

Investigation report

The quality of healthcare services provided to a patient by the
Gold Coast Hospital and Health Service



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**HEALTH
OMBUDSMAN**

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Investigation report: The quality of healthcare services provided to a patient by Gold Coast Hospital and Health Service

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For more information contact:

Office of the Health Ombudsman, PO Box 13281 George Street, Brisbane QLD 4003, email info@oho.qld.gov.au, phone 133 OHO (133 646).

An electronic version of this document is available at www.oho.qld.gov.au.

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1. Background

This matter was referred to me as part of the transitional process from the Health Quality and Complaints Commission (HQCC) following legislative changes on 1 July 2014. As it was a HQCC transitional file, my investigation related only to the Gold Coast and Robina hospitals and not to individual providers.

2. The complaint

On 21 January 2014, a woman (the complainant) raised concerns with the HQCC by way of a written complaint regarding the health service her late mother (the patient) received from the Gold Coast and Robina hospitals between 28 March 2013 and 25 June 2013. The patient died on 25 June 2013 whilst in the care of the Gold Coast Hospital. The complainant raised the following concerns:

- there was a two to three month delay in diagnosing the patient's duodenal ulcer
- following diagnosis of the patient's duodenal ulcer, no immediate treatment was taken to treat the ulcer
- the duration of the patient's illness on her death certificate is incorrect and should be amended.

3. Health service provider

A review of the medical records failed to identify any specific health service provider involved in the treatment and care of the patient during her admission on 28 March 2013.

A review of the medical records identified the patient was admitted on 8 May 2013 under a medical practitioner. However, it is unclear the extent of the treatment and care they provided in this instance.

A review of the medical records identified the patient was admitted on 17 June 2013 under another medical practitioner. However, it is unclear the extent of the treatment and care they provided in this instance.

4. Investigation scope

A review of the original written complaint failed to identify any one practitioner responsible for the treatment and care provided to the patient. The HQCC investigation scope covered the health service provided by the Gold Coast and Robina hospitals.

In scoping this investigation, as no individual health service providers were identified I determined to continue to investigate the Gold Coast and Robina hospitals and to consider the treatment and care provided to the patient during each presentation at the health service. Therefore, the issues identified in the investigation were as follows.

4.1 Issue one

During the patient's admission to the Robina Hospital on 28 March 2013:

- an alleged failure to appropriately diagnose the patient correctly and ascertain if the patient was improperly discharged in this instance.

4.2 Issue two

During the patient's admission to the Robina Hospital on 8 May 2013 to 14 May 2013:

- an alleged failure to diagnose and treat the patient appropriately
- an alleged lack of appropriate follow up of the patient's CT scan results conducted on 8 May 2013.

4.3 Issue three

During the patient's admission to the Robina and Gold Coast hospitals on 17 June 2013 to 25 June 2013:

- an alleged delay in the treatment and care provided to the patient from the time of admission on 19 June 2013 to the time of death on 25 June 2013
- an appropriate follow up after the patient's endoscopy performed on 19 June 2013
- a death in this instance was a 'reportable death' as defined in part 2 of the *Coroners Act 2003*.

4.4 Issue four

The adequacy of the verbal communication between the patient, her family and the treating practitioners and the adequacy of the notes recorded in the patient's clinical records:

- the alleged lack of verbal communication between treating staff and family members
- the alleged deficiencies in written patient notes and record keeping.

4.5 Issue five

The overall treatment and management of the patient during her three separate admissions to the Robina and Gold Coast hospitals:

- the appropriateness of the overall treatment provided to the patient at each admission to the Robina and Gold Coast hospitals
- the appropriateness of the way the patient's treatment was managed by the Robina and Gold Coast hospitals.

5. Inquiries by the Health Quality and Complaints Commission

During its investigation, the HQCC obtained the following information and evidence:

- On 22 January 2014, a notice was issued to the Gold Coast Hospital and Health Service (GCHHS) to obtain the patient's medical records and other relevant information. An invitation to make a submission was provided with this notice.
- On 14 February 2014, the medical records were received at the HQCC.
- On 25 February 2014, the submission from the GCHHS was received at the HQCC.
- On 8 May 2014, a Human Error and Patient Safety (HEAPS) report from the GCHHS was received at the HQCC.
- On 21 May 2014, the HQCC issued a letter to the GCHHS seeking an update about service improvement implemented relative to the HEAPS report.
- On 20 June 2014, the HQCC received the response from the GCHHS.

No further information was obtained by HQCC and no further investigations were conducted into this matter by the HQCC after 20 June 2014.

6. Inquiries by the Health Ombudsman

During my investigation, the information gathered by the HQCC was received and analysed. As adequate evidence had been gathered, it was clear that the matter required clinical advice from an independent clinical expert with a specialty in gastroenterology and hepatology (the clinician) in order to identify any areas of poor clinical performance by a specific provider or failures in overall clinical coordination by the hospitals concerned.

Independent clinical advice was initially requested on 11 December 2014. Information was forwarded to the clinician on 25 February 2015. I received the clinician's response on 30 March 2015.

A complete analysis of the clinical advice as well as all the evidence obtained during this investigation has now been conducted including:

- The patient's medical records from the Gold Coast and Robina hospitals.
- GCHHS submission
 - The submission from the GCHHS advised that the health service had conducted a review of the patient's clinical records where concerns relating to the care of the patient were identified and the health service had recommended a HEAPS review be conducted by the Patient Safety Team.
- HEAPS report
 - The HEAPS report identified training requirements for medical and nursing staff regarding VTE prophylaxis education. The GCHHS has therefore introduced a new position within the clinical team to ensure improvement in this area. The role is to establish methodologies and education

material specific to VTE prophylaxis treatment. A VTE clinical improvement lead position was created and has been filled since approximately 30 March 2014.

- GCHHS follow up submission
 - The GCHHS advised in its response that some strategies and processes have been implemented since the completion of the HEAPS, including the introduction of the VTE clinical improvement position.
- The patient's medical records from her general practitioner.

7. Analysis of the information/evidence:

The evidence considered in this matter is summarised below.

The HEAPS review was performed as a result of a SAC 1 clinical incident, namely, the death of the patient in June 2013.

The GCHHS was invited to make a submission in relation to the complaint lodged by the complainant. The submission predominately focused on the patient's admission in May and June 2013.

The clinical advice was obtained from the clinician, who was asked to provide advice on the three separate presentations of the patient to the Gold Coast and Robina hospitals and asked to address a series of questions. Each series of questions was defined over three issues.

The evidence has been analysed and summarised by issue as follows.

7.1 Issue one: The patient's admission to the Robina Hospital on 28 March 2013

On 28 March 2013, the patient presented at the Robina Hospital with pain on the right side of her lower chest. The patient was reported to have no cough, fevers, trauma or urinary symptoms. The clinical staff conducted investigations specific to the patient's presenting symptoms and the patient was released to the care of her general practitioner on 28 March 2013.

7.1.1 Condition and presenting symptoms

- Right lower chest pain, radiates anteriorly
- No trauma
- No cough
- No fevers
- No urinary symptoms
- No weight loss

7.1.2 Analysis of evidence

HEAPS analysis

This admission did not result in a SAC 1 clinical incident. Therefore, a HEAPS was not conducted in this instance.

Gold Coast Hospital and Health Service submission

GCHHS made no reference to the diagnosis, clinical assessments and investigations conducted in this instance.

Clinical advice

The clinician believed appropriate diagnosis, clinical assessments, investigations and treatments were undertaken in this instance based on the patient's presenting condition and clinical symptoms.

The clinician noted, *'the patient has symptoms potentially related to a previous fall, fractured ribs, musculoskeletal issues related to osteoporosis and no obvious GI [gastro-intestinal] bleeding, anaemia and bloods unremarkable for significant upper abdominal pathology'*.

The clinician stated, *'the treatment plan reflected the provisional diagnosis of osteoporosis, bone, musculoskeletal pain'*.

The clinician declined to comment on whether the patient was appropriately discharged in this instance, however noted, *'if the patient was feeling improved and was tolerating oral intake and pain was managed, it could be deemed reasonable for the patient to be discharged into the care of her family to represent and be reassessed if symptoms persist'*.

The clinician did not identify a health practitioner whose performance or conduct in this instance was below the standard reasonably expected.

The clinician believed the Robina Hospital acted reasonably in this instance to rule out immediate life threatening problems and noted, *'a letter dated 28 March 2013 by the Robina emergency registrar ... requested further assessment and investigation by the patient's general practitioner seemed appropriate'*.

7.2 Issue two: The patient's admission to the Robina Hospital on 8 May 2013 to 14 May 2013

On 8 May 2013, the patient presented again at the Robina Hospital with pain on her right side. The patient presented with no fevers or urinary symptoms. The clinical staff conducted investigations specific to the patient's presenting symptoms and the patient was admitted as an inpatient as a result.

7.2.1 Condition and presenting symptoms

- Right flank pain radiating to right upper abdomen
- No fevers
- No urinary symptoms

7.2.2 Analysis of evidence

HEAPS analysis

This admission did not result in a SAC 1 clinical incident. Therefore, a HEAPS was not conducted in this instance.

Gold Coast Hospital and Health Service submission

GCHHS believes the patient was appropriately investigated for her pain and during this admission there were multiple investigations attempting to ascertain the cause of the patient's pain:

The history obtained and investigations do not support the diagnosis of duodenal ulceration and I particularly note that she was at no time anaemic during this admission.

GCHHS notes the patient's *'pain was improving by the time she was discharged'*.

Clinical advice

The clinician believed appropriate diagnosis, clinical assessments, investigations and treatments were undertaken in this instance based on the patient's presenting condition and clinical symptoms.

The clinician noted:

I feel there were some clues to the upper GI problems with ongoing weight loss, low serum albumin and drop in HB with IV hydration and the potential to seek upper GI endoscopy and abdominal ultrasound as part of the investigations considered would have been helpful.

A referral to the Gold Coast Hospital would have been required and I would expect should have been triaged as category 1 or 2 depending on the overall clinical illness of the patient – I find it difficult to paint a picture of how critically ill or not the patient appeared when assessed.

Category 2 review would ideally happen within three months of a referral being received. This time frame would still have been too long for the patient to wait for.

The clinician stated:

The diagnosis was limited by the available technologies but the efforts were made with bone scan, non-contrast CT scan and medical assessment. The issue of adequate diagnosis of symptoms depends on how the patient presented as she was reviewed each day. A perforating or penetrating duodenal ulcer can be a cause for significant pain and a pancreatic cancer can also be a cause for pain. The underlying chronic renal disease limited the power of the CT scan as the risk of triggering renal failure from IV contrast did not permit ideal assessment. It was not clear if oral contrast was administered as this may have found gastroduodenal pathology.

Based on the May 2013 CT report as stated there were no clues that a perforation or sub diaphragmatic or sub hepatic collection was present at the time.

The clinician believed the patient's discharge in this instance, 'was made after the investigations found no other cause for the symptoms. No further inpatient tests were planned and ongoing care could be managed as an outpatient if the patient was well enough to be out of hospital and well supported at home'.

The clinician also noted, 'I do not see that a consideration was given to recommending upper GI endoscopy or further testing as part of the immediate management plan'.

The clinician did not identify a health practitioner whose performance or conduct in this instance was below the standard reasonably expected, however noted:

The record gives no clear indication as to who assessed the patient at what time and does not provide a clear outline of how the decision or investigations were planned or intended to be followed up if symptoms persisted or progressed. This seems in part to be a limitation of the electronic medical record and how it is reproduced.

The treatment and discharge planning should have been discussed with the general practitioner and I saw no record this direct communication had taken place.

It would have been necessary to refer the patient to the Gold Coast Hospital to seek the tests needed for a diagnosis of duodenal ulceration and the CT scan failed to provide the necessary clue that there was a significant duodenal ulcer. I would like to see the CT scan from the emergency embolization and have this compared to the Robina May 2013 CT scan as there is a chance the very large, advanced duodenal ulcer was not present in May but developed thereafter.

The clinician believed, 'the Robina Hospital and the medical and nursing staff could have focused more on the GI tract to exclude problems by arranging an oral contrast study. This may have helped diagnose the advanced ulcer in the duodenum if it indeed was as severe as found at the June 2013 admission'.

7.3 Issue three: The patient's admission to the Gold Coast Hospital on 17 June 2013 to 25 June 2013

On 17 June 2013, the patient presented at the Robina Hospital after losing consciousness at home. The patient denied having a cough, fever, vomiting or PV bleeding, however, was in significant pain. The clinical staff conducted investigations specific to the patient's presenting symptoms and as a result the patient was admitted to hospital as an inpatient.

7.3.1 Condition and presenting symptoms

- Experienced loss of consciousness at home
- Right sided chest pain
- No cough
- No fever
- Decreased appetite
- No recent vomiting
- No PV bleeding

7.3.2 Analysis of evidence

HEAPS analysis

The HEAPS report notes the patient was given a provisional diagnosis of 'acute anaemia', with a differential diagnosis of a suspected upper GI bleed or malignancy and was transferred to a medical ward at 8.45 pm on 17 June 2015.

The conclusion of the HEAPS was that:

[The patient] received investigation and treatment for gastrointestinal bleeding from a suspected malignancy. [The patient] was assessed as at significant risk for venous thromboembolism (VTE) development, and as a result received chemo prophylactic anti-coagulation medication.

[The patient] experienced a catastrophic gastrointestinal bleed, and although emergency embolization of the bleeding vessels occurred, [the patient] subsequently died'.

Gold Coast Hospital and Health Service submission

GCHHS stated the patient was admitted on this occasion for the same pain as the patient experienced during the previous admission and noted:

[The patient] by this stage was noted to have lost a considerable amount of weight, was anaemic and mildly hypotensive.

[The patient] also reported a pre-syncopal episode. It was at this point a GI bleed needed to be excluded and [the patient] was booked for an endoscopy and transferred to the Gold Coast Hospital to have the procedure that subsequently identified a large duodenal ulcer that had features concerning for malignancy.

GCHHS stated the patient was kept at the Gold Coast Hospital under the care of the gastroenterology team and noted:

[The patient was] reviewed regularly as expected, received appropriate blood transfusions for her anaemia, was appropriately treated for the ulcer and a second endoscopy was planned for the week after her initial scope to reassess the ulcer and one assumes perform a biopsy if possible'.

Unfortunately [the patient] suffered a large GI haemorrhage prior to the second scope, and had an emergency endoscopy in the middle of the night following her collapse. This revealed a large bleed that could not be treated due to the amount of blood in the stomach. [The patient] had a successful embolization of the bleeding vessels that same night but unfortunately died as a result of the bleed and possible perforation the same night in the Intensive Care Unit.

Clinical advice

The clinician believed appropriate diagnosis, clinical assessments, investigations and treatments were undertaken in this instance based on the patient's presenting condition and clinical symptoms.

The clinician noted:

The clinical picture was more obviously pointing to an upper GI problem and upper GI endoscopy was quickly arranged but the resultant complication of the catastrophic gastrointestinal bleeding in the setting of sodium heparin 5000U bd SC administered 24 June 2013 after the treating team considered the risk and benefit of VTE prophylaxis based on a malignancy (I thus presume the biopsies taken at endoscopy indeed confirmed a cancer but this was not provided in the records given to me to review and no medical entry clearly confirms the diagnosis of cancer).

I feel this decision to administer SC heparin was not the correct decision – mechanical prophylaxis (in the form of sequential calf compression devices and early mobilization) would have been a safer choice.

The clinician believed:

The actions taken to manage the complication (repeat emergency endoscopy and subsequent radiological embolization) reflect the available resources but did not see documentation by the surgical team that should have been involved in the management as failure to control ulcer bleeding usually requires laparotomy and surgical intervention if benign disease was present.

The clinician stated:

An oral contrast study would have helped diagnose a perforation and would have then required a surgical input for benign disease (if the patient was otherwise medically fit) or in the presence of a malignant ulcer not amenable to curative surgical intervention, should have made palliation and comfort measures a key priority.

The clinician did not identify a health practitioner whose performance or conduct in this instance was below the standard reasonably expected.

The clinician stated:

It would appear that the diagnosis was promptly made and the management based around this new provisional diagnosis.

The medical team ward round considered VTE and this was commenced on 24 June but not prior as the risk:benefit was assessed as being in favour of VTE prophylaxis. I would have preferred a mechanical option but this decision is not able to be faulted without resorting to hindsight as the duodenal ulcer was not actively bleeding for some days after it was diagnosed and triggering bleeding by VTE prophylaxis is not universally as dramatic or critical as it proved in this patient.

The clinician advised he felt the steps taken by the Gold Coast and Robina hospitals in this instance seemed appropriate and noted, 'medical treatment with twice daily proton pump inhibitor therapy, allowing the patient a fluid diet and repeating the endoscopy as planned seem reasonable'.

7.4 Issue four: The adequacy of verbal and written communication

During the investigation, issues were identified relating to the possible lack of verbal communication between staff and the patient's family and the possible deficiencies in the patient's written clinical records.

7.4.1 Analysis of evidence

HEAPS analysis

The HEAPS review team considered definitive documentation of clinical decision making for VTE prophylaxis by the treating team would assist in improving practice within the GCHHS. It was suggested a referral of the HEAPS findings be provided to the Medical Education Unit to ensure education provided to medical officers includes VTE prophylaxis screening in the standard assessment of patients and documentation of same in the patient's medical record.

No other references were made in relation to the verbal or written communication issues in this matter.

Gold Coast Hospital and Health Service submission

The GCHHS made reference in their submission to the possible lack of communication as to what was happening in the treatment of the patient after her diagnosis was made. They noted that whilst there was a record of conversation about a potential management plan, the outcome of the discussion was not known.

Clinical advice

The clinician noted:

Clear communication with the patient and the family are required in this setting to ensure that questions and concerns can be dealt with and this seemed to be clearly lacking in this patient's care. The problem arises if the patient gave directions not to inform her family as this would prevent such communication from taking place.

I think medical staff need to document discussion including important opinions such as surgical consultations or informal review if the resultant decisions are impacted by such – documentation in electronic records can also be more limited and disjointed so I would particularly like to see the reasons for commencing the VTE prophylaxis and the discussion/consent with the patient documented.

7.5 Issue five: The overall treatment and management during the patient's admissions to the Gold Coast and Robina hospitals

The patient presented on three separate occasions over a three month period to the GCHHS and was assessed and treated on each occasion based on her presenting clinical symptoms.

7.5.1 Analysis of evidence

HEAPS analysis

The overall conclusion of the HEAPS was that:

[The patient] received investigation and treatment for gastrointestinal bleeding from a suspected malignancy. [The patient] was assessed as at significant risk for venous thromboembolism (VTE) development, and as a result received chemo prophylactic anti-coagulation medication. [The patient] experienced a catastrophic gastrointestinal bleed, and although emergency embolization of the bleeding vessels occurred, [the patient] subsequently died.

The HEAPS identified some contributory factors specific to the development of VTE with a more specific focus on the development of deep vein thrombosis (DVT) with four *Lessons Learnt* (LL). Each LL focuses on improving VTE screening in patients and the education gaps in the medical and nursing staff.

The GCHHS has introduced the position of Clinical Improvement Lead to establish audit methodologies and educational material for VTE prophylaxis. This role will be required to assist with investigations of and completion of reviews in cases similar to the patient.

Gold Coast Hospital and Health Service submission

The GCHHS accepted there was a delay of two to three months in making the patient's initial diagnosis and that the duodenal ulcer was further advanced than it would have been had it been diagnosed earlier.

They also accepted there were some concerns regarding the patient's care after the endoscopy and that these concerns should be fully investigated by the GCHHS. These concerns are with the GCHHS patient safety officers.

Clinical advice

The clinician was not able to identify that the patient's presentations were inappropriately diagnosed, assessed, investigated or treated at each presentation within the GCHHS.

The clinician was also unable to identify any health practitioner whose performance or conduct was below the standard reasonably expected of the health practitioner.

7.6 General comments by the clinician

The clinician concluded by noting:

If the patient had been consulting with a gastroenterologist for the time period of 6 months prior to her death, I feel the diagnosis may have been made sooner if the patient was ready for care and willing to consent to elective endoscopy under sedation.

The root cause analysis carried out was very good and I do not think further action is required beyond this as it addresses the major issues raised. I am a specialist who manages similar scenarios in a tertiary centre with much back up and expertise in colleagues to draw upon and my comments reflect this.

I do not believe the medical management reflects poor care but simply a difficult diagnosis due to non-classical symptoms and investigations that proved negative and thus unhelpful in making the correct diagnosis. The time it takes to arrange referrals and tests can reach into months and thus this patient had limited time to be diagnosed and treated.

8. Discussion

The patient was an elderly woman whose death certificate indicated she died as a result of a catastrophic gastrointestinal bleed. The patient presented on three separate occasions over a three-month period to the GCHHS where pain from various sources was predominantly the presenting symptom. Each presentation was reviewed individually.

8.1 Issue one

Analysis of the clinical records and the clinical advice obtained from an independent clinical expert indicated that, in this presentation, the patient's symptoms potentially related to previous medical conditions and that this clinical presentation was appropriately assessed, investigated and treated.

The clinician did not identify the clinical performance or conduct of any one individual practitioner involved in the patient's treatment as below the standard reasonably expected and further advised that the Robina Hospital as a whole in this instance acted reasonably in their brief assessment of the patient to rule out immediate life threatening problems.

The clinician concluded that the request by the Robina Hospital to the patient's general practitioner to conduct further assessments and investigations seemed appropriate.

Therefore, the evidence in this instance does not suggest that the GCHHS (namely, the Robina Hospital) failed to provide adequate clinical assessment, treatment and care to the patient at this presentation.

8.2 Issue two

Analysis of the clinical records and the clinical advice obtained from an independent clinical expert indicated that, in this presentation, the patient was clinically assessed, investigated and treated appropriately. However, the clinician was of the view that there were some clues that indicated upper GI problems (specifically, ongoing weight loss, low serum albumin and drop in haemoglobin with intravenous hydration).

While the clinician considered there were some clinical indications upper GI problems may have existed, the diagnosis in this instance was limited by the available technologies at the Robina Hospital. Nevertheless the clinician's view was that appropriate efforts were made with a bone scan, non-contrast CT scan and medical assessments. The clinician also noted that an adequate diagnosis of symptoms can depend on how the patient presented each day at review.

The clinician did not identify any clinical performance or conduct of any one individual practitioner involved in the patient's treatment that was below the standard reasonably expected. The clinician made note that the clinical records viewed in his assessment gave no clear indication as to which medical practitioner assessed the patient; neither did the records appear to provide a clear outline of how the decisions or investigations were planned or intended to be followed up if symptoms persisted or the patient's condition deteriorated.

The clinician considered the patient's discharge in this instance and noted that, while the hospital should have discussed the patient's discharge with her general practitioner, there was no record of this direct communication having taken place.

The GCHHS made reference in their submission that there may have been a lack of communication around the patient's treatment and stated, *'the notes record that there was a conversation with the surgeons about a potential plan although the outcome of that discussion is not obvious'*.

The HEAPS report did not make specific references to *verbal* or *written* communication issues within the facilities. There were brief comments relating to documenting decisions made in relation to VTE prophylaxis.

Although the clinician made references to the lack of evidence of verbal or written communication surrounding the patient's treatment, the clinician believed the patient was appropriately assessed and investigated at this time. Therefore, the evidence in this instance does not substantiate a view that the GCHHS (the Robina Hospital) failed to provide adequate clinical assessment, treatment and care to the patient at presentation or during her admission. However, I do not consider that the clinical notes were of an adequate standard and this issue requires further consideration by the GCHHS.

8.3 Issue three

Analysis of the clinical records and the clinical advice obtained from an independent clinical expert indicated that, in this presentation, the patient's symptoms indicated an upper GI problem and that this clinical presentation was appropriately assessed, investigated and treated (with an upper GI endoscopy quickly arranged).

The patient transferred to the Gold Coast Hospital from the Robina Hospital where an endoscopy was performed on 19 June 2013. The endoscopy identified the duodenal ulcer that ultimately resulted in the death of the patient.

The clinician did not identify any clinical performance or conduct of any one individual practitioner involved in the patient's treatment at either the Robina or Gold Coast hospitals that was below the standard reasonably expected during this admission. In the clinician's view, the steps taken by the medical and nursing staff were appropriate. The clinician stated, *'it would appear that the diagnosis was promptly made and the management based around this new provisional diagnosis'*.

The clinician further noted the treatment of the gastrointestinal haemorrhage appears to have been managed as an emergency situation and dealt with satisfactorily.

The clinician concluded that the steps taken by the Robina and Gold Coast hospitals in this instance seemed appropriate and stated, *'medical treatment with twice daily proton pump inhibitor therapy, allowing the patient a fluid diet and repeating the endoscopy as planned seemed reasonable'*. The clinician also stated that he did not believe that, *'the medical management reflects poor care but simply a difficult diagnosis due to non-classical symptoms and investigations that proved negative and thus unhelpful in making the correct diagnosis'*.

The GCHHS acknowledged through their submission that there was a delay of two to three months in making the initial diagnosis and that the duodenal ulcer was further advanced than it would have been if diagnosed earlier.

The clinician stated that the *root cause analysis* (note: a HEAPS was conducted, not a root cause analysis) was very good and he did not think any further action was required beyond this as he considered it addressed the major issues raised.

While the GCHHS has acknowledged there was a delay in diagnosing the patient's duodenal ulcer, the clinician outlined that at each presentation the patient was appropriately assessed, investigated and treated. Therefore, in my view, the evidence in this instance does not substantiate a view that the GCHHS (the Robina and Gold Coast hospitals) failed to provide adequate clinical assessments, treatments and care to the patient at presentation, during her admission and prior to her untimely death.

8.4 Issue four

Analysis of the clinical records and the clinical advice obtained from an independent clinical expert indicated that there were some minor issues in relation to the written and verbal communication that occurred in providing care to the patient.

Specifically, the clinician commented on the verbal communication between the patient and her family and stated, *'this seemed to be clearly lacking in this patient's care'*. However, the clinician went on to say that a *'problem arises if the patient gave directions not to inform her family as this would prevent such communication from taking place'*. The clinician stated, *'I think medical staff need to document discussions including important opinions such as surgical consultations or informal review'*.

When patient notes are written by medical and nursing staff, it is reasonable to accept, where practicable and in line with the requirements of hospital procedure, *sufficient and accurate* information must be written in medical charts. This is to ensure a contemporaneous record of a patient's clinical assessment, review, progress and overall management that supports the provision of consistent and cohesive care to patients.

While the GCHHS acknowledged in their submission that there may have been a lack of communication around what was happening with the patient's treatment, the GCHHS did not provide comment on why the documentation was lacking.

The concerns raised by the clinician in relation to possible verbal and written communication deficiencies in relation to the care of the patient are difficult to substantiate on the evidence. Noting that the issues arose in relation to a patient undergoing care in 2013, and the patient is now deceased and cannot confirm whether she gave directions not to inform her family of her condition and progress, it is difficult to conclude that the hospitals failed to communicate effectively during her treatment.

It is also relevant to note that there is no evidence of systemic issues across the GCHHS in relation to communication and record-keeping, and that the clinical advice did not state that better communication would have resulted in a different outcome for the patient. The clinician concluded the matter was *'simply a difficult diagnosis due to the non-classical symptoms and investigations that proved negative and thus unhelpful in making the correct diagnosis'*.

I also note that the GCHHS has acknowledged that the record-keeping in relation to the patient was less than ideal.

In the circumstances, I consider that this issue does not itself justify further investigation and can be adequately dealt with by reminding the GCHHS of its obligations in relation to communication and record-keeping about patient care in final correspondence.

8.5 Issue five

Analysis of the clinical records and the clinical advice obtained from an independent clinical expert indicated that there were no substantiative issues regarding the overall treatment and management of the patient. The clinician concluded by stating he *'did not believe the medical management of [the patient's] conditions reflects poor care but simply a difficult diagnosis due to the non-classical symptoms and investigations that proved negative and thus unhelpful in making the correct diagnosis. The time it takes to arrange referrals and tests can reach into months and thus this patient had limited time to be diagnosed and treated'*.

Therefore, in my view, the evidence in this instance does not substantiate a view that the GCHHS (the Robina and Gold Coast hospitals) failed to provide adequate clinical assessments, treatments and care to the patient during each admission and prior to her untimely death.

9. Conclusion

In making a decision under the *Health Ombudsman Act 2013* (the Act), the paramount guiding principle is to protect the health and safety of the public.

Taking into consideration all the evidence, I am of the view that the overall clinical coordination, treatment and care provided to the patient by the Robina and Gold Coast hospitals was adequate.

Given the clinical complexity of the patient's multiple presentations and the fact that no individual health practitioner was identified as exhibiting unsatisfactory professional performance in this matter, I am of the view that no further action should be taken in regard to this matter pursuant to section 44(1)(iv) of the Act, as the matter has now been appropriately investigated and finalised.

Leon Atkinson-MacEwen

Health Ombudsman

26 August 2015