Canterbury District Health Board

A Report by the
Health and Disability Commissioner

(Case 17HDC00497)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by Canterbury District Health Board (CDHB) to a man with alcoholic hepatitis. The man was discharged inappropriately, and was not provided further assistance by the hospital when he continued to be unwell on the day of discharge. The Commissioner found CDHB in breach of the Code of Health and Disability Services Consumers' Rights (the Code). The Commissioner was concerned about a lack of effective response to the man's need for help, and commented on the need for staff to think critically and recognise when a patient's condition indicates that staff need to speak up and advocate for the patient.

2. The man was admitted to the Gastroenterology Ward at the hospital and treated for alcoholic hepatitis. Around three weeks later he was discharged, despite remaining unwell and requiring ongoing medications, and having no suitable accommodation arrangements in place. The man was considered to be deliberately engaging in behaviour intended to prevent his discharge.

3. The man was escorted from the hospital by security staff and taken to a nearby bus stop while wearing hospital pyjamas. He remained at the bus stop for many hours. Members of the public and security staff raised concerns about his condition, but he was not reassessed. Later in the day, the Police were called to remove the man. He was issued a trespass notice and taken to the social service agency. While there his condition deteriorated further and he was returned to the hospital, where he died two days later.

Findings

4. The Commissioner found CDHB in breach of Right 4(1) of the Code for discharging the man while he had unresolved medical and accommodation issues, and for failing to reassess him, issuing him with a trespass notice, and requesting the Police remove him from the hospital. The Commissioner also found that CDHB breached Right 3 of the Code for failing to respect the man's dignity, and commented that there was a striking lack of compassion in failing to take seriously the concerns raised by security staff and members of the public.

Recommendations

5. The Commissioner recommended that CDHB apologise to the family, audit the operation of its new trespass policy, ascertain whether staff in the Gastroenterology Department feel free to raise their concerns and escalate these if necessary, review the Gastroenterology Department staff's ability to access test results, and develop a protocol for the readmission of patients who re-present following discharge.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs B concerning the care provided to her son, Mr A (dec), at Canterbury District Health Board (CDHB). The following issue was identified for investigation:

- *Whether Canterbury District Health Board provided Mr A with an appropriate standard of care in 2013.*

7. The parties directly involved in the investigation were:

Mrs B	Consumer's mother
Canterbury District Health Board	Provider

8. Further information was also reviewed from the New Zealand Police and the Coroner.[1]

9. Other parties named in the report are:

Ms C	Consumer's former partner
Dr D	Gastroenterologist
Ms E	Clinical Manager for Social Work Services
Ms F	Social worker
Ms G	Case manager
Dr H	Gastroenterologist
Dr I	Gastroenterology registrar
RN J	Associate Clinical Nurse Manager
RN K	Registered nurse
RN L	Registered nurse

Also mentioned in this report:

Ms M	Security officer
Mr N	Security officer
Mr O	Constable
Mr P	Constable
Mr Q	Night attendant

10. Independent expert advice was obtained from Nurse Practitioner (NP) Michael Geraghty (**Appendix A**) and Gastroenterologist Associate Professor Alan Fraser (**Appendix B**).

[1] The Coroner completed an inquiry into Mr A's death in 2017.

Information gathered during investigation

Background

11. Mr A (aged 47 years at the time of these events) had a background of depression and anxiety and had abused alcohol for many years.

12. Ms C was in a relationship with Mr A from about mid 2012. Ms C said that she found out that Mr A was consuming three litres of wine per day. Mr A stopped drinking alcohol for about five months. However, he began drinking alcohol again in 2013.

13. Ms C stated that she and Mr A attended an appointment at an Alcohol and Drug Service, during which Mr A was assessed and advised that he would need to undertake a 10-day medical detoxification, and then a three-month residential rehabilitation. However, there was a three-month wait before a bed would be available.

14. Ms C said that Mr A continued to drink heavily, his behaviour became erratic, and he did not eat for about six weeks. She stated that following Mr A's admission to CDHB, their relationship ended. She arranged for him to be served with a trespass notice so that he could not return to her home.

CDHB

15. Mr A was admitted to CDHB under the Gastroenterology Service. At the time of admission he was generally unwell, and was requesting detoxification. On examination, Mr A was found to have a very enlarged liver and to be jaundiced.[2] The impression was that he had acute alcoholic hepatitis.[3] A Maddrey score[4] was calculated to be greater than 32.

16. Mr A was under the care of a consultant gastroenterologist, Dr D. Mr A was treated with steroids (prednisone) and other standard measures to treat alcoholic hepatitis and potential alcohol withdrawal. Dr D stated that after seven days of steroid treatment, there was no sign of an improvement, so the steroids were tapered, but full supportive care was continued. Mr A's clinical state stabilised, but he remained jaundiced with biochemical evidence of ongoing alcoholic hepatitis. His symptoms of confusion improved, and he showed an ability to look after himself on the ward. His liver function tests improved, and his renal function remained within the normal range. Dr D stated that as Mr A's condition had stabilised, discharge options began to be considered.

17. The Clinical Manager for Social Work Services, Ms E, stated to the Coroner that on Day 3[5] a social worker, Ms F, saw Mr A. Ms F established that Mr A had received care from the Community Alcohol and Drug Service (CADS), and liaised with his case manager, Ms G, regarding the option of discharging Mr A to a drug and alcohol rehabilitation facility.

[2] Jaundice is yellowing of the skin and the whites of the eyes. Normally it indicates a problem with the liver or bile duct.
[3] A liver infection mainly caused by frequent, heavy alcohol use.
[4] A model for evaluating the severity and prognosis in alcoholic hepatitis, and the efficacy of using alcoholic hepatitis steroid treatment.
[5] Relevant dates are referred to as Days 1–23 to protect privacy.

However, subsequently it was established that no bed would be available in the foreseeable future, and that the waiting period would be several months.

18. Ms E stated that the social work discharge plan was to give Mr A information regarding alternative accommodation options. On Day 11, Ms F told Mr A that there was no bed available in a rehabilitation facility. He acknowledged that he could not return to his former residence with Ms C, and asked about backpackers' accommodation or hostels. He was referred to CADS, and an appointment was made for the following week.

19. On Day 14, Mr A was reviewed by a gastroenterology registrar, Dr I, who noted that Mr A had increased leg oedema and abdominal swelling, lacked energy, and was coughing up yellow phlegm. His prednisone was decreased to 20mg. Mr A was started on spironolactone[6] 50mg daily and frusemide[7] 40mg. An ultrasound scan confirmed moderate ascites.[8]

20. On Day 16, Dr D noted that Mr A said that he could not cope in backpackers' accommodation and had nowhere to go. It is documented that Mr A spent the majority of the shift in bed, was nauseous and vomiting, declined food, and said that he was constipated. Intravenous fluids were charted. The nursing notes state that he was very vague when asked questions about his nausea or his bowels, or how he was feeling. Mr A's C-reactive protein (CRP)[9] was 113mg/L, his white blood cell count (WBC)[10] was 14.3 x 10^9/L, his international normalised ratio (INR) was 1.8,[11] and his albumin[12] level was 18g/L. On Day 17, Mr A's WBC was 18.6 x 10^9/L, his creatinine[13] was 86µmol/L, and his bilirubin[14] was 390µmol/L.

21. It was planned to discharge Mr A on Day 17, but he failed to progress any of the options given to him by the social worker. Dr D stated that on Day 18, Mr A said that he would be willing to leave the ward on the following Monday, and would make arrangements over the weekend. Monday was a public holiday.

22. Dr H told HDC that he was the consultant gastroenterologist on call from 8am on Day 18 until 8am on Day 22. He stated that this involved reviewing gastroenterology patients each day, accepting admissions referred by the emergency department and general practice, and performing acute endoscopies.

[6] To treat fluid retention.
[7] To treat fluid retention.
[8] Accumulation of fluid in the abdominal cavity. Common causes are liver disease or cirrhosis, cancers, and heart failure.
[9] In healthy adults, the normal concentration of CRP varies between 0.8mg/L and 3.0mg/L.
[10] Normal range is 4.5 to 11 x 10^9/L.
[11] Used to evaluate the ability to clot blood. An INR result of 1.0 to 1.5 is normal.
[12] A normal serum albumin range is 35–55g/L.
[13] A waste product in the blood that passes through the kidneys to be filtered and eliminated in urine. The normal range is 45 to 90µmol/L.
[14] A normal level is around 1.71 to 20.5µmol/L.

23. Dr H said that he was aware of Mr A's condition and his behaviour on the ward, as information had been communicated to the entire Gastroenterology Department at the weekly departmental handover meeting throughout Mr A's admission. In addition, Dr H said that on the morning of Day 18, information about Mr A was provided to him directly.

24. Dr H stated that Mr A was pleasant to talk to, but he would lie in his bed for long periods with a damp flannel over his face. Dr H noted that Mr A had multiple episodes of faecal incontinence around the toilet despite the nursing staff being confident that he was able to toilet himself independently. Dr H stated: "Other patients in the six-bed room where he was based also commented on his unusual behaviour to the nursing staff." Dr H said that when Mr A was examined there was never objective evidence of encephalopathy (confusion caused by liver failure), nor was there worsening of his blood test results. Mr A's liver function test results had not returned to normal, but they were stable, and it was decided to discharge him and to monitor his medical condition as an outpatient.

25. On Day 18, the nursing notes state that Mr A's observations were stable but he was eating poorly. The notes refer to Mr A having spread faecal matter around the toilet.

Days 19–21

26. Dr H said that he reviewed Mr A on Days 19, 20, and 21. Dr H stated: "This involved discussing [Mr A's] progress with the nurse assigned to him, reading the hospital notes about progress since the day before and clinically reviewing him."

27. On Day 19, the nursing notes record that Mr A's observations had been stable over the previous 24 hours. Dr H recorded that at 9.15am on Day 19 he found Mr A to be asleep, and did not wake him. Dr H noted that Mr A was for discharge on Monday "as planned". It is documented that Mr A was asleep for most of the morning shift.

28. Dr H told HDC that on Day 20, he reviewed Mr A and discussed with him his planned discharge the following day. Dr H said that Mr A voiced no concerns about the plan. There is no record of this conversation. Dr H recorded: "For [discharge] tomorrow as planned."

29. The afternoon nursing notes state that Mr A's breath was "faecal smelling", he had not eaten anything offered to him for the previous two and a half to three days, he appeared a little muddled in conversation, and he had picked up a cup and dropped water over himself and the bed. When asked to assist with making the bed, he was unable to follow instructions. The nurse suggested that Mr A was constipated, and a plain abdominal X-ray was arranged. This was interpreted as showing constipation, although a subsequent formal radiology report did not confirm that.

30. The notes record that overnight Mr A was "up to the toilet +++ — loose bowels and [incontinent] on bathroom floor".

31. Registered Nurse (RN) K stated that on Day 21 she was the nurse in charge of the ward during the morning shift. She said that she was responsible for overseeing all the patients and nursing staff, and was also responsible for the ward clerk administration duties, as it

was a public holiday and no ward clerks were rostered on. RN K stated that she was aware that Mr A's care had been planned during the multi-disciplinary team meetings, but she had not been involved in the meetings.

32. RN K said that she saw Mr A walking around the ward that morning in his hospital net underpants, and it appeared that he had been incontinent. She stated that at around 9.30am Dr H approached her and asked why Mr A was still on the ward, as he was a planned nurse-led discharge for that day. RN K stated: "[Dr H] appeared unhappy that this had not yet occurred." She said that she spoke to RN L, who was Mr A's assigned nurse, and RN L said that she was uncomfortable about discharging Mr A, and that he had been incontinent.

33. RN K said that she told Dr H that Mr A had been defecating around the ward and wearing only hospital net underpants, and that nursing staff were not comfortable about discharging him, as he appeared unchanged from the previous day. She stated that she raised concerns about Mr A's cognition (as had been recorded in the notes the previous day) and his ability to make decisions about transport and residence. She said that she asked Dr H to read the nursing notes from the afternoon shift on Day 20.

34. Dr H stated that he noted that the nursing notes recorded that Mr A had not been eating well, had been spilling water, not following instructions, and had continued to be incontinent of faeces. Dr H was also aware that Mr A had been walking around the ward without pants on, which had upset other patients. Dr H stated: "These behaviours were consistent with his previous conduct on the ward that had been attributed to behaviour rather than related to his underlying medical condition."

35. RN K stated that Dr H expressed the view that Mr A was deliberately incontinent. She said that she reiterated to Dr H RN L's concerns that Mr A did not appear well enough to be discharged. RN K stated that Dr H then saw Mr A, and returned and directed that Mr A be discharged, and that if he did not leave on his own accord then she was to notify security to escort him. RN K stated:

> "I advised [Dr H] that nursing staff would not be comfortable calling security to discharge a patient and that if he wished this to occur that he needed to document this in the clinical notes."

36. Dr H said that when he reviewed Mr A he found that Mr A was not obviously confused or distressed and was able to engage in discussion. At 9.30am, Dr H recorded: "For [discharge] today. Patient deliberately incontinent on ward. If does not leave please ask security to escort off premises."

37. Dr H said that when he explained to Mr A that he would be discharged that day, Mr A said that he had not arranged accommodation. Dr H stated that initially Mr A's discharge had been planned to be nurse-led, meaning that a nursing decision could be made concerning his discharge unless any specific problems were identified. However, because the nursing staff had expressed concerns that Mr A's behaviour was inappropriate, Dr H said that he reviewed Mr A clinically, as a nurse-led discharge was no longer appropriate.

38. Dr H stated that his opinion was that Mr A's medical condition was no different from what it had been over the preceding week. Dr H said that having met Mr A on several days, discussed his case with Dr D, and being aware of the multi-disciplinary team's opinions, he believed that he was in a good position to make the decision for discharge. Dr H stated:

> "While the nursing staff had concerns, the nurses involved had not looked after [Mr A] regularly and were therefore less aware of the medical and behavioural issues over the preceding two weeks. As such, I requested that the nurses facilitate this discharge after I had reviewed [Mr A]. The nursing staff informed me if this was to happen then security would need to be called. I agreed that this was appropriate in the circumstances. After my review of [Mr A], I told the nursing staff that they should contact security if [Mr A] declined to leave the ward."

39. CDHB told HDC that the discharge process had been underway since about Day 3, and was led by the clinical team. It said that it was mainly due to the delays in finding accommodation for Mr A that the discharge process had not happened earlier.

40. Dr H stated that it had been planned that Mr A would have a blood test on the morning he left the ward, to check his liver and renal functions, but Mr A refused to have the blood test. The results of a blood test taken on Day 18, which showed that Mr A's renal function had deteriorated, were not available at the time of discharge[15] (discussed further below).

41. RN K stated that she and RN L discussed their discomfort with the decision to discharge Mr A, but conceded to the decision. RN L recorded that Mr A was assisted with a bed wash, as he was not interested in having a shower. She recorded that Mr A was given clean hospital clothes, as his own clothing was soiled. He was given his medication (including prednisone and diuretics) and discharge paperwork, and reminded that there were accommodation information leaflets in his bag.

Removal from hospital

42. RN L recorded that Mr A had been notified that he would have a security escort to the main entrance of the hospital. She documented that Mr A began to get agitated but was easily calmed by security and was escorted off the premises at approximately 10.30am.

43. Ms M told the Police that on Day 21, she was working as a security officer with Mr N. Ms M stated that they were asked to go to the ward to deal with a patient. They were taken to Mr A and told to remove him because he had "overstayed his welcome". She stated that Mr A was "really yellow", and said: "We asked the nurse if they were sure we were to remove him because he looked really sick." Mr N told the Police that he noticed that Mr A was "bright yellow". Mr N stated: "[Mr A] was fumbling around, slurring his words and to me he appeared really sick." Mr N said that he spoke to the nurse, and then the doctor came down and said: "All his tests are fine and he is pretty much just looking for a free

[15] The results of the blood tests performed on Day 18 were not reviewed until after Mr A's discharge on Day 21. The results were: creatinine 122µmol/L, albumin 18g/L, bilirubin 375µmol/L, CRP 182mg/L, WBC 17 x 10^9/L, INR 1.7, neutrophils 15.2 x 10^9/L (normal 2.0–8.0 x 10^9/L), and metamyelocytes 0.17 x 10^9/L.

ride." Mr N said that the doctor told him that Mr A was fine until they told him that he had to leave, and then he started the current behaviour.

44. Mr N said that they put Mr A in a wheelchair, took him to the bus stop outside the hospital, and cut off the hospital bracelet that was on his arm. They then left Mr A in the bus stop with his possessions.

45. Ms M said that they checked Mr A approximately every hour. He was sitting at the bus stop then later he lay down and slept. Ms M stated that members of the public came into the hospital because they were concerned about Mr A.

46. During the day, Mr N telephoned Police communications to advise them of the risk that Mr A presented to himself and other people because he was walking in the traffic and lying down on the side of the road; however, a Police unit did not attend at that time.

47. Mr N said that on three occasions one of the security staff went to the nurses' station and asked for someone to check Mr A and, each time, the nurse called the ward, and the doctor there said that there was nothing wrong with him. Mr N said that the security staff were told to tell concerned members of the public that Mr A was fine.

48. In response to the provisional opinion, CDHB said that none of the three nurses identified as being on triage that afternoon have recorded that, or have any recollection that, Mr A was brought to the triage desk. CDHB submitted that there is no evidence that the nurses' station put calls through to the ward, which then responded by saying there was nothing wrong with Mr A. CDHB said that it would expect that if a person was brought to the triage desk in the Emergency Department, the nurses would triage the person and have them assessed, irrespective of when they were discharged.

49. RN K stated that at approximately 2pm, a security staff member contacted her by telephone and stated that members of the public were concerned about the behaviour of a man at the bus stop who appeared unwell. She stated that she said that if the man was Mr A, he had been medically cleared and discharged from the ward by the consultant that morning. She said that she advised security to take him to the Emergency Department and, if necessary, to call the Police to assist. She said that the process at CDHB to re-assess whether a discharged patient needs re-admission is through an assessment in the Emergency Department.

50. RN J, an Associate Clinical Nurse Manager in the CDHB Emergency Department, said that he read the security incident notes that record that security contacted him about Mr A, and suggested that the security officer contact the ward from which Mr A had been discharged. RN J stated that he has no recollection of these events, and noted that the Emergency Department is a busy environment. RN J said: "Other than referring security to the ward [Mr A] was discharged from, I believe that I would not have given the matter much further consideration given the immediate pressures of my role."

51. At 4.30pm, an orderly took Mr A to the Emergency Department waiting room. In response to the provisional opinion, CDHB highlighted comments made by the Coroner:

> "The information provided to me is clear that the ED waiting room is busy, and often crowded. If Security were managing the situation (as they were, having already escorted [Mr A] from the hospital and subsequently seemingly taking responsibility for him in the ED) [Mr A] would likely have been seated near the security office located at the back of the waiting room. For him to have been further triaged by medical staff in the ED it would have been necessary for him to have been taken to the triage desk with a request that he be reassessed or otherwise treated. There is nothing to indicate that that was pursued."

52. Hospital security then contacted the Police and requested that Mr A be removed. The Police attended and recorded that Mr A had a yellow complexion, looked unwell, did not speak, and appeared to be in pain when he moved. Mr O, a Police constable, stated to the Coroner that, on arrival, he spoke to one of the hospital security staff, who told him that Mr A had been discharged by senior medical staff five days earlier and had been sleeping in the Emergency Department. Mr O said that he was told that Mr A was becoming a nuisance to staff and patients, and that staff had asked for him to be removed.

53. Mr O said that he asked whether Mr A had been "trespassed", and the security staff replied that they had not done so, but they could if it made it easier for Police to remove him. Security staff then issued Mr A with a trespass notice, and Mr O arranged for Mr A to be transported to the social service agency night shelter.

54. Police Constable Mr P stated to the Coroner that Mr A said very little while being transported, and appeared to be confused. Mr P said that upon arrival, Mr A was handed over to the social service agency staff and advised that Mr A had been trespassed from CDHB. Mr P said that he asked social service agency staff to contact the Police if there were problems, or to call an ambulance if they were concerned about Mr A's health and well-being.

Social service agency

55. A night attendant, Mr Q, completed an incident report, which states that at about 6pm on Day 21 two Police officers arrived with Mr A and said that he had been discharged from CDHB five days previously and had been sleeping at the hospital trying to get re-admitted.

56. Mr Q noted that Mr A was wearing pyjama trousers and a jacket and was very unsteady on his feet. The Police explained to Mr Q that they had no option other than to bring Mr A to the night shelter, as they were not in a position to arrest him.

57. Mr Q agreed to take Mr A in on the understanding that social service agency staff would assess whether he was suitable for the night shelter and, if he was not suitable, Mr Q would telephone the Police and they would take Mr A to psychiatric services or back to the hospital.

58. Mr Q noted that he and the other attendant on duty attempted for 45 minutes to feed Mr A and get details from him. They concluded that they could not admit Mr A to the night

shelter and, at approximately 7pm, Mr Q telephoned the Police, who agreed to collect Mr A.

59. Mr Q said that at around 9.30pm Mr A started to vomit. He appeared to be vomiting blood, and was almost unconscious. Mr Q telephoned the ambulance service, and a paramedic examined Mr A and found that his blood sugar level was extremely low. The ambulance staff were unable to find a vein to insert a cannula.

60. Mr A was transported to CDHB by ambulance and admitted. At that stage he was vomiting, confused, and unable to communicate. Mr A continued to deteriorate, and died two days later.

Further information — CDHB

Blood test results

61. Dr H told HDC that at the time of Mr A's discharge on Day 21, he was not aware that Mr A had had a blood test on Day 18. CDHB stated that Dr H had viewed his dashboard in the electronic system (Éclair) for patient results, but Mr A's result did not appear as it was coded to a specific team code, "GASTRO4", as documented on the request form. Dr H's Éclair account was not set up to link to the "GASTRO4" code on his dashboard.

62. CDHB stated that as Dr H was not aware that there was a test result to check, he did not manually check the individual entry for Mr A. Dr H stated that he would not have discharged Mr A if he had known the results were pending, or if he had seen the results of the Day 18 blood test, which demonstrated a deterioration that was not clinically clear at the bedside.

63. CDHB stated that only two of the gastroenterologists in the team had added the "GASTRO4" team code to their dashboard display. The DHB said that the process cannot be automated with the electronic system, and relied on clinicians knowing that the team code existed, manually searching for the team code, and saving it to their results dashboard. CDHB stated that Dr D was able to see results under the "GASTRO4" team code, and was not aware that Dr H was not able to see the results under that code.

64. CDHB stated:

> "[Dr H] was not aware of the team code at the time of [Mr A's] case. As such, [Dr H] would have been expecting the results to appear in his main dashboard … which is pre-programmed as part of the creation of the clinicians' user account within Éclair."

65. CDHB noted that this has been flagged as an area of further improvement for services where a patient is admitted under a team rather than under an individual consultant. CDHB stated that training and refresher courses on Éclair are available for clinicians to attend.

66. CDHB said that the blood test on the morning of Day 18 was performed as part of the daily[16] routine testing, and Mr A's blood test results had been unchanged throughout the week. The DHB stated: "There was no indication to suggest that his condition would suddenly change at that point."

67. CDHB said that any test results received after a patient's discharge are available to the GP who has continuing oversight of the patient or, if the specialist is planning on a follow-up outpatient clinic, the results can be reviewed and then discussed with the patient as necessary.

Trespass notice

68. CDHB stated that Mr A remained in the vicinity of the public bus stop on the street along from the hospital and was becoming a public nuisance, so the Police were asked to attend. CDHB said that the trespass notice was issued at the request of the Police to provide the authority to remove Mr A from the hospital premises. CDHB stated that a trespass notice does not prevent a person re-presenting or accessing necessary health care.

69. CDHB told the Coroner that CDHB does not have a formal trespass policy. It stated that occasionally individuals (generally visitors to the hospital) are "trespassed" owing to violence, threats of violence, or intoxication, where the behaviour is believed to pose a risk to patients, staff, and visitors.

70. The DHB stated that at the time Mr A was issued with a trespass notice on Day 21, there was no centralised process requiring senior management involvement as a "check and balance" of the decision. However, any decision to issue a trespass notice now requires input from the hospital Duty Manager.

Discharge

71. CDHB told HDC that if nursing and security staff expressed concerns or reservations about a discharge, it would have expected the matter to be raised with the Duty Manager. It stated:

> "The duty manager would provide additional scrutiny on the decision making around discharge, and again if they became aware of [Mr A] being brought back into the emergency department."

72. CDHB stated that with regard to Mr A's accommodation, attempts were made to find an NGO (non-governmental organisation) provider that offered supported accommodation, but there were no beds available.

73. CDHB said that on the morning that Mr A was discharged, his reluctance to leave was seen to be behavioural rather than a result of deterioration in his medical condition. The DHB stated that this perception seems to have heavily influenced the subsequent decision-making regarding his re-admission to hospital.

[16] Mr A did not have a blood test performed on Days 19 and 20, and refused a test on Day 21. CDHB stated that Mr A was considered competent to decline the test.

74. CDHB does not, and did not at the time, have a specific policy in relation to failed discharges. CDHB told HDC: "The general rule is that if a patient readmits with a diagnosis the same as their discharge service then they will be readmitted to that service."

75. CDHB stated that the Gastroenterology Department has reviewed the discharge processes to help to prevent this scenario happening again, and any patient who would be homeless if discharged would now remain an inpatient until a solution could be found.

Other matters

76. CDHB told the Coroner that since these events it has implemented "Speak Up", a tool for encouraging staff, particularly nurses, to raise any concerns and to empower them to take their concerns further if necessary.

77. CDHB stated that at this time the impact of the Canterbury earthquakes was still apparent. The Gastroenterology Service had changed its location twice in two years, and at the time of this incident was responding to a further relocation to another building on a semi-permanent basis.

78. Since April 2016, the Gastroenterology Ward has had a gastroenterologist on the ward during the week, and a separate gastroenterologist on call after hours. The gastroenterologist who is on call over the weekend will then be rostered on the ward until the following Friday morning, at which time he or she will hand over at a departmental ward round. CDHB advised that this has improved continuity of care for inpatients.

79. CDHB now has a Security Guidance and Trespass policy, which requires general manager approval before an individual can be issued a trespass notice. CDHB stated that it believes that security would not now be called in to remove a patient deemed fit for discharge, and that other methods, including discussion with the patient and any family or friends (as permitted by the patient) would occur instead.

80. CDHB accepts that at the time of Mr A's admission there was a lengthy waitlist for detoxification and residential alcohol and other drug (AOD) addiction treatment. It advised that since 2013 there have been changes to the delivery of AOD community care, including an integrated system between CDHB and NGO AOD providers; a physical centre where all agencies have a presence; more active follow-up, including home visits; investment in expansion of clinical capacity; more focus on long-term engagement in a community support network; more services available to people with addiction issues that previously had been available only to people with mental health conditions; and a reduction in wait times or no waitlist in community residential detoxification and residential rehabilitation/ respite facilities.

Coroner's findings

81. The Coroner conducted an inquiry following Mr A's death. The findings were issued on 29 August 2017. The Coroner commented:

> "[Mr A's] death was caused by his alcoholic liver disease. His discharge, resulting lack of medical evaluation and treatment, coupled with what took place for [Mr A] through

> [Day 21] until he was readmitted to hospital that night, may not have caused his death but did not enhance his chances of survival."

Responses to provisional opinion

82. Mrs B and CDHB were given an opportunity to comment on relevant sections of the provisional opinion. Where appropriate, comments have been incorporated into the report.

83. Mrs B confirmed that she had no comments.

84. CDHB said that it accepts that it is in breach of the Code, and also accepts the recommendations and follow-up actions in the report. It stated:

> "The DHB accepts that its systems and processes did not function adequately and that we failed in giving [Mr A] the ability to die with dignity in hospital. It is accepted that the usual checks and balances we expect to have in place did not operate here, particularly involvement of the Duty Manager, who would expect to be contacted where staff have concerns around discharge, and where security have concerns about a patient."

85. Dr H told HDC:

> "It should not be underestimated how much the documented behavioural issues throughout [Mr A's] admission, and after his liver disease was stable, made it difficult for those caring for him to differentiate between his behaviour and signs of advancing liver disease. As previously advised, when nursing staff expressed their concerns with me about [Mr A], I did not dismiss or disregard these concerns, rather I undertook a further review of [Mr A] including a history and examination, and because of the difficulty distinguishing between behavioural issues and clinical symptoms, a further blood test was offered to [Mr A] to objectively rule out any medical cause.
>
> I agree that it is essential for hospitals to develop a culture in which staff feel free to raise concerns and it has always been my practice to engage with and listen to all members of our team. Indeed, I actively encourage all medical and nursing members of our team to raise any concerns they may have with me at any time."

86. Dr H confirmed that he has undertaken further training in the use of Éclair and is aware of how to manually access patient results when a patient had been admitted under a different or specific team.

87. Dr H stated: "I am truly sorry about [Mr A's] death and for the events around his discharge."

Opinion: Canterbury DHB — breach

Introduction

88. Mr A was admitted to CDHB with apparent acute alcoholic hepatitis. Initially he was treated with the steroid prednisone and other medications, but as there was no sign of improvement the steroids were tapered down. At the time of discharge, Mr A was still being treated with prednisone and diuretics. This report considers the decision to discharge Mr A, and the events that occurred following his discharge.

89. DHBs are responsible for the operation of the clinical services they provide, including any service failures. It is incumbent on all DHBs to support their staff with systems that guide and support good decision-making and promote a culture of safety.

90. It is also essential that staff think critically and recognise when a patient's condition indicates that they need to speak up and advocate for the patient. In addition, teams need to communicate well, and ensure that concerns are escalated appropriately. I consider that the care provided to Mr A by staff at CDHB was significantly suboptimal, as discussed below.

Decision to discharge

91. During his admission, Mr A's condition had stabilised to some extent, although he remained jaundiced with biochemical evidence of ongoing alcoholic hepatitis. Social worker Ms F liaised with Mr A's CADS case manager, Ms G, regarding the options of discharging Mr A to a drug and alcohol rehabilitation facility. However, no bed was available in the foreseeable future. Mr A was given information regarding alternative accommodation options, but by the time of discharge he had no accommodation arranged.

92. On Day 14, Mr A was feeling unwell, and had increased leg oedema and abdominal swelling, a lack of energy, and was coughing up yellow phlegm. My expert advisor, gastroenterologist Associate Professor Alan Fraser, stated that this was the beginning of the deterioration of Mr A's liver condition. Dr Fraser said: "The interpretation was fluid overload but this was the onset of decompensation or worsening liver function."

93. On Day 18, Mr A was incontinent, and this was interpreted as a deliberate attempt to avoid discharge. He still had no suitable accommodation available. His discharge was delayed, but it was planned that he would be discharged on Day 21, which was a public holiday.

94. Mr A underwent blood tests on Day 18, but the results were not reviewed by the gastroenterologist on duty over the weekend, Dr H, prior to Mr A's discharge. CDHB stated that Dr H was not aware that Mr A had had a blood test on Day 18. Mr A's test results did not appear on Dr H's dashboard for patient results, because the result was coded to a specific team code, "GASTRO4". As Dr H was not aware that there was a test result to check, he did not manually check the individual entry for Mr A. Dr H stated that he would not have discharged Mr A if he had known that results were pending, or if he had seen the results of the Day 18 blood tests that suggested that Mr A's condition was deteriorating.

95. Dr Fraser advised that the results indicated that Mr A's condition was unstable and required monitoring. In my view, the service had sufficient information to identify Mr A's deterioration, but through a systems failure, that information was not available to Dr H. However, despite the blood test results, there were a number of indicators that there should have been concerns about Mr A's condition.

96. On Days 19 and 20, Mr A slept for much of the time. On Day 20, the afternoon nursing notes record that he had not eaten for two and a half to three days, appeared muddled in conversation, and had dropped water on himself and the bed. When asked to assist with making the bed, he was unable to follow instructions. He had been incontinent and walked around the ward dressed inappropriately.

97. A discharge had been planned for Day 21. However, both RN K and RN L expressed to Dr H their disquiet about discharging Mr A. RN K asked Dr H to review the nursing notes from Day 20, and reiterated RN L's concerns that Mr A did not appear well enough to discharge. Dr H then instructed that Mr A was to be discharged and, if he did not leave, security was to be asked to escort him off the premises.

98. Dr Fraser stated that from Day 14, there was a failure to recognise the significance of Mr A's clinical deterioration. Dr Fraser said:

> "Increased leg oedema and abdominal distention was the first sign of worsening liver function. Appropriate treatment was given but planning for discharge should not have occurred until his condition was stable."

99. Mr A was discharged wearing hospital pyjamas, as his own clothing was soiled, and he was given discharge paperwork and medications, including prednisone. Dr Fraser noted that discharge over a long holiday weekend is always a risk, and stated: "Discharge with no plans for continuing care should not be made at any time." Dr Fraser stated that there were a number of unresolved issues with regard to Mr A, including:

- The reason for the faecal incontinence was not known.
- Mr A had no appropriate accommodation with supervision.
- It was unclear whether Mr A had the ability to manage multiple medications including a high daily dose of prednisone (20mg).
- It was not known how Mr A's ascites and leg oedema, which had been unresponsive to diuretic treatment, were to be managed.

100. Dr Fraser said that it was clear that Mr A would be unlikely to be able to take medication with any reliability without supervision. Dr Fraser stated:

> "Continued accurate compliance with Prednisone treatment and diuretics was important. There was a continued need for monitoring and dose alteration depending on response."

101. I accept Dr Fraser's advice. In my view, Mr A's unresolved medical and accommodation issues, and his need for ongoing compliance with treatment, meant that it was not appropriate for him to be discharged at that time.

102. Dr Fraser advised that, in his view, Dr H could not be blamed for the events on Day 21, although there was an opportunity that morning to revise the decision that had been made on Day 18 to discharge Mr A.

103. Despite this advice, I am concerned that Dr H disregarded the concerns raised by two nurses that Mr A was too unwell to be discharged. I consider it essential that hospitals develop a culture in which staff feel free to raise concerns and are listened to. After the concerns were raised with Dr H, he undertook a further assessment of Mr A, which included offering a further blood test, and concluded that there were no clinical symptoms or signs suggesting that Mr A's behaviour reflected a deterioration of his liver disease. The behavioural issues described to Dr H were consistent with those seen over the preceding week, which previously the Multidisciplinary Team caring for Mr A had attributed to behavioural issues, rather than being due to his liver disease. Dr H therefore considered that Mr A was deliberately engaging in behaviour intended to prevent his discharge. However, I note that Dr H's contact with Mr A over the weekend was limited. Mr A was asleep on Day 19, and there is no record of any assessment on Day 20. Dr H said that when he reviewed Mr A, he found that Mr A was not obviously confused or distressed, and was able to engage in discussion. However, Dr H recorded only: "For [discharge] tomorrow as planned."

104. I find it extraordinary that Mr A was discharged to a bus stop wearing hospital pyjamas, and while he was obviously unwell. The hospital security staff and Police refer to Mr A being extremely yellow, and members of the public were sufficiently concerned to attempt to obtain hospital assistance for Mr A. I agree with my expert that discharge to a bus stop should never happen, and I note Dr Fraser's comment: "All patients deserve equal care regardless of personal circumstances."

Events following discharge

105. Mr A was reluctant to leave the ward, and so security was called. At around 10am he was escorted out of the hospital and left with his belongings at a bus stop outside the hospital. From around 11.30am, members of the public reported concerns about Mr A to the Emergency Department, including that he was wandering in traffic and lying on the ground.

106. Security staff checked Mr A from time to time, and stated that they went to the Emergency Department nurses station on at least three occasions and asked for someone to check Mr A. While security staff stated that a nurse called the ward and was told that there was nothing wrong with Mr A, in response to the provisional opinion, CDHB submitted that there is no evidence that the nurses station called the ward. RN K stated that when she was contacted by a security staff member, she advised security to take Mr A to the Emergency Department and, if necessary, to call the Police to assist.

107. Mr A remained in the vicinity of the bus stop until an orderly took him to the Emergency Department waiting room at 4.30pm. CDHB stated that the triage nursing staff who were on duty do not have any record or recollection of Mr A being brought to the triage desk. Hospital security then contacted the Police and requested that Mr A be removed. Mr O, a Police constable, stated that the hospital security staff told him that Mr A had been discharged five days earlier, and that he had been sleeping in the Emergency Department. It is unfortunate that by that stage the information being provided regarding Mr A's circumstances was grossly inaccurate. Mr A was issued with a trespass notice, and the Police transported him to the social service agency.

108. Dr Fraser advised that it was not acceptable that multiple requests over several hours were made to have Mr A assessed. Dr Fraser stated:

> "The failure of reasonable care was not due to poor medical treatment, but a loss of concern for basic human dignity and a duty of care for all people regardless of their behaviour underlying reasons for their illness."

109. My expert nursing advisor, Nurse Practitioner (NP) Michael Geraghty, advised that the most appropriate action would have been for the Emergency Department staff to contact the ward from which Mr A had been discharged and seek directions. NP Geraghty noted that there are no ward notes documenting any conversations with Emergency Department staff. However, I note that RN K said that she was contacted by security staff at about 2pm, and that she advised them to take Mr A to the Emergency Department, and if necessary to call the Police to assist.

110. NP Geraghty noted that alternative options available to Emergency Department staff would have been to contact the on-call gastroenterology registrar, or seek support from the Emergency Department ACNM or the Emergency Department consultant. NP Geraghty stated that in light of the concerns expressed by members of the public, further assessment of Mr A should have taken place. NP Geraghty said that both the College of Emergency Nurses NZ and the Australasian College of Emergency Medicine have policy statements that no person should be denied access to health care via an emergency department, and the triage nurses had a responsibility to act.

111. NP Geraghty advised that at the very least, a set of vital signs, including an assessment of Mr A's level of consciousness, should have been recorded. NP Geraghty stated that in the absence of any clear documentation, it can only be assumed that Mr A received no further clinical assessment and was denied access to ongoing care. NP Geraghty stated: "This represents a significant departure from the expected standard and would be viewed unfavourably by a group of peers."

112. In response to the provisional opinion, CDHB stated:

> "It is accepted that the usual checks and balances we expect to have in place did not operate here, particularly involvement of the Duty Manager, who would expect to be

contacted where staff have concerns around discharge, and where security have concerns about a patient."

113. While I accept that Mr A was present in the Emergency Department waiting room, in the differing circumstances described by CDHB and the security staff, I am unable to make a finding whether Mr A was specifically brought to the attention of the triage nurses at the nurses' station. In either event (whether Mr A was or was not brought to the attention of the triage nurses), I am concerned that the matter was not escalated to the Duty Manager by either nursing or security staff, and Mr A was not reassessed.

Trespass notice

114. At the time of these events, CDHB had no formal trespass policy. The DHB stated that most trespass notices were issued to individuals who were violent, threatened violence, were intoxicated, or posed a risk to staff or patients. In my view, Mr A did not fit into any of those categories.

115. NP Geraghty advised that as Mr A did not fit the normal criteria for trespass, he required nursing and medical assessment to determine his clinical status. NP Geraghty noted that no CDHB policy document outlined the management of acute hospital readmissions, although there is a "general rule" that patients who re-present to hospital with a complaint pertinent to the original diagnosis will be accepted back under the care of that specialty team.

116. NP Geraghty noted that once Mr A was discharged, most decisions were taken by non-clinical staff, which placed them in an unenviable and inappropriate position. NP Geraghty stated: "For the majority of [Day 21] [Mr A] was subjected to a level of distress and uncertainty that should never have occurred."

Conclusion

117. CDHB had a responsibility to provide services to Mr A with reasonable care and skill. Mr A had unresolved medical and accommodation issues, and there were ongoing concerns from hospital staff and members of the public that Mr A required further assistance. The decision to discharge Mr A in these circumstances was very poor. There was also a breakdown in the system, which meant that Dr H was not aware of the blood test results from Day 18 that showed that Mr A's renal function had deteriorated. Further, I am particularly concerned that there was a lack of effective response to Mr A's obvious need for help. I consider that failing to reassess Mr A, issuing him with a trespass notice, and requesting the Police to remove him, were breaches of his right to receive services of an appropriate standard. In my view, CDHB failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

118. Furthermore, security staff and members of the public raised concerns at the Emergency Department about Mr A's condition on multiple occasions, as he was outside the hospital at a bus stop for many hours, dressed in hospital pyjamas and a jacket, and some of the time he was lying on the side of the road appearing obviously unwell. I consider that in these circumstances, Mr A's dignity was not respected, and that there was a striking lack of

compassion by failing to take these concerns seriously. Accordingly, I find that CDHB breached Mr A's right to have services provided in a manner that respected his dignity, and breached Right 3 of the Code.

Recommendations

119. I recommend that CDHB undertake the following actions and report back to HDC within three months of the date of this report:

a) Audit the operation of the trespass policy for the previous three months to ensure that in all cases the hospital Duty Manager has approved the decision to issue a trespass notice.

b) Undertake a review of the staff in the Gastroenterology Department to ascertain whether staff feel free to raise concerns and take concerns further if necessary.

c) Ensure that all clinicians in the Gastroenterology Department have undertaken adequate training in the use of Éclair.

d) Review the steps taken to ensure that all consultants in the Gastroenterology Department are aware of how to access patient results when a patient has been admitted under a team.

e) Develop a protocol for the readmission of patients who re-present following discharge.

120. I also recommend that CDHB provide a written apology to Mr A's family for its breaches of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

Follow-up actions

121. A copy of this report will be sent to the Coroner.

122. A copy of this report with details identifying the parties removed, except the experts who advised on this case and CDHB, will be sent to the Health Quality & Safety Commission, the Medical Council, and the Director of Mental Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Nurse Practitioner Michael Geraghty:

"Disclaimer.

I have been asked to provide a nursing opinion to the Health and Disability Commissioner on case number C17HDC00497. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Personal Statement
I am an Emergency Nurse Practitioner (NP) and currently employed at Auckland City Hospital, Adult Emergency Department (ADHB) and have been in this role since 2001.

I hold a Masters of Nursing degree (University of Auckland); I am an Honorary Professional Teaching Fellow (University of Auckland) and actively involved in a variety of professional and academic groups pertinent to emergency care.

Information reviewed
This report was based on the following information provided by the Commissioner and in respect to the care provided to [Mr A] at [CDHB], the complainant being his Mother, [Mrs B].

Letter of complaint dated […]

Canterbury DHB (CDHB) responses dated […] including relevant disclosures

Clinical records from CDHB covering the period of [admission]

CDHB response to questions re: readmission policy. 31st July 2018.

Information requested
I have been asked to make particular comment, from a nursing perspective on the following and advise whether I consider the care provided was reasonable under the circumstances:

[CDHB]'s emergency department (ED) refusal to admit [Mr A] on [Day 21].

The decision to trespass [Mr A] from the hospital.

Processes and policies expected to be in place in regard to trespass at that time.

Processes and policies expected to be in place in regard to admission processes at the time of events

The delay in the ED in diagnosing hepatic encephalopathy.

The availability of senior nursing expertise in the ED.

Any other matters in this case I may consider comment on.

In acknowledging the above points this is contextualised further by addressing the following questions:

What is the standard of care/accepted practice?

If there has been a departure from this standard(s), how significant is this departure?

How would a peer group view this?

Recommendations for improvement that may help to prevent a similar occurrence in future.

Summary of events

[Mr A] was admitted to [CDHB] on [Day 1] with vomiting and diarrhoea, abdominal pain and with a background history of alcohol abuse, depression, anxiety and a previous brain injury [in 2011]. He was admitted under the Gastroenterology team and with a diagnosis of acute gastritis, acute liver disease as a consequence of his alcohol abuse. He spent the next three weeks in hospital undergoing detoxification and optimizing his health. At the time of his admission he was homeless, estranged from his partner and a good deal of effort was spent during that time endeavouring to find [Mr A] suitable accommodation, ongoing rehabilitation as part of his discharge plan. An agreement had been made with [Mr A] that he would be discharged on [Day 21] with some emphasis placed on him to ensure he had arranged accommodation.

On [Day 21] he was discharged from hospital despite his reluctance to go, and hospital security staff were required to remove him from the hospital grounds.

In the hours after this and having been trespassed from the hospital the Police were called and he was escorted to the social service agency. His condition deteriorated whilst in the social service agency and that same evening he was readmitted to hospital via ambulance and died two days later.

A multidisciplinary meeting was held within the gastroenterology department [in] 2013 to discuss this case. It has been acknowledged that the deterioration noted in his actions in the days immediately prior to [Day 21] were wrongly attributed to behavioural issues when it was likely a sign of his deteriorating health. It has been agreed that he would not have been discharged on [Day 21] if this had been considered.

The focus of this report is around the handling of [Mr A]'s care on [Day 21] from the time he was removed from the hospital and until being re-admitted from [the social service agency].

Report

1. Canterbury DHB's emergency department (ED) refusal to admit [Mr A] on [Day 21]

There a very few notes in respect to this and no triage or ED notes.

From the statement given by the security staff and a timeline provided by the Customer Services Facilitator, [Mr A] was removed from the hospital at 09.45 hours,

taken to a bus stop close to the hospital. Members of the public coming to the hospital reportedly expressed their concerns for [Mr A] who had been seen laying on the ground, looked unwell and in their opinion a danger to himself. The security staff subsequently sought advice from the ED Associate Clinical Nurse Manager (ACNM), at his suggestion the security staff were asked to make direct contact with the staff on [the Gastroenterology Ward]. The advice from the ward was that [Mr A] was medically fit to be discharged.

At 16.40 hours an orderly brought [Mr A] back into the hospital (the circumstances around this are unclear) and to the ED triage area. From the limited notes available it seems some contact was made with [the ward] at that time.

Comment:
The ACNM has provided a statement in respect to the above and acknowledges having no recall of the conversation with the security staff. His advice to the security staff was appropriate, particularly as [Mr A] was not in the hospital at that stage. Without knowing the specifics of [Mr A]'s condition the best people to advise on this would have been the ward/medical staff who had been caring for him. This would be considered routine practice and is often in the best interest of the patient as it saves time, unnecessary tests etc if a person has to be re-admitted unexpectedly. ED staff are not in a position to attend to incidents or issues outside the physical space of the ED. The ACNM *could* have suggested an ambulance be called if there were sufficient concerns but this would very much depend on the context, information provided to him in that brief space of time.

— *I believe the actions taken by the ACNM in this context to be acceptable and would be viewed favourably by his peers.*

As noted above there are no triage or nursing assessment notes from ED in respect to the time when the orderly brought [Mr A] back.

In the first instance the most appropriate action from the triage area would have been to contact [the ward] and seek direction from them. There are no ward notes documenting any conversations with the ED staff. In a statement provided by a [ward] nurse, she acknowledges a phone call from the security staff, her advice was for [Mr A] to be directed to the ED. Alternative options open to the triage staff would have been to contact the on call gastroenterology registrar, and to seek support from the ED ACNM or the ED SMO (it is not clear whether the latter two individuals were aware that [Mr A] was in the triage area).

It has to be assumed at this stage that [Mr A] was in no condition to advocate for himself and there was sufficient concern being expressed by members of the public and security staff that further assessment should have taken place at this point. In the absence of any engagement from the gastroenterology team the needs of the patient should take precedence over any real or perceived barriers. This role falls to the ED staff and in the first instance the triage nurses. The College of Emergency Nurses NZ (CENNZ) and the Australasian College of Emergency Medicine (ACEM) both provide

policy statements that state no person should be denied access to healthcare via an emergency department. At the very least a set of vital signs (including an assessment of his level of consciousness) should have been recorded, this would have likely provided objective data to better inform staff as to his clinical state at that time.

— *In the absence of any clear documentation it can only be assumed that he received no further clinical assessment and was denied access to ongoing care. This represents a significant departure from the expected standard and would be viewed unfavourably by a group of peers.*

2. The decision to trespass [Mr A] from the hospital

Security staff were initially used to remove [Mr A] from the hospital and at the suggestion of the on call gastroenterologist overseeing his care that day. The decision to trespass him came later in the day and at the request of the Police who required that documentation in order to remove him from the hospital premises.

Comment:

The CDHB trespass notice states that an individual under such order is allowed back in to the hospital for emergency treatment, it is unclear whether [Mr A] would have been given a copy of this but I suspect the nuances of this would arguably have been lost on him at that stage.

Neither the security staff nor Police have the necessary skills or training to determine if an individual's behaviour is the result of illness or not and their actions were guided by the responses given by clinical staff that he was medically cleared.

— *I believe the actions taken by the security staff to be reasonable in this context. They had sought appropriate advice from clinical staff and acted on that information.*

3. Processes and policies expected to be in place in regard to trespass at that time

A statement from the CDHB Chief Medical Officer states there was no formal trespass policy at the time, in elaborating on this she acknowledges that most trespass notices are issued to individuals who are violent, threaten violence or are intoxicated and pose a risk to staff or patients. [Mr A] did not fit in to that category. The Security company cite the Occupier in Trespass Act (1980) as their reference for issuing such notices which can be either in writing or verbal. As mentioned above the decision to issue a trespass notice on this occasion was to enable the Police to remove him, as they otherwise had no other reason to do so.

Comment:

Again as noted above [Mr A] did not fit the 'normal' criteria for trespass and required some assessment (nursing and medical) to determine his clinical status.

As a consequence of this particular case CDHB have now instigated a process by which the Duty Manager will be involved in all future trespass notices which is appropriate.

4. Processes and policies expected to be in place in regard to admission processes at the time of events

The monitoring of acute readmission rates is a common quality indicator and low numbers in/a reduction in unplanned acute admissions can be seen as an indication of improving quality of care. CDHB like most DHBs check this as part of their performance monitoring, there is no CDHB wide policy document that outlines the management of acute hospital re-admissions either in 2013 or currently. There is a 'general rule' that patients presenting back to hospital with a complaint pertinent to their original diagnosis will be accepted back under the care of that specialty team.

Comment:
There are many patient centred and resource related issues why a patient should be re-evaluated by their original specialty or team should they re-present within a specified time period. Having a 'general rule' is open to misinterpretation and misuse and it would seem logical to make this a DHB wide policy involving all in-patient specialties.

5. The delay in the ED in diagnosing hepatic encephalopathy
There is an ED Medical Assessment Record completed that outlines the initial assessment, exam and differential diagnoses for [Mr A] when he was admitted from the social service agency. Amongst the diagnosis considered was the concern of an encephalopathy; he was transferred to a ward within a six-hour period. I believe the care given to him in the ED was timely and appropriate.

— *I believe the care provided taken by the ED team that evening to be entirely appropriate.*

6. The availability of senior nursing expertise in the ED
See comment above in report no. one.

— *I believe the actions taken by the ACNM in this context to be acceptable and would be viewed favourably by his peers.*

Summary
The Swiss cheese model of accident causation is a model used commonly in healthcare as well as many other organisations. It infers that whilst an error may occur at one level of an organisation, checks and balances already in place usually ensure that an error is identified before it becomes an irreversible failure.

In this particular case the decision to discharge [Mr A] was in error and this has since been acknowledged and reviewed by the hospital, and specifically the gastroenterology team. Once discharged however a number of incidents occurred that should have highlighted the need for an objective, clinical review and most of those decisions were taken by non-clinical staff placing them in an unenviable, inappropriate position.

[Mr A] was not eligible for a liver transplant and sadly it was inevitable that he would die at some stage as a result of his severe, chronic disease; fortunately he passed away peacefully in hospital and with family present two days after his re-admission. Whilst there were some organisational and arguably hierarchal barriers to him being re-admitted during that day more should have been done in the emergency department triage area to facilitate his re-admission. For the majority of [Day 21] [Mr A] was subjected to a level of distress and uncertainty that should never have occurred and in breach of his rights to respect, dignity and fair treatment.

CDHB have since made changes that impact on the trespass process, the security staff role should a similar event occur. As mentioned above (no.4) a more prescriptive CDHB wide re-admission policy may also be useful in removing any ambiguity about patient review accountability given that small but significant numbers of patients are always likely to be readmitted.

References

Code of Conduct for Nurses. Nursing Council of New Zealand. June 2012.

Competencies for Registered Nurses. Nursing Council of New Zealand. 2007.

College of Emergency Nurses — NZNO Position Statement Triaging Away 2007.

Quality Standards for Emergency Departments and other hospital based emergency care services. 1st Edition 2015. ACEM/CENA joint publication.

Understanding Duty of Care. NZNO. 2016.

Code of Health and Disability Services Consumers' Rights. 1994."

Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Gastroenterologist Associate Professor Alan Fraser:

"I have been asked to provide an opinion to the Commissioner on case number 17HDC00497 [Mr A].

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications and experience

I am a gastroenterologist qualified with MB, ChB 1980, FRACP 1990. I have an additional research qualification with MD 1994 following three years of research at the Royal Free Hospital, London, UK. I have been an academic gastroenterologist at the University of Auckland from 1992 to 2013. I had 12 months experience at the John Radcliffe Hospital, Oxford, UK completing research projects on inflammatory bowel disease during my sabbatical. I have written 130 research papers.

I am currently Honorary Associate Professor of Medicine, University of Auckland. I have been a consultant gastroenterologist at Middlemore and Auckland Hospitals from 1992–2007. I am currently working in private practice at the Auckland Gastroenterology, Mercy Specialist Centre and have a 1/10th position in the Gastroenterology department, Auckland Hospital training nurses in endoscopy. I have been President of the NZ Society of Gastroenterology (2011–2013) and Chair of the RACP Training committee on Gastroenterology (1998–2005). During this time I visited many gastroenterology departments in New Zealand advising on registrar training. I have been involved in training of gastroenterology registrars since 1992. I am currently a member of PTAC (Pharmacology and Therapeutics Advisory committee — advising to PHARMAC).

Sources

Letter of complaint dated […]

Canterbury DHB response [date] with relevant enclosures

Clinical records from [admission]

Specific requests for comment (per email)

The diagnosis of encephalopathy

The electronic management of gastro test results

Discharge requirements where there has been a hand-over of primary care

Team culture issues in regards to decision making processes

Procedures in relation to trespass notices against patients

From letter 1st March 2018

Appropriateness of care during [admission]

Appropriateness of decision to discharge on [Day 21]

Reasonableness of care by [Dr H]

Timelessness of diagnosis of encephalopathy

Adequacy of gastroenterology electronic test results systems

The team culture. What processes would you expect to be in place to ensure team co-operation and clinical decision making

The decision to trespass [Mr A] from [CDHB]. What processes should be involved

Any other matters

Summary of clinical case with comments

Only the inpatient records were provided from [Mr A's admission]. The clinical details were obtained from medical records and nursing notes. Comments are included in italics.

It is apparent that [Mr A] had a long history of heavy alcohol intake with multiple failed attempts at rehabilitation.

The stated reason for admission on [Day 1] was for management of alcohol withdrawal. The request for inpatient 'detox' came from his partner who called an ambulance. He was awaiting inpatient detoxification at the [inpatient facility] (for at least 3–4 months — since CADS assessment in [2013]). His partner was distressed by his increasing alcohol intake — reported as 3 litres of wine per day — and deteriorating general condition including incontinence and that he was needing increasing assistance for daily cares. He had been eating very little over the last 4 weeks.

On admission the major symptoms noted were diarrhea, vomiting and abdominal pain. On examination he was able to give a reasonable history. He had tender hepatomegaly but no abdominal distension. He was given intravenous fluids for 24 hours because of his vomiting.

He was noted to have abnormal liver tests and was diagnosed as having alcoholic hepatitis. This was assessed to be severe by a clinical score (Maddrey score > 32) and that the most appropriate treatment was with Prednisone 40mg daily (according to clinical trial evidence) — this was started on [Day 2].

Blood tests on admission included a serum albumin of 24 g/L, CRP 92, Bilirubin 293, INR 1.6, and serum creatinine normal at 54.

The medical assessment was of acute alcoholic hepatitis without decompensation — in particular no ascites (confirmed by ultrasound [Day 2]) and no encephalopathy. Blood tests were performed to exclude other possible causes of liver disease

On [Day 3] the staff were advised that the family was putting on a protection order. He was described as alert and orientated.

[Day 7]. Seen by Dr D. He was observed to have delirium tremens (DTs) and was prescribed valium. This problem typically presents 3–5 days after alcohol withdrawal. This appears to have been mild requiring only a few doses of valium.

The level of communication between staff and [Mr A] seems reasonable after initial detoxification. The plan initially was for transfer to [inpatient care] but after several enquiries it became clear that they would be unable to provide inpatient care for several weeks — actually […] was the final given date for possible admission.

[Day 8] Gastroscopy was performed to check for evidence of advanced cirrhosis — this was normal apart from showing oesophageal candidiasis.

[Day 9] He was examined by medical staff. No evidence of hepatic encephalopathy. Regular lactulose 10 ml b.d. prescribed and an oral antifungal added.

[Day 12] The ward Pharmacist noted he was confused and couldn't explain his medication with any confidence.

His condition appeared stable at least until [Day 14]. He was seen by the Gastro Registrar. He stated he was not feeling well. Examination showed pitting oedema of both legs and increasing abdominal swelling. There was tender hepatomegaly. The Prednisone was decreased to 20mg. He was started on Spironolactone at 100mg daily and Frusemide 40mg. Ultrasound confirmed moderate ascites.

This is the beginning of some deterioration in his liver condition. The interpretation was fluid overload but this was the onset of decompensation or worsening liver function.

The following day he was seen by the Gastro Reg. He said he was fatigued. He was told that discharge was planned at the end of week ([Day 18]) however no place was identified for him to stay. There was no place at [residential care]. The patient suggested a backpacker's hostel and this appeared to be accepted as a reasonable possibility and that the patient would need to arrange this.

The clinical diagnosis was decompensated liver disease. He was started on Baclofen 5mg tds.

Baclofen has been used in alcoholics to reduce dependency or craving for alcohol. This is a low starting dose. The safety of this medication with decompensated liver disease is uncertain.

[Day 16]. Spent majority of shift in bed. Complained of nausea and vomited; eating poorly, complained of constipation. Intravenous fluids were restarted.

He was started on Movicol and Laxsol prn. The nursing notes state that he was very vague when asked questions about nausea, bowels etc.

CRP was 113. WBC 14.3. INR 1.8. Albumin 18 g/L.

The records I had to review did not show any bloods from [Day 2–Day 15].

Blood tests on [Day 17] WBC 18.6. Creat 86, Bilirubin 390.

[Day 18]. He was incontinent of urine and faeces — faeces were present throughout the bathroom floor. This was interpreted as a deliberate attempt to avoid discharge. He was noted to be eating poorly.

S/B Consultant — discharge delayed but planned for nurse led discharge on [Day 21] (a public holiday). Patient stated he wanted to be discharged … and that he was trying to sort out places.

Blood tests were performed on [Day 18] but not reviewed until after discharge on [Day 21].

Creat 122 (mild increase)

Albumin 18 g/L (worse compared with admission; severely low serum albumin)

Bili 375 (mild increase but continued severe elevation)

CRP 182 (significant increase)

WBC 17 Neu 15.2. Metamyelocytes 0.17 (suggestive of infection)

INR 1.7 (no change)

The main red flags were the left shift of white blood cells with early forms of white blood cells and a significant increase in CRP highly suggestive of infection. The increase in serum creatinine on [Day 18] was mild but reflected an unstable situation that required monitoring. There was a rapid decline in renal function over the next 72 hours but this was not recognized as no further blood tests were taken.

Detection of infection during the course of alcoholic hepatitis is difficult because of the intense inflammatory response due to the liver disease. In this case the bloods of [Day 18] showed a clear change when the expectation was that the alcoholic inflammation in the liver should be gradually improving.

[Day 19] Seen by on-call consultant. Patient asleep.

[Day 20] Slept most of the day.

Nursing notes: Breath smells feculent. Kitchen staff stated that he has not eaten anything for last 2–3 days. His nurse noted that he was muddled; he couldn't follow instructions to help make the bed. He was walking around ward undressed. Other patients in room were complaining about his behaviour. [Day 20] evening — Nursing notes: Not eating, refusing Fortisip. Very lethargic, needs prompting.

[Day 21]. He was incontinent of faeces and urine around his bed space.

In retrospect these observations show that he was developing hepatic encephalopathy from [Day 18] (probably earlier).

Blood tests were planned but staff could not obtain sample.

Nurse-led discharge from ward went ahead as planned … There was discussion with the on-call consultant confirming discharge. He was discharged on Prednisone 20mg and multiple other medications.

It is clear that he would be unlikely to be able to take medication with any reliability without supervision. Continued accurate compliance with Prednisone treatment and diuretics was important. There was a continued need for monitoring and dose alteration depending on response.

He showed some reluctance to leave the ward. He was escorted out of the building by security (who were contacted by ward staff at 0945). He was left on bus stop outside hospital with his belongings.

He was reported to be showing troublesome behaviour by public. From 1130 onwards members of public were coming to ED reporting that the patient was lying on the ground not that he was confused.

1400 — Senior nurse at ED contacted. It was stated that he was cleared medically fit by the ward. Staff told security he was 'wasting staff time'.

He was taken to emergency department by an orderly at 1640. Police called.

Clinical review was refused and a trespass notice was arranged (maybe suggested by Police). He was taken to the social service agency by Police at approx. 6pm.

Ambulance was called by social service agency. Ambulance officer report at 9.30pm states he was vomiting and combative. He was described as unconscious and had vomited blood.

He was readmitted at 2200 [Day 21]. Emergency department notes state that he was confused and agitated. He was pulling off bedclothes and monitoring equipment. No history was possible from the patient. On examination the abdomen was distended (tense) and maybe tender. Both feet were grossly swollen with oozing. The respiratory rate was 24.

The clinical diagnosis was bacterial peritonitis with encephalopathy and hepatorenal syndrome (probably from over-diuresis in the setting of poor fluid intake and vomiting over the weekend).

Bloods on readmission [Day 21] 2055hrs

Creat 451 (significantly worsening renal function)

Albumin 17g/L (very low)

Bilirubin 402

CRP 156 (increased suggesting sepsis)

INR 2.4 — significantly impaired liver function — worse than [Day 18].

Nursing note 0300 [Day 23]. Very distressed state. Unresponsive to voice. Rolling eyes around and making grunting sounds.

He died 32 hours after readmission with liver failure and probable sepsis from unknown source.

Assessment of care

Treatment of medical condition

The diagnosis of alcoholic hepatitis was made on admission and this proved to be correct.

The assessment of severity of this condition and treatment with steroids was appropriate. His condition was stable for 2 weeks. His alcohol withdrawal symptoms had been well managed.

Steroid treatment for alcoholic hepatitis has risks, in particular, the risk of severe infection. Rapid deterioration can occur at any time and the timing of discharge was unfortunate just as his condition was changing for the worst.

There was a failure to recognize the significance of the clinical deterioration from [Day 14]. Increased leg oedema and abdominal distension was the first sign of worsening liver function.

Appropriate treatment was given but planning for discharge should not have occurred until his condition was stable.

His behaviour was interpreted as usual for patient, that is, part of a known personality disorder rather than due to hepatic encephalopathy. A few hours after discharge in emergency department the diagnosis of encephalopathy was not in doubt.

Unfortunately for the clinical team the rapid deterioration occurred over a holiday weekend and the discharge was planned on a holiday … when there was limited clinical assessment.

The ward staff on the day accepted the recommendation from the [Day 18] ward round without question. There were multiple unresolved issues on discharge and he needed to remain in hospital for monitoring. This became obvious within 12 hours.

These unresolved issues were:

Appropriate accommodation with supervision

What was the reason for faecal incontinence? He was initially constipated then perhaps over-treated with laxatives. The situation was changing and appropriate treatment was unclear.

How was he to manage multiple medication including Prednisone 20mg daily — still a high dose.

What would be the management of ascites and leg oedema that was clearly unresponsive to diuretic treatment.

It is easy to understand the difficulties involved in the care of this man. In retrospect different decisions may have been made but his care would be seen as within the boundaries of acceptable care with errors of judgements that could have been made by another competent medical team.

Systems errors and shortfalls

The outcome may not have been different if he had stayed in as an inpatient but the hospital is seen to be uncaring and the family can understandably have some concerns.

This experience calls into question the process of the nurse-led discharge that was planned 3 days before actual discharge. There needs to be a senior nurse with experience in liver disease overseeing any discharge.

The emergency department staff did not give acceptable care. It is not acceptable that multiple requests were made to assess this man over several hours. It is not reasonable to blame the earthquake for this failure of judgement. The stressful nature of hospital work, particularly in emergency department, is acknowledged but the fact is that 4 hours later he was given the intensive medical treatment that should have been given earlier in the day. The resources were available.

The failure of reasonable care was not due to poor medical treatment but a loss of concern for basic human dignity and a duty of care for all people regardless of their behaviour underlying reasons for their illness. His long history of heavy alcohol intake and failure to respond even for a short period to any treatment programme meant that he was heading for a premature death from alcohol-related complications. A sense of compassion fatigue and helplessness to prevent a premature death is understandable but does not give an excuse for the outcome.

It is difficult not to believe that there was a less than adequate response from many staff involved in his care because of value judgements about his alcoholism and

personality problems. All of this is understandable but not at the level of care that we should aim for.

[…] The initial plan for the admission was simply detox then to discharge to an inpatient treatment facility for alcoholism. The acute medical ward staff often consider that alcohol detox is not part of their role. This attitude may have led to a delay in recognizing that there was a serious medical problem developing while he was in their care.

The use of a trespass notice was inappropriate. This shows a complete lack of basic human care. This was a denial of care to allow the Police to make a completely unacceptable transfer to [the social service agency]. [The social service agency] [is] justified in their letter of complaint.

The explanation that admissions should arrive in the Emergency department by ambulance is not a reasonable explanation for the response of the Emergency department. There was an inability for think outside of usual processes to realise that there was a serious medical situation evolving outside their doors.

Failure to review the blood test on [Day 18] over the weekend and failure to perform repeat tests over the long weekend, particularly on [Day 21] when there had been a significant change in clinical status, was critical to subsequent poor judgement regarding him being fit for discharge. The systems involved in review of investigations over a long weekend need to be reviewed.

Improvements

Discharge to a bus stop should never happen. This was a failure of all of the ward staff including nursing and social workers who were aware of the developing situation all week (from [Day 14] when discharge was first planned).

I do not believe that the on-call consultant can be blamed for the sequence of events on [Day 21], although there was an opportunity in the morning to revise the decision from the ward round on [Day 18].

The assessment that he had a behavioural issue rather than encephalopathy was an error in retrospect but understandable given the information provided and the incomplete knowledge of the patient as an on-call consultant. The assessment was there was *no evidence to change the previous decision to discharge.*

I cannot find blame with the medical staff despite the incorrect decision to discharge this patient. The particular set of circumstances meant that competent doctors were unable to make the best decisions. There may have been some problem in the interaction between the complainant and [Dr H] but I cannot comment as no details are given apart from the letter of complaint. There was a failure of all staff on the ward to be compassionate.

All patients deserve equal care regardless of personal circumstances. I can only guess that [Mr A] tested the limits of human compassion such that good and competent staff appeared to make uncaring decisions.

I agree that he would have died in hospital during this admission and that no treatment would have made any difference to that outcome. There is general agreement that the interval discharge and readmission was 'traumatic to all involved'.

I am concerned that there was not nursing expertise on the ward to recognize a deteriorating patient with liver disease. There should be dedicated staff for liver patients who have some training in the area particularly if nurse-led discharge is a continuing practice.

Discharge over a long holiday weekend is always a risk. Discharge with no plans for continuing care should not be made at any time. [Mr A] was 'homeless' in the sense that the legal actions of his next of kin gave him limited options after discharge but he was not 'homeless' such that he wanted to be discharged to the streets or worse, a bus stop outside of the hospital.

I note that the Gastroenterology department has made a commitment not to make any further discharges without suitable arrangements in the community. It was not acceptable to leave it to [Mr A] to make arrangements in the absence of any suitable plans from the hospital/social work staff.

Associate Professor Alan Fraser
Gastroenterologist"

Addendum 22 June 2018

"Overall the ward staff, medical, nursing and administrative, departed from what would be considered appropriate and humane care to a moderate extent."