1506 03 Sepetitions

Western Cape Government
Health

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Dr A Kharwa
Chief Executive Officer
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Investigation regarding the complaint of alleged assault of Tamara Fuzane (KHA 62008768).

Thank you for allowing access to -

1. Complete file notes of Ms. Tamara Fuzane's stay in KH (Medical and Nursing as well as all prescriptions)
2. Statements of all staff involved in the care of Ms. Fuzane
3. Compliments and Complaints received from Medical Ward 2 patients from November 2013 to March 2014
4. Medical Ward 2 – allowed to visit ward to interview staff and patients
5. Doctors – allowed to interview doctors involved.

The complaint and request –

1. The complaint was made by Mrs. N.G. Fuzane (Mother and primary caregiver of Ms. Tamara Fuzane) – complaint not dated
2. According to Mrs. Fuzane her daughter was admitted to Khayelitsha Hospital on 04/02/2014 and "had no injuries of assault in her body, she is staying with me only."
3. On 07/02/2014 "I went to visit her and she had no injuries."
4. On 13/02/2014 "I noticed the marks on her right arm and back and on the hip as well."
5. On 14/02/2014 "I took my daughter Tamara to a private doctor on 2014-02-14 for further examination Dr Mawisa told me that the marks were from assault.
6. "I desire investigation on this case..."

Emergency Centre stay –

1. Triaged on 06/02/2014 at 22h00 as orange and seen by doctor on 06/02/2014 at 22h50
2. No mention made in medical or nursing notes regarding "marks on her right arm and back and on the hip", mention of right soft tissue injury on right foot.
3. Admission to Medical Ward 2 on 07/02/2014 22h50 (exactly 24 hours later)

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Medical Ward 2 –

1. Admitted 07/02/2014 22h50 – nursing admission note does not mention any injuries or bedsores
2. First mention of "bedsores + blister" on 10/02/2014 on hourly turning chart at 21h30. No turning record available from 07/02/2014 22h50 to 10/02/2014 21h30.
3. First mention of "big blister on her right foot" made in nursing notes at 05h00 on 11/02/2014, added "bedsores between the buttocks"
4. No mention in any nursing notes regarding "marks on her right arm and back and on the hip"
5. Medical/Doctor's notes only refer to blister on right foot. Good description only on 12/02/2014 at 11h25 – "massive blister involving most of anterior half of sole of right foot, no cellulitis, clear fluid in blister". Assessment of "pressure related blister" made. No mention in medical notes of "marks on her right arm and back and on the hip".

Discharge –

1. First mention of "marks on her right arm and back and on the hip" made by Mrs. Fuzane at discharge of Ms. Fuzane
2. Immediately reported to nursing staff (Incident report)
3. Doctor informed and lesions described (Incident report). According to incident report by doctor Mrs. Fuzane indicated that these wounds were not present the previous day (12/02/2014). The doctor was under the impression that the wounds "looked several days old".
4. Complaint procedure activated and appointment made with Dr S Lahri on 17/02/2014 at 09h30

Statements –

1. According to all the statements supplied none of the staff on duty noticed that Ms. Tamara Fuzane had "marks on her right arm and back and on the hip" until it was brought to their attention
2. The first attending doctor noted "superficial longitudinal scabs on the right shoulder" that "look like abrasions" and "several days old"
3. Dr S Lahri (Head of Emergency Services) the "wounds are approximately a few days old with scabs and are healing."

Dr P.S. Mawisa –

1. Dr Mawisa was the independent practitioner consulted by Mrs. Fuzane regarding Ms. Fuzane's alleged assault and completed the relevant J88 to open an investigation
2. Dr Mawisa is registered with the HPCSA as an independent practitioner and obtained her MBChB at the University of Transkei on the 15th of November 1993 and has been registered as an independent medical practitioner from 31/12/1994
3. Dr Mawisa examined Ms. Fuzane On 14/02/2014 at 12h00 and noted "multiple linear abrasions and contusions criss crossing the (R) upper arm, shoulder and hip – broken completely developing ulcer". Height 165, Mass 98kg, general body build overweight.
4. Conclusion of "soft tissue injury" stated on J88

Ward visit –

1. The ward is spacious, clean with lots of light and windows.
2. The beds are clean, comfortable, with adjustable cot sides and new
3. Patients are easily visible from the hallway
4. Nursing and medical staff are organized, calm, professionally dressed and easily identifiable
5. Spent about 40 minutes just unobtrusively observing all staff at work – they all seemed genuinely dedicated and committed to giving good care

6. None of the patients appeared to be distressed and all were well cared for. No obvious signs of neglect, verbal or physical abuse apparent
7. The staff were friendly, engaging and willing to talk about the alleged assault of Ms. Fuzane

What was done well in this case –

1. The incident received immediate and high level attention and an investigation opened
2. Written statements were obtained quickly while the case was still fresh and memories sharp
3. Copies of folder and all notes made immediately
4. Patient follow-up and support immediately organized
5. Hospital Management willingness to participate in an open and transparent investigation with feedback to patient and family

What could have been done better –

1. Record keeping (but this is the same almost universally as staff would rather actively engage in patient care than document what was done)
2. The adage is "if it is not documented it is not done". Unfortunately it is perceived that proper documenting robs precious patient interaction time.

Questions arising from the above summary –

1. The patient was admitted to Medical Ward 2 for 6 days. It seems that according to the notes, the only time pressure care was actively practiced was at the turning of the patient. When was the patient washed? By whom? Surely the person washing the patient would have noticed and reported these injuries? How often does the bedridden patient (needing turning) get washed? Surely the patient gets undressed to receive a full wash?
2. In Dr Stadler's incident report Mrs. Fuzane states that the injuries were not present the previous day (12/02/2014). Did she visit Ms. Fuzane and specifically look or change her clothing? Is there a visitor's log?
3. ***On the turning chart the patient was turned on her left side at 05h00 on the morning of the 12/02/2014 by nurses MBANGULA & MAGANDELA (skin intact?), but on another turning chart spanning the same date and time it states that at 05h00 Ms. Fuzane was turned by NANTI & MBATA onto her backside. This does not correlate?***
4. Last turning recorded 12/02/2014 at 17h00 onto RIGHT SIDE. Patient only discharged the next day at 15h00. Was the patient turned or washed again before discharge?
5. Two of the doctors mentioned scabs. Scabs imply bleeding. When the patient's hospital gown was changed there would have been blood stains on the sleeve? Did someone notice any bleeding?
6. ***According to Dr Mawisa, the patient was overweight at 98kg. How difficult would it be to turn Ms. Fuzane onto her left side? According to the neurological assessment her power in her left side was 3/5. Could the abrasions on the right upper arm and hip be the result of difficult turning? Maybe by someone with long nails or trying to turn a heavy patient on their own with the patient slipping back? This could have been an unintentional and unnoticed injury in an effort to perform a difficult task single handedly? How does the mom (Mrs. Fuzane) manage this on her own at home?***

Conclusion and recommendations –

1. Clearly between admission to Medical Ward 2 and discharge the patient developed abrasions to the right upper arm and right hip. There probably would have been some bleeding present for scabs to develop.

2. Intentional and overt assault would have been noticed by other patients and staff during the day as visibility is quite good in the ward. This would have been unlikely during day time.
3. From the ward visit and all the written compliments received from patients since November 2013, I feel it extremely unlikely that an **intentional** assault took place. There is no similar (to this case) complaint lodged by any other patient during, or before, the same time period.
4. The medical care the patient received was of a very high standard.
5. In-service training regarding good record keeping and the importance thereof should be reinforced. When bedsores or injuries are reported, photographic records should be obtained.
6. Patient turning and full wash protocols should be revised regarding method, documentation and especially taking size and functional impairment of patient into consideration.
7. Difficult home based care should be anticipated and, if possible, family members invited to participate in the in-hospital basic care management to enable them to -
    a. Get used to the idea of home based care (Address their fears and expectations of the eventual outcome)
    b. Learn the proper (and easy) way to wash/dress/feed/care for their family member at home
    c. Meet the home based care practitioner that will be assisting them at home and build a relationship with them
    d. Foster an appreciation for the tremendous dedication and caring hard work the nursing staff perform 24 hours a day.

Kind regards,

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