Office of the HEALTH OMBUDSMAN
Listen. Respond. Resolve.

Complaint about treatment provided by Rockhampton Hospital

Executive summary

Background

On 7 July 2014, I received a complaint from a complainant about the standard of care that her father (the patient) received at Rockhampton Hospital between July 2013 and his death in August 2013.

The patient suffered from multiple health problems, including severe chronic obstructive pulmonary disease and right sided heart failure (right ventricular failure). He died after developing haemorrhagic shock following a bleed from an undiagnosed duodenal ulcer.

The scope of my investigation was to determine whether:

- the clinical treatment provided to the patient at Rockhampton Hospital was appropriate
- there should have been an available staff member to place an orogastric tube in the patient's stomach so as to drain the bleeding
- the patient's pain management was appropriate
- the quality of communication between the patient, his family and the nursing staff at the hospital was reasonable and appropriate
- the record keeping practices of associated practitioners were of a standard reasonably expected
- the discharge and transfer arrangements were reasonable and appropriate
- the standard of care by the practitioners involved in the patient's care was of a standard reasonably expected
- there are any areas for improvement within Rockhampton Hospital's policies and procedures
- this matter was identified as a reportable death by Rockhampton Hospital and, if it wasn't, should it have been
- Rockhampton Hospital has undertaken corrective actions in response to any systemic issues identified as a result of this complaint.

Summary of findings

Issue	Findings
Whether the clinical treatment provided to the patient at Rockhampton Hospital was appropriate in the circumstances.	Failings in the medical care afforded the patient are substantiated.
Whether there should have been an available staff member to place an orogastric tube in the patient's stomach in order to drain the bleeding.	Failings in the medical care afforded to the patient are substantiated. Sufficient trained staff should have been available to place an orogastric tube into the patient's stomach. The clinical advisor confirmed that the delay was due to the lack of coordination between the intensive care unit (ICU) and medical teams, and the lack of ability of nursing staff to find an appropriately trained individual.

Issue	Findings
	The recommendations within the hospital's action plan include provision for improved liaison between ICU and the medical teams which should address this deficiency in care and the availability of trained staff.
Whether the patient's pain management was appropriate.	Failings in patient's pain management are substantiated. Amendments have now been made to the policies and procedures in relation to the management of dying patients. These changes adequately address the deficiencies identified.
Whether the quality of communication between the patient, his family and the nursing staff at the hospital was reasonable and appropriate.	This allegation is substantiated. The hospital has acknowledged that the quality of communication between staff, patient and the family requires improvement. Revised policies now address the systemic deficiencies.
Whether the record keeping practices of associated practitioners were of a standard reasonably expected.	This allegation is substantiated. The standard of record keeping was below the standard reasonably expected. Significant recommendations have been made within the hospital's action plan to improve record keeping and ensure consistency within the clinical notes.
Whether the discharge and transfer arrangements were reasonable and appropriate.	This allegation is substantiated. The transfer from the ICU to the ward was below a standard reasonably expected. Revised policies address the failures in the transfer arrangements.
Whether the standard of care by the practitioners involved in the patient's care was of a standard reasonably expected.	The issues identified are systemic and not the failing of individual health practitioners.
Whether there are any areas for improvement within Rockhampton Hospital's policies and procedures.	The hospital has recognised deficiencies in its systems.
Whether this matter was identified as a reportable death by Rockhampton Hospital and, if it wasn't, should it have been.	This allegation is not substantiated. Hospital staff contacted the Coroner as required.
Whether Rockhampton Hospital has undertaken corrective actions in response to any systemic issues identified as a result of this complaint.	As set out above, the hospital has recognised deficiencies in its systems.

Conclusions

I have considered the outcome of the investigation undertaken by Rockhampton Hospital, which resulted in an RCA. There are considerable learnings following the patient's death.

To satisfy me that the health and safety of the public is protected in the future, and to determine whether the lessons learned from this incident and actions undertaken have effectively mitigated the risks, I consulted with Rockhampton Hospital about the findings within this report and the proposed recommendations. I am now monitoring Rockhampton Hospital's compliance with my recommendations.

Recommendations

As a result of my investigation, I made the following recommendations:

1. Rockhampton Hospital amend its *Anticoagulants—safe use of* policy, effective from 24 December 2014, to include the requirement to document within the nursing plan, prior to administration of the drug, the consideration of contraindications to administration of prophylactic anticoagulants.

2. Rockhampton Hospital develop, implement and evaluate a communication strategy to inform staff of the amendments to the *Anticoagulants—safe use of* policy.

3. Rockhampton Hospital undertake a baseline and follow-up audit to assess staff compliance with the amended *Anticoagulants—safe use of* policy.

4. Rockhampton Hospital report on the implementation status of all recommendations identified in the RCA report and provide evidence of implementation. Where not fully implemented, continue to implement or provide information on what alternative risk mitigation strategies have been put in place.

Leon Atkinson-MacEwen
Health Ombudsman

13 October 2016

Please note: on 12 January 2018 information in this report was redacted and the amended report approved by the Acting Health Ombudsman Andrew Brown.