



**Office of the
Health Complaints Commissioner
2007**

700-0508040 Public hospital – standard of care

s.25(1)(e) of the Health Complaints Act 1995 “a health service provider failed to treat a health service user in an appropriate professional manner” and s. 25(1)(f) “a health service provider failed to respect a health service user’s privacy or dignity”. Report issued December 2006.

The complainant lodged a complaint on behalf of his deceased wife about the standard of care provided to her by staff at the George Town District Hospital (GTDH) in 2005. Specifically that the staff failed to respect her privacy or dignity, exposed her to an infection and failed to act in a sensitive manner in dealing with her personal belongings that remained at GTDH on her death.

The complainant’s wife was admitted to the GTDH on 22 June 2005 with possible pneumonia then transferred to the Launceston General Hospital (LGH) and diagnosed with advanced stage lung cancer for which she commenced chemotherapy treatment. On 1 July she was transferred back to the GTDH then transferred to the LGH on 7 July 2005. She was diagnosed at the LGH on 7 July 2005 with neutropaenic sepsis post chemotherapy and died on 10 July 2005.

The complainant alleged that at the GTDH his wife was transported in a patient sling from her room down the ward passage past patients and visitors to the ward toilet. She was not wearing underwear at the time and reported to her husband that she felt humiliated. It was concluded that the complaint under s. 25(1)(f) was substantiated and that transferring a patient on a hoist through a public area does not show respect for the individual’s comfort, dignity or privacy. An appropriate manner would be to transfer the patient by hoist onto a wheelchair or commode chair with appropriate cover such as a dressing gown and blanket or sheet. A written apology was provided to the complainant for the manner in which his wife was transported in the hoist. The apology was accepted. An apology was also made for the manner in which the possessions of his deceased wife were returned to him.

A further issue was whether the complainant’s wife was exposed to infection which contributed to her death and whether her standard of care was adequate. A review of the medical records showed that the documentation and the frequency of observations did not meet the current requisite standard. The documentation was basic and did not reflect the nursing care required of an acute non ambulant patient.

The complainant’s wife had undergone chemotherapy treatment at the LGH prior to her transfer back to the GTDH. As the GTDH is an acute care facility, staff should be familiar with the monitoring and treatment required for patients under their care. The patient was susceptible to

infection post chemotherapy and had shown early signs of neutropenia. The nursing observations at GTDH were inadequate and when the patient was transferred back to the LGH she was diagnosed as having neutropenic sepsis post chemotherapy and died three days later. The conclusions following this investigation were that there were deficiencies in her nursing care and that the complaint under s.25(1)(e) was substantiated. The complainant's concern that his wife had been infected by her co-patient in the shared ward was not substantiated, but it is clear that the facility did not create a satisfactory environment for patient care.

DHHS advised that redevelopment of GTDH, to provide a new integrated health facility for the George Town community and its surrounds, commenced in May 2006. As a result of the complaint an audit was undertaken of the GTDH and identified that a significant and extensive remedial action plan was required to address the areas in which the GTDH was non-compliant. The audit identified that there was no system for continuous improvement or planned quality improvement activities being conducted. A series of recommendations were made identifying the need for additional resources and a program of continuous improvement was developed.

The recommendations from the audit have provided a working plan for the GTDH to implement specific changes to improve overall care standards. This complaint was incorporated into the working plan which is part of the quality improvement plan (QIP) currently being implemented at the GTDH. The recommendations of the Review of George Town Hospital (July 2005) and the QIP are endorsed. The recommendations have been developed into a QIP and are being implemented.

In addition to the QIP audit recommendations, the recommendations from the investigation were that all GTDH nursing staff undertake structured training to ensure they are familiar with post chemotherapy care, all GTDH staff undertake training in maintaining and promoting patient dignity and respect, and that current work practices be reviewed to ensure that patient dignity is maintained by all staff during personal care tasks.
