even triggering the development of a Treatment Plan which would have supported ongoing investigations and coordination of this — see Policy # 3–5, Health Services Health Care Pathway, section 10.

As outlined previously, it is usual practice for enrolment process to include a review of notes and in fact the organisational policy is that this does occur (see Policy # 3–5, Health Services Health Care Pathway, section 7 and 8). There are many reasons for reviewing previous records which include ensuring the PMS is accurate and up to date,

that allergies, sensitivities or alerts are in place and appropriate, and that medications and other therapies that need to be continued can be arranged. In this instance, a review of the notes would have highlighted the ongoing concerns related to [Ms A's] health status and the requirement for ongoing follow up. Notes review is a fundamental aspect of ensuring continuity of care and ultimately patient safety. Of significance in this case is that the opportunity to identify that [Ms A] required more complex and ongoing investigations was missed. This contributed to delays in [Ms A] receiving an appropriate diagnosis and treatment of what was a malignant disease process and falls outside of the organisational policy.

The lack of a formal review of the records is a highly significant departure from accepted practice.

From 14th [Month5] until the 3rd of [Month7] [Ms A] reported on 9 separate occasions that she was experiencing a range of symptoms. These included vomiting, burping, bloating, reflux, sore throat, nausea, sleep disturbance, sore R ear, light headed, weakness, discomfort. During this time [Ms A] was started on several medications including colofac (IBS), omeprazole, mylanta, ranitidine (for reflux), metoclopramide and prochlorperazine (for nausea), and paracetamol. Several entries note that [Ms A] reported the medications weren't helping or helped intermittently.

There are several points that require comment.

There is no evidence of physical examination in any of the RN notes during this period. The only observations recorded are two blood pressures and one weight on the 2nd of [Month7]. The RN on the afternoon of the 2nd [Month7] documents 'observations were all normal' however the only observation recorded was a blood pressure. Heart rate, temperature, respiration rate and oxygen saturations are not recorded. On all 8 occasions, RNs record a range of reported symptoms, however no assessment or examination findings are documented. In addition, minimal documentation is found that demonstrates any history taking or questioning related to presenting signs and symptoms. The notes record verbatim patient comments, however there is minimal evidence of the RNs asking specific questions to elicit more information. For example, frequency and onset, the presence or absence of pain/discomfort, specific fluid/food intake and urine output, fevers, chills, nausea, vomiting, bowel motions, visible blood or dark colour of stools.

Physical examinations form part of health assessments and are fundamental to establishing a true sense of what is happening. Physical examinations are completed in response to adequate and accurate history taking, and should be done relevant to the problem and symptoms reported. In this case, [Ms A] was reporting gastro-intestinal problems and it would be usual for RNs to perform a basic examination of at least an abdominal palpation and bowel sounds.

Given [Ms A's] history of IBS, I would have expected care that reflected an awareness of the context of her health history and current health status. This falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 7.5.

The lack of assessments and physical examinations is a highly significant departure from accepted practice.

It is generally standard practice that consultation notes follow a format which ensure they are more complete and clearer to understand. A common format would be SOAP (Subjective, Objective, Assessment and Plan) but there are also many others that are similar. In all the narrative notes reviewed there is no standardisation or any evidence of a consistent approach to documentation across the RNs.

This is a minor departure from expected practice.

There is no evidence that the GP who saw [Ms A] on the 3rd of [Month7] received specific information from an RN about the frequency of her reports of symptoms. Even though the GP would have had access to the records and could have reviewed this themselves, the RNs had been almost totally responsible for providing [Ms A's] care to date. This falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 8.2.

The RN who saw [Ms A] on the 2nd of [Month7] documented that [Ms A] appeared unwell, was continuously vomiting and was unable to tolerate any food intake. I would have expected to see evidence of a summary or handover from the RN to the GP to highlight these concerns. This may have been done but is not provided within the documents reviewed. The GP note on the 3rd [Month7] is not congruent with the RN note on the 2nd related to severity and persistence of symptoms.

When reviewing the RN notes, very little if any reference is made by one RN, about previous consultations or issues documented by colleagues. This suggests there was little interaction between the team (both RN to RN and RN to GP) or awareness of the whole series of events.

In primary health care settings, there are points at which red flags are raised and clinicians will take time to review the situation more broadly — taking a 'helicopter view'. This would occur for example when patients frequently present, when they consistently report little or no effect from treatment, or when they report an escalation of symptoms. It is every clinician's responsibility to be vigilant in keeping an overview of the care plan and progress of patients. This is essential to maintain continuity of care. In this case, I can see little evidence that any of the RNs had recognised the red flags (frequency of presentation, little effect from treatment and escalation of symptoms), or taken responsibility to ensure the coordination of care and follow up was completed — the helicopter view. At no stage can I find evidence that any RN identified an awareness how often [Ms A] had presented to request

assistance — 9 times within 7 weeks. This falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 8.2.

The lack of communication and coordination between team members, and the unrecognised red flags, are highly significant departures from accepted practice.

[Ms A's] response states she had been told by [RN F] she would be reviewed by the doctor on 1st [Month7] so had a reasonable expectation this would occur. This is supported by the documentation confirming a GP appointment had been booked. However, a note in the record states [Ms A] was not seen by the medical officer on the 1st and was re-booked, but no further details are documented as to why this occurred. Given that [Ms A] had requested a GP review 7 times in the preceding weeks (and further actions at many of these contacts were deferred considering the upcoming GP appointment), it is unacceptable that the appointment on the 1st [Month7] did not occur. There is no account for this delay and considering the symptoms [Ms A] was experiencing, it left her suffering without effective care, treatment and support for an extended period. This falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 7.4.

The inaction by RNs over multiple occasions and subsequent delay in [Ms A] receiving a medical review is a highly significant departure from accepted practice.

During this time [Ms A's] family (or representatives) contacted staff at [the corrections facility] to express concerns about her wellbeing and to request that she be reviewed by the GP. These contacts are documented. Correctly, the RNs have explained the issues related to privacy, however little is documented about the family's specific concerns or what [Ms A] may have relayed to them. In the primary health care setting we are often contacted by families of patients. We are limited in what we can discuss or what information we can provide, however, we are always able to listen and document their concerns.

Often, hearing from families provides an opportunity to recheck whether we have obtained an accurate sense of what is happening for patients as patients may express things to families that they don't to clinicians. Family contact with clinicians should raise questions for RNs about whether they have a full understanding about the situation. There is no evidence this occurred. [Ms A's] response also indicates she had consented for her family to access information on the 31st [Month6]. However, on the 2nd [Month7] staff were apparently unaware of this. This falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 8.5 & 8.6.

In primary health care settings, it is important that accurate information regarding who a patient has agreed may receive their information, is updated in a timely manner. This ensures all staff can protect patient privacy whilst involving those the

patient wishes to be involved. The role of families as advocates and support for patients should not be underestimated.

Of note is that [a friend of Ms A] contacted staff at 10.00 am on the 2nd of [Month7] with concerns about [Ms A's] condition right after [Ms A] had been seen in the walk-in clinic. From [Ms A's] response document it appears she knew she was to be reviewed by the GP rather than in the nurses' clinic. It appears [Ms A] may have relayed this concern to [her friend] leading [her] to contact staff. Clearly the contact by [Ms A's friend] did not prompt earlier follow up especially around the confusion related to the GP appointment. In retrospect, this demonstrates the importance of considering family contacts as potential triggers for further follow up.

The lack of a timely process to ensure staff were aware of [Ms A's] consent to family discussion is a moderately significant departure from expected practice.

As requested I have given particular consideration to the episode of the 4th [Month7].

At 1900 hours [Ms A] was seen in her cell during the medication round. The notes report that [Ms A] complained of continued frequent vomiting, worse with lying down, and that [Ms A] indicated she had no 'particular pain' but did have discomfort which was assumed to be related to the retching. She had ongoing nausea.

The vomitus was described as 'black'. The RN comments on [Ms A's] history of long standing bloating which they identify as coming from the previous notes. There is no physical examination or observations documented. There is no additional assessment information documented.

My previous comments related to the general lack of health assessments, physical examinations, observations and unrecognised red flags extend to this episode. Viewed as a single episode the care provided on the 4th [Month7] was inadequate and falls well below the expected standard of practice. This also falls outside of the organisational policy. See Policy # 3–5, Health Services Health Care Pathway, section 7.4 & 7.5.

In any clinical setting, it would be expected that an RN would identify haematemesis (or suspected haematemesis) as a red flag — an urgent and potentially life threatening situation. Any RN would be expected to be able to assess at a minimum, the frequency, volume and nature of the vomiting. Any RN would be expected to complete at a minimum, important relevant basic observations, for example blood pressure and a heart rate. Whilst in general, detailed and diagnostic abdominal examination may fall outside the scope or abilities of RNs, I would expect a primary health care RN to be able to palpate and auscultate a patient's abdomen to assess for signs of pain, bowel sounds, rebound or guarding which provides critical information to assist decision making about the urgency and the response required. Throughout this episode, a distinct lack of urgency was displayed by the RN in their response to suspected haematemesis, particularly within the context in this case and [Ms A's] history.

The lack of adequate assessment, physical examination and urgent response is an extremely significant departure, and falls well below accepted practice standards.

In summary, I would comment that although the care provided to [Ms A] on [Month7] 4th was inadequate, a generally poor standard of care was provided following [Ms A's] arrival at [the corrections facility].

The documents demonstrate several systemic issues that are prevalent both from professional practice and organisational policy compliance perspectives.

Clinicians are not infallible. In daily practice an individual RN may miss significant issues and important aspects of care. This highlights that the requirements for communication, teamwork and vigilance are critical for patient safety and that all clinicians share responsibility for keeping a helicopter view.

However, it would be almost impossible for multiple RNs, at the same time, to all demonstrate the same lack of awareness, consistently poor health assessment and physical examination skills, and inadequate care coordination. The actions and inactions of the staff involved evidence in this situation a faulty system at work as well as individual failings.

The system faults identified in the review include: no standardised documentation format, poor new patient process and responsibility (including formal notes review), lack of care coordination processes, multiple missed opportunities to provide appropriate interventions and a sometimes chaotic appearing under-resourced health service (rescheduled and deferred appointments and documented staffing shortages).

Recommendations

That [the corrections facility] review the processes for new patients. This should include assigning specific responsibilities for care planning, follow up scheduling of assessments, timely obtaining and review of previous records and care planning. Audit activities should be introduced to ensure compliance with internal policies and expected standards of practice.

That [the corrections facility] implement a standardised documentation format i.e. SOAP and ensure adequate training of staff. Audit activities should be introduced to ensure compliance with internal policies and expected standards of practice.

That [the corrections facility] review the Standing Orders and associated policy and procedures to ensure full compliance with the Ministry of Health guidelines and the Medicine (Standing Orders) Regulations 2002 and amendments. Audit activities should be introduced to ensure compliance with the regulations and expected standards of practice.

That [the corrections facility] provide a skills training programme for RNs specifically aimed at improving competencies related to history taking, health assessment and basic physical examination. In addition, consideration of environmental and organisational barriers to comprehensive professional RN practice be reviewed and modified to promote clinical skill and expertise development. Audit activities should be introduced to ensure compliance with internal policies and expected standards of practice.

That [the corrections facility] consider implementing a process to provide structure and format for early warning or red flag situations. The system should include pre-identified situations and conditions that will trigger an alert, for example, bleeding or suspected bleeding, frequency of presentations. Audit activities should be introduced to ensure compliance with internal policies and expected standards of practice.

That [the corrections facility] ensure compliance with their organisational policies related to team communication especially those outlined in section 8.2 of the health services health care pathway policy.

That [the corrections facility] review the policy and ensure compliance with timely identification of when patients provide consent for the involvement of families in their care as per section 8.5 & 8.6 of the health Service Health Care Pathway policy.

That further consideration is given to the issue of the professional competence of the RN involved in providing care on the 4th [Month7].

Kim Carter
RN, PG Cert Ad Nsg, FCNA(NZ), NZCPHCN (NZNO)"

RN Carter provided the following further advice:

"Thank you for the request that I provide further clinical advice in relation to the complaint from [Mrs B] regarding the care provided to [Ms A]. The complaint concerns care received between the dates of 16th [Month1] to 5th [Month7] while [Ms A] was at [the corrections facility]. In preparing the advice on this case, to the best of my knowledge, I continue to have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have reviewed the following documentation: Additional response from the Department of Corrections, including the response to expert advice, statements from [RN F], [RN G] and [RN H], Position Descriptions of Nurse and Health Centre Manager, sections of the Local Operating Manual and my previous advice.

I have been asked to review these documents and advise whether this information changes my initial advice in any way.

I note that in the response from the Department of Corrections, many of my initial recommendations have been accepted and in fact significant work has already been undertaken to implement changes.

In the Department of Corrections' response Pg. 8 final paragraph, questions are raised about how I came to determine the significance of the departures from practice that I identified. In addition to utilising the listed documents and drawing on my own extensive 28-year practice history and a general review of relevant literature, I incorporated guidance from a common type of Risk Assessment Matrix utilised by health organisations for quality improvement and prioritisation activities. I did not provide a copy of this in my initial advice and accept that I should have. See Appendix 1.

I note that [RN H] confirms that she did complete clinical observations and I see evidence of this in the screenshots that are attached to her statement: This information and the three statements were not available or provided to me initially.

The statements of [RN G] and [RN H] clarify and provide additional information about the clinical interactions and organisational systems during [Ms A's] time at [the corrections facility]. However, the degree of detail about the clinical care and decision-making processes undertaken by [RN G] and [RN H] as outlined in their statements, was not reflected in the clinical records themselves.

The New Zealand Nurses Organisation's *Documentation Guideline 2017* states:

> 'Documenting all relevant information ensures others know what you observed and what nursing interventions you took. Documentation must show evidence of clinical judgement and escalation/referral as appropriate and documenting evaluation of the care provided. If care is not recorded, then it is assumed the care was not given.'

Therefore, my initial advice related to concerns about documentation and expected care standards has not changed.

8. In Paragraph 20 of my initial advice I summarise my findings that there were system faults and individual failings. I believe the identified system faults are more significant than individual issues which is why all but one of my recommendations are aimed at improving these. I also stated that in reviewing this complaint, the appearance in the documents reviewed was one of a chaotic and under-resourced health service, and I listed the evidence of this: Clinical and organisational records related to rescheduled and deferred appointments, omissions in care planning and follow up and documented staffing shortages. This is further supported in [RN F] and [RN H's] statements, in which multiple references are made to staffing and workforce shortages, and the work pressures that arise from this. In addition, within these statements and in the Department of Corrections' response, many references are

given to the organisational or system practices that made providing comprehensive and well supported clinical practice challenging at the time i.e. lack of or poor adherence to policies, inadequate levels of clinician and practice support, staffing resource issues, lack of electronic real time access to laboratory results/discharge summaries/medication lists/outpatient appointments.

In full consideration of the documents provided, my overall advice regarding recommendations and the comments made in my summary (paragraph 20) has not changed.

Kim Carter
RCompN, PG Dip Nsg, FCNA(NZ), NZCPHCN (NZNO)"

RN Carter also provided the following further advice:

"1. Thank you for the request that I provide further clinical advice in relation to the complaint from [Mrs B] regarding the care provided to [Ms A]. The complaint concerns care received between the dates of 16th [Month1] to 5th [Month7] while [Ms A] was at [the corrections facility]. In preparing the advice on this case, to the best of my knowledge, I continue to have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation: letter from [RN D's lawyer], and the Personal Response and Response to Health and Disability Commissioner from [RN D]. I have been asked to review these documents and advise whether this information changes my initial advice in any way.

3. For my initial review of this case I was not provided with any statements or information from any of the nurses involved in [Ms A's] care. Therefore, my advice was based on [Ms A's] clinical records, the Department of Corrections' (DoC) response to the complaint and a timeline document.

4. [The lawyer's] letter outlines several concerns regarding my initial advice. Paragraph 1 of her letter requests reconsideration of my advice related to the DoC setting and the fact it is unlike 'any clinical setting'.

5. I agree that there are specific issues related to the care environment within the DoC's health services that are different to other settings in primary health care. However, many primary health care nurses work in relative isolation, in remote and rural areas, frequently without immediate access to medical practitioners, comprehensive clinical records or electronic communications, and often out of traditional clinical rooms/facilities. Despite this, all registered nurses (RNs) share a Scope of Practice that is defined and regulated by the New Zealand Nursing Council. This scope of practice does not recognise setting specific differences and is underpinned by competencies that all RNs must meet.

6. In my initial advice, I made many recommendations that I believed should be implemented by the DoC. These recommendations were specifically aimed at improving the practice environment to ensure RNs were better supported to provide an acceptable standard of care; in recognition of the difficulties of this health care setting.

7. Paragraph 2 of [the lawyer's] letter raises the issue of whether [Ms A's] reported haematemesis on the 4th of [Month7], should have been identified by [RN D] as a medical emergency. Particularly given the non-distressed appearance of [Ms A] and the absence of any direct evidence of vomitus seen by [RN D]. For my initial advice I reviewed the literature regarding the identification of gastrointestinal (GI) bleeding and the appropriate response(s).

8. The literature is very clear that GI bleeding is always an abnormal finding. In every situation, the appropriate first response is further assessment, including taking a comprehensive history and completing observations (i.e. temperature, blood pressure, heart and respiratory rate). Objective assessment that a patient is not distressed or in pain, or whether a nurse personally sees the vomitus, is not adequate information on which to base a judgement about the urgency of the clinical presentation.

9. I have attached two relevant papers. 'The management of acute upper gastrointestinal bleeding' (Nursing Times, 2004) confirms that not only do patients presenting with haematemesis tend to have more severe bleeding than those presenting with melaena, and therefore may be potentially more unwell; but that investigation and management of GI bleeding is limited in primary care and usually requires immediate hospitalisation.

10. There are specific GI bleeding risk assessment tools that are discussed in the literature (i.e. Glasgow-Blatchford Bleeding Score). However, these certainly would not be routinely utilised by RNs. Such tools incorporate a range of data, most of which require access to urgent laboratory testing. Therefore, given the limitations of most general practice/primary health care settings, including DoC health services, it would be expected and usual practice that these patients are immediately referred to secondary care services.

11. The chapter 'Haematemesis, Melaena and Haematochezia' (NCBI Bookshelf, 1990) defines acute GI bleeding as haematemesis which may be red or coffee ground in appearance. I acknowledge that in this situation, the vomitus was described as small amounts of coffee ground or black, and not frank fresh blood. However, the colour and quantity of the vomitus does not indicate severity nor urgency. Haematemesis '*is an acute potential emergency and must be considered as such until its seriousness can be evaluated'.*

12. I acknowledge that in the course of [Ms A's] care, many factors compounded to cause unacceptable departures from expected standards of care. I was cognisant of these factors in preparing my advice and did consider the effect they could have on the practice of nurses working in this setting. These included system and

process inadequacies that created an environment in which nurses experienced short staffing, workload pressures, and lack of continuity of care; as reiterated in [RN D's] statement and outlined in my report (paragraph 20).

13. [RN D's lawyer] is correct in noting that if care had been provided to an acceptable standard previously, neither [RN D] or [Ms A] would have been in the unfortunate situation they found themselves in, on the 4th [Month7]. However, in view of the literature and my own experience, I cannot change my advice; reported haematemesis must always be identified as an urgent potentially life-threatening emergency, irrespective of any other mitigating or confounding factors.

14. In my advice I recommended that consideration be given to the competence of the RN involved in [Ms A's] care on the 4th of [Month7] (Recommendations, paragraph 8). [RN D's lawyer] requests that I reconsider my opinion as it appears harsh given the circumstances.

15. Importantly, I would like to reiterate, I did not state that I believed [RN D] was incompetent to practise, nor did I state that [RN D] should be referred to the New Zealand Nursing Council or be subjected to a formalised competence review process. In fact, paragraph 19 of my advice focusses only on concerns about the lack of identification, assessment and response by [RN D], around the single issue of haematemesis. I cannot come to any other position regarding the critical importance of not identifying a 'red flag' such as this, and the concern it raises around competence; but again, only as it relates to this single issue.

16. In reviewing [RN D's] response to the Health and Disability Commissioner and my advice, I note significant evidence of reflective practice; and more importantly, the identification of key learnings from this experience. Reflective practice is a skill that underpins the RN scope of practice competencies. In my view, [RN D] has demonstrated insight and understanding of what occurred and what could be done differently; not only with regards to her practice, but at a systems/process level as well. In addition, [RN D] has identified some areas in which she would find further professional development helpful.

    In my opinion, the reflection and learning that [RN D] has clearly demonstrated, appropriately achieves what I intended from the recommendation; that is, meaningful consideration of competence, in this case evidenced through a willingness to engage with a reflective process, and to identify opportunities for practice development around this issue.

Kim Carter
RCompN, PG Dip Nsg, FCNA(NZ), NZCPHCN (NZNO)

References

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