SPECIAL INVESTIGATION PANEL ON THE COMPLAINT BY FAMILY MEMBERS OF THE DECEASED PATIENT MADAM CHAN WUN SIK

BACKGROUND

Madam CHAN Wun Sik ('Madam CHAN WS') was a 74 year-old female patient admitted to Princess Margaret Hospital ('PMH') through the Accidents and Emergency Department ('AED') on 3/7/2007 for fever investigation. She died on 21/7/2007, Day 19 of her hospital stay. On the day of the patient's death, her family members lodged and publicized a number of complaints related to the quality of care at the medical ward. A Special Investigation Panel ('the Panel') was appointed on 22/7/07 by the Cluster Chief Executive of Kowloon West Cluster & Hospital Chief Executive of PMH ('CCE(KWC) & HCE(PMH)'), to investigate on the complaint case, to provide an account of facts, and to make recommendations to CCE(KWC), if any.

PANEL MEMBERSHIP

Mr CHOW Yick Hay, BBS, JP - PANEL CHAIRMAN
Chairman, Kwai Tsing District Council
Member, Hospital Governing Committee, Kwai Chung & Princess Margaret Hospitals
Chairman, Community Relations & General Affairs Sub-committee, Hospital Governing Committee, Kwai Chung & Princess Margaret Hospitals

Dr Derrick AU Kit Sing
Hospital Chief Executive, Kowloon Hospital
Service Director, (Geriatrics and Community Care), Kowloon Central Cluster

Ms Sylvia FUNG Yuk Kuen
Cluster General Manager (Nursing), Kowloon West Cluster &
General Manager (Nursing), Kwong Wah Hospital & TWGHs Wong Tai Sin Hospital

Ms Kitty SIU Kam Sau, Ward Manager (Patient Services Department), Princess Margaret Hospital, provided secretarial support to the Panel throughout the investigation.

TERMS OF REFERENCE

1. To investigate facts and circumstances surrounding the complaint from relatives of the deceased Madam CHAN Wun Sik
2. To make recommendations, if any, to the Cluster Chief Executive of Kowloon West Cluster.

COMPLAINTS AND ALLEGATIONS

Complaints and allegations raised by family members of Madam CHAN WS were:

1. That the ward nurses were unhelpful in assisting the family to book private computerized tomography scan to examine the intra-abdominal and adrenal pathology of Madam CHAN WS. Specifically, it was alleged that in the afternoon of 11/7/2007, a ward nurse had only attempted to call one private hospital to check available appointment and to get price quotation. When the son urged her to make additional calls to other private hospitals, the ward nurse was said to have asked him to do it himself.

2. That ward nurses were negligent in the observations and care of Madam CHAN WS. In particular, in the early morning of 19/7/2007, when Madam CHAN WS sustained hip fracture after a fall at her bedside, she was said to have been left unattended for a few hours, and that her fall was found by a ward attendant rather than by the nurses.

3. That Madam CHAN WS, in the incident of fall, had been reluctant to call ward nurses for assistance in toileting, because previously the ward staff was unhelpful when she requested assistance. One particular staff was said to have bad attitude towards Madam CHAN WS, telling her to get her own private helper, and a few other nurses were also said to be uncaring.

4. That in the morning of 21/7/2007, when Madam CHAN WS suffered from acute deterioration of her respiratory condition, there was delay of portable X-ray investigation, and that this delay contributed to her death.

5. That in the same incident of respiratory deterioration, the nursing attention to the case was inadequate.

FACT-FINDING AND INVESTIGATION

The Panel conducted its investigation and fact-finding over a 4-week period (23/7/2007 – 17/8/2007) and completed the Investigation Report ('the Panel Report') on 22/8/2007. In conducting the investigation, the Panel obtained, reviewed and cross-checked information from the following sources:

- Full set of medical and nursing records of Madam CHAN WS. This was a true photocopy of the same set of medical and nursing records sealed and submitted to the Coroner on the day of the death of Madam CHAN WS;
- Electronic records obtained from the Hospital Authority Clinical Management System ('CMS'), which contained, among other information such as laboratory investigations data, entries of electronic ordering of X-rays;
- Electronic records obtained from the paging system of PMH;
- Interviews of 23 hospital staff, including doctors, nurses, health care assistant, ward steward of Ward C3, radiographer, department manager and workman of Radiology Department in 4 sessions, totally 16 hours.
- 4 written statements of accounts by ward nurses, 2 written statement by radiographer and workman of Radiology Department;
- Additional information provided by the Ward Manager, the Medical Team consultant in-charge, and the Chief of Service of the Radiology Department;
- 2 visits (on 9/8/2007 and 17/8/2007 respectively) by the Panel members to the ward cubicle where Madam CHAN WS was cared for during her hospital stay.

Family members of Madam CHAN WS declined to attend interview sessions arranged by the Panel on 26/7/2007 and 9/8/2007 respectively.

The Panel acknowledged that this posed some difficulty in documenting the precise complaints and in ascertaining the details of allegations lodged, as these were verbal complaints expressed to the Patient Relations Officer ('PRO'), and to CCE(KWC) & HCE(PMH) on different occasions. (To PRO on 19/7/2007 after the fall incident; to CCE(KWC) & HCE(PMH) on 21/7/2007 after patient's death.)

SUMMARY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

1 Among the complaints raised by family members of Madam CHAN WS, three allegations were related to specific incidents or encounters:

- Booking of CT scan at private hospital on 11/7/2007
- Patient fall and fracture at bedside on 19/7/2007
- Deterioration of respiratory condition and subsequent cardiac arrest and death on 21/7/2007, in particular concerning the portable chest X-ray

Less specific complaints, raised retrospectively after patient fall and fracture, were related to nursing attitude, nursing observation and attention to Madam CHAN WS, from admission on 3/7/2007 to before the fall on 19/7/2007.

2 Before discussing summary findings of the Panel on the above complaint areas, it is important to make a number of general observations on this case:

i). The Panel noted that the relationship between Madam CHAN WS and her sons and daughter was very intimate. They were keenly concerned about her well-being, her diagnosis, and the care that she received.

ii). Expectations of active and prompt investigations and interventions by the sons and daughter were high from the beginning. When the initial blood tests and ultrasound study suggested serious underlying illness and likely malignancy, the urge was to proceed with further diagnostic and treatment procedures as soon as possible. After Madam CHAN WS sustained the fracture, their expressed wish from the son was focused on early orthopaedic operation.

iii). The sons were looking for more timely communication and information on matters related to their mother (e.g. investigation findings, progress of patient's condition).

iv). Madam CHAN WS had a general idea that she had a serious condition requiring investigations (such as the CT scan, the scheduled fine-needle aspiration of liver). She had not been directly informed of the provisional diagnosis of metastatic cancer, as the sons requested ward staff not to break the bad news to her.

Care and treatment plans were mostly made by discussion with the sons, rather than directly communicating with Madam CHAN WS, except where explicit consent for procedure or operation was required.

v). Madam CHAN WS was not the type of patient that habitually complained and demanded. Instead, she appeared to be appreciative of physical attention and personal touch in bedside care, e.g. her appreciation of the care by the HCA.

vi). The Panel found that the relatives had used foul languages to threaten the nurses on at least two occasions. Such threatening foul languages would constitute a form of verbal violence. The Panel understood that these might be due to strong emotions and resentment on the part of the relatives. Nonetheless, the Panel considered that healthcare professionals deserve the respect from the patients as well as their relatives.

<u>On booking of CT scan at private hospital on 11/7/2007</u>

3. The Panel found that ward nurses had, within their available time and resources, made substantial efforts to attend to the booking of CT scan for Madam CHAN WS. They were unable to meet the expectations of a particular son. In the evening of 11/7/2007, the ward steward was off duty, RN xxxxxxx and RN in-charge xxxxxxx both made telephone calls to different private hospitals, but only one could be reached by RN xxxxxxx. The Panel considered it reasonable to leave the calling of other private hospitals to the next morning, to be done by the ward steward. However, the communication was such that the key message perceived the son was that it would be up to him to make more calls.

4. ***The Panel considered that the existing practice of requiring nurse to book CT at private hospitals might need to be reviewed***. The practice of ward staff doing booking private CT scan for patients and relatives appeared to have evolved overtime without explicit policy and guidelines. One would have thought that, if a CT investigation was truly urgent in the medical sense, it should have been performed by the Radiology Department without resorting to private imaging study (e.g. a patient with acute stroke would have urgent CT of brain in the hospital, rather than done outside). It was hence not a cost-effective use of nursing time to have nurses call up private hospitals to solicit non-clinical information. The role and procedure should be made explicit to staff and public for having clerical

staff rather than nurses to make such calls.

5. In this regard, ***the Panel also suggested that the information file for private imaging/CT scan booking could be improved***, to become more value-added, by incorporating information such as summary list of hospital contacts, flow-chart of procedural guide. Information pamphlet in Chinese and English should be made available, to outline the steps of booking, and related arrangements such as home leave and transport, both during and outside office hours. This would facilitate communication and minimize ad hoc handling.

<u>On patient fall and fracture at bedside on 19/7/2007</u>

6. The Panel noted that ward nurses had complied with the nursing standard of patient assessments regarding the risk of fall. Patient's general conditions, pain level and progress were assessed and reassessed daily. Appropriate interventions on fall prevention, lower limb oedema, hydration supplement and pain relief were implemented.

7. The Panel considered that the provision of bedpan on plastic chair for patient's bedside toileting use was undesirable and needed to be reviewed. Though nurses would provide assistance to patient toileting with bedpan under this instance, it did have an inherent risk of improper use by patient. Granted that it might be a common phenomenon that patients would request to keep a bedpan by bedside, ward management should try its best to provide aids and devices in the most appropriate way. In this ward setting, ward cubicles are small and space between beds is narrow, making the use of appropriate aids and devices difficult. Nevertheless, ***feasibility of using bedside commode should be studied***.

8. On the complaint that ward nurses were negligent in the observations and care of Madam CHAN WS, the relatives alleged that, in the early morning of 19/7/2007, when Madam CHAN WS sustained hip fracture after a fall at her bedside, she was said to have been left unattended to for a few hours, and that her fall was found by a ward attendant rather than by the nurses. On these two allegations, the Panel was able to ascertain, by crosschecking the attendance sheets of the patient next to Madam CHAN WS, that nurses had been in and out of the ward cubicle regularly and frequently before Madam CHAN WS fell. ***The Panel also ascertained that it was the nurse rather than the HCA who first found Madam CHAN WS sitting on the floor***.

9. Both nurses attested that when Madam CHAN WS was being assisted to return to the bed, she had denied having actually sustained a fall, but rather just slipped slowly to sit down, being too weak to transfer from chair to bed after toileting. In this regard, ***the Panel considered that in balance of likelihood, Madam CHAN WS did actually have a fall from sitting position, to end up being on the floor with the bedpan spilt*****.**

10. The Panel also considered that the hip fracture was likely a result of the fall. In the absence of post-mortem pathology report, the Panel could not ascertain whether this was a pathological fracture (i.e. whether the hip was prone to fracture due to cancer metastasis or not).

<u>On the care provided during deterioration of respiratory condition on 21/7/2007</u>

11. The Panel found the nursing observation of Madam CHAN WS in the morning of 21/7/2007 to be adequate. Regular bedside oximetry to check blood oxygen was able to detect oxygen de-saturation while the patient was still fully conscious with normal vital signs, and the on-call house officer (HO) and MO were informed (HO at 0704 hrs and MO at 0727 hrs respectively) without delay. Oxygen flow was stepped up by verbal order of HO between 0700–0730 hrs. ***Madam CHAN WS was assessed and managed by on-call MO Dr*** xxxxxxx ***(at 0805 hrs), then by Case MO Dr*** xxxxxxx ***(at 0855 hrs). The care was found to be appropriate***.

12. The complaint on portable X-ray service in the morning of 21/7/2007 was that, when Madam CHAN WS suffered from acute deterioration of her respiratory condition, portable X-ray could not be done within half an hour. The relatives believed that this delay contributed to her death. This allegation was investigated exhaustively. In summary, the ordering of portable X rays (abdomen + chest) by the on-call MO Dr xxxxxxx was part of a general first line investigation for a patient presenting with respiratory distress (and in this case also epigastric discomfort). In this case, the on-call MO Dr xxxxxxx ordered the X rays together with a number of blood tests and electrocardiogram. The order was transmitted to the AED clerk station at 0820 hrs, and the portable X ray first arrived at the ward at 0910 hrs, but by that time, case MO in-charge Dr xxxxxxx already clinically assessed the patient and was considering possible diagnosis of pulmonary embolism. Chest X ray is not a useful means to diagnose pulmonary embolism and in this case did not affect clinical decision or outcome.

13. Nonetheless, on reviewing the arrangements for portable X ray service, the Panel did find room for improvement. In particular, in the period of 0800-0900 hrs each day, portable X ray machine was moved from AED to the Main X Ray Department (HLG1) level. This meant that, in practice, the route to the wards in the Main Building (as in this case) got longer. The portering time from HLG1 X Ray Department to the ward might take 5-15 minutes longer than that departing from AED (depending on whether elevators are busy). The Panel also found that in this case, the time taken for the portable X Ray to arrive at the ward (50 minutes after order was made) to be somewhat longer than the usual time taken, even for the long route (HLG1 to Ward C3, usually should take 25-40 minutes).

14. The Panel therefore suggested that the Radiology Department should look into ways and means to improve on the arrangements of portable X Rays during the morning transitional period of 0800 – 0900 hrs.

<u>On nursing attitude, nursing observation, and attention to Madam CHAN WS, from admission on 3/7/2007 to before the fall on 19/7/2007</u>

15. The Panel noted that, throughout her hospital stay, Madam CHAN WS did not usually call nurses or ward attendants for assistance in daily activities. Instead she appeared to strive for her pre-morbid independence (she expressed fear that staying in bed all the time was making her weak).

16. The Panel heard that individual nurses were under the impression that Madam CHAN WS was independent in character, and therefore not in the habit of calling for assistance. However, the incident on 20/7/2007 unexpectedly witnessed by the anaesthetist would seem to suggest that Madam CHAN WS did have genuine negative feelings to some nurses. She was particularly resentful towards one un-named staff. Although the investigation could not ascertain whether Madam CHAN WS did correctly identify the nurse, the Panel had reason to believe that Madam CHAN WS did have perception that such call for personal assistance would be unwelcome.

17. The Panel noted that ward nurses and manager were unaware of such negative feeling, until the incident where the son scolded the nurse in the presence of the anaesthetist. Individual nurses, by taking turns to take care of Madam CHAN WS as assigned in each shift, did not detect the accumulated negative feelings of Madam CHAN WS. There was no

scheduled occasion for counseling or therapeutic encounter for patient or relatives after the breaking of unanticipated bad news, in this case, possible malignancy.

18. On investigation, the Panel found that, although the ward had implemented cubicle nursing as model of patient care, nurses there appeared to have fallen short of establishing rapport or trust with the patient and relatives in a continuous manner. It was noted that towards the later part of the hospitalization, different nurses were assigned to take turns in the care of Madam CHAN WS. This may be due to sick leave and vacation leave relieving and other assignment considerations.

19. The Panel found that in the acute medical ward setting, nursing care appeared to be focused on efficient discharge of task-oriented duties (napkin rounds, medication rounds, etc). This approach would probably be adequate for most short stay cases with clear-cut diagnosis and treatment plans, but could not work well in managing difficult cases and complaints. In this case, inadequate communication with nursing staff had led to strong resentment from the relatives. The Panel considered that a named-nurse (designated case nurse) system could provide more proactive care and support for complex cases. Ward manager or nursing officer could have more active and proactive involvement in handling the dissatisfactions expressed by relatives, rather than just receiving incident reporting from nurses in-charge and handling indirectly. However, the Panel noted that there were only 2 nursing officers on the ward and one of them was on annual leave in 2 of these 3 weeks. The Ward Manager had to take care of 2 wards (Ward C3 and Ward D3) with bed state totaled to more than 60. Consequently, the senior coverage was very thin.

20. As noted in the opening paragraphs of this section on Summary Findings, Madam CHAN WS appeared to be receptive to personal touch and bedside listening. Without basic rapport or trust, the chance of more proactive nursing care and bedside nursing counseling was lost. ***The Panel would recommend a close look at the nursing care delivery model, to simplify task-oriented duties and to enhance the quality of holistic nursing*.**

TABLE: Recommendations by the Special Investigation Panel

Panel Recommendations

1. ***On booking CT scan at private hospitals, the Panel considers that the existing practice of nurses booking CT scan at private hospitals need to be reviewed.***
2. ***The Panel suggests that the information file for private CT scan booking should be improved, to include explicit instructions to staff and user-friendly information leaflet for patients and their relatives.***
3. ***On fall prevention, the Panel considers the provision of bedpan on plastic chair for patient's bedside toileting use to be undesirable, and recommended a review of such practice.***
4. ***On portable X-ray service, the Panel recommends that the Radiology Department should look into ways and means to improve on the arrangements of portable X-ray service during the period of 0800 – 0900 hrs, between night and day shift.***
5. ***On communicating with family members of patients in complex cases, the Panel suggests that Ward Manager/Nursing Officer should have more direct and continuous involvement.***
6. ***Overall, the Panel recommends a close look at the nursing care processes, to simplify task-oriented duties and to enhance the quality of holistic nursing.***

APPENDIX: Terms of Reference, Objectives, Guiding Principles and Procedures of the Special investigation Panel

TERMS OF REFERENCE

1. To investigate facts and circumstances surrounding the complaint from relatives of the deceased Madam CHAN Wun Sik
2. To make recommendations, if any, to the Cluster Chief Executive of Kowloon West Cluster.

Pursuant to the above Terms of reference, the Panel will adhere to the following objectives:

1. To obtain relevant evidence, whether documentary or oral, and, for this purpose, to interview such persons ("Relevant Persons") as the Panel may consider appropriate; and
2. To prepare a report to the Cluster Chief Executive of Kowloon West Cluster by the end of August 2007.

GUIDING PRINCIPLES

The Panel will be guided by the following guiding principles:

Nature of investigation - This is an internal investigation. The purpose of the investigation is to establish a factual account of the care process of the deceased Madam CHAN Wun Sik during her stay at Princess Margaret Hospital from 3/7/07 to 21/7/07. This is in response to complaints from her relatives who are dissatisfied with the care provided to the deceased Madam Chan Wun Sik at Princess Margaret Hospital.

Confidentiality – The Panel will observe the need to respect confidentiality of information that comes into its possession during the course of its work.

Impartiality – The Panel will conduct itself in a way that is independent, fair and impartial.

Effectiveness – The Panel will endeavour to proceed with its work as efficiently as possible in the circumstances. The Panel will set its own timetable and deadlines and will do all that it reasonably can to overcome delays which lie outside its direct control.

Accessibility – The Panel will conduct itself in all its dealings with the Relevant Persons and will operate as informally as circumstances permit. This is an internal investigation only. All interviews are conducted for the purposes of fact finding. As such no legal representation is required or permitted.

Openness – The Panel will conduct itself in accordance with the processes and methods of working as set out in this document.

Accountability – The Panel will hold itself accountable to the Cluster Chief Executive of Kowloon West Cluster for adherence to the above Terms of reference.

PROCEDURES

The Panel may adopt such procedure as it may consider fair and efficient to conduct the investigation.

Without limiting the procedure which the Panel may adopt, the Panel may consider adopting the procedure set out below.

Documents – The Panel will commence the investigation by obtaining relevant information/documents from the Relevant Persons. The Panel may request more information/documents if necessary.

Interviews – Following the review of relevant information/document, the Panel will arrange for interviews to take place. The Panel will request interviews with such Relevant Persons from whom it considers appropriate to hear oral evidence. These interviews will allow the Relevant Persons and/or the Panel to clarify and elaborate on points in their prior written statements (if applicable), to answer questions raised by panel members, and to address any issues that were not covered by the questions raised by the Panel.

Other Relevant Persons who is not called for interview but who has been included in the process, can request an interview with the Panel. Relevant persons may provide additional information/clarifications in written memo form or through emails to the Panel if necessary. The interviews are non-adversarial and will focus on fact finding. Each Relevant Person will be interviewed individually and in privacy.

The Panel may obtain evidence by the above methods from all appropriate sources.

After the fact-finding processes are completed, the Panel will prepare a report as required in the above objectives and submit it to the Cluster Chief Executive of Kowloon West Cluster.