CASE

Date: 01/12/03
Incident number: [redacted]
A: 1C
B: 1
Unit number: 4404
Start case km:
End case km:
Received: 03:46
Dispatched: 03:47
On case: 03:49
On scene: 04:05
At patient: 04:07
Departed scene: 04:32
At destination: 04:46
Clear:
Hospital notified:
Called assistance:
Appointment:
AMPDS dispatched: 10/01/03
AMPDS found:

INCIDENT/PATIENT LOCATION

Sub address (lot / unit / shop):
Place name (property / building / bridge):
Address (street number, name): [redacted]
Suburb / town:
Postcode: 4670
THIS TRANSPORT C: 0001
TOTAL TRANSPORT Facility of origin:

MULTI-STAGE TRANSPORT

TO

Destination / address: Base Hosp
R. Bay
Postcode: 4670
D THIS TRANSPORT: 1663
Facility of destination:

PATIENT

Surname: CONNELLY
Given names: DOREEN
Permanent address (number, street, suburb, town): [redacted]
Postcode: 4670
Gender (M/F): F
Date of birth: 23/04/1934
Est. age: 69
PCC / Senior / DVA: [redacted]
Patient telephone:
Next of kin (name, relationship):
Next of kin telephone:

ADMINISTRATION

Employer / group subscription / guardian name / occupation:
Billing address (if different from above):
Postcode:
Subscriber number:
Expiry date:
Customer number:
Date account raised:
Chargeable km:
Account type:
Service charge: $

OFFICE USE ONLY

SIGN

ID number	Level	Station	Officer
170516	12	219	1 Stand
15257	19	219	2 Kim Chatten
			3
			4
			Checked by

CODE

E	F	H	J
10	27	01	000

K	L	M	O
022	000	3	1

R	S	T	X	Y	Z
4	0000	5	00	02	02

Times	0408	0413	0423	0438	0444	
Pulse rate + regularity (Regular (R) Irregular (I))	99 iR	87 iR	88 iR	90 iR	82 iR	
Respiratory rate + effort (Normal (N) Retractive (R))	18 iN	18 iN	18 iN	18 iN	18 iN	
Oxygen saturation	96%	100%	98%	98%	98%	
Et CO_2						
BP Systolic	132	123	122	117	105	
BP Diastolic	91	84	73	69	81	
SKIN Temperature (Cold (C) Normal (N) Hot (H))	N	N	N	N	N	
SKIN Colour (Flushed (F) Normal (N) Pale (P) Cyanosed (C) Jaundiced (J))	N	N	N	N	N	
SKIN Moistness (Moist (M) Normal (N) Dry (D))	N	N	N	N	N	

OBSERVATION

ECG Rate		100	→	→	
ECG rhythm		SR			
Blood sugar level					
Pain level (0–10)	5	0	0	0	0	
PUPIL L (size (mm) / reaction)	4 / +	4 / +	4 / +	4 / +	4 / +	/
PUPIL R (size (mm) / reaction)	4 / +	4 / +	4 / +	4 / +	4 / +	/

Pupil: 8 7 6 5 4 3 2 1 • — Reacts (+) No reaction (-) Eyes closed (c)

GCS					
Eye opening (Spontaneous (4) To voice (3) To pain (2) None (1))	4	4	4	4	4	
Verbal Response (Orientated (5) Confused (4) Inappropriate (3) Incomprehensible (2) None (1))	5	5	5	5	5	
Motor Response (Obeys (6) Localized (5) Withdraw (4) Flexion (3) Extension (2) None (1))	6	6	6	6	6	
Total GCS	15	15	15	15	15	

0093

QUEENSLAND AMBULANCE SERVICE

CASE

Date: 19/09/02 | Incident number: 469AH1 | A: 2 | B: 1
Unit number: 112 | Start case km | End case km
Received: 0224 | Dispatched: 0230 | On case: 0231 | On scene: 0248
At patient: 0250 | Departed scene: 0302 | At destination: 0321 | Clear
Hospital notified | Called assistance | Appointment | AMPDS dispatched: 05A01
AMPDS found

PATIENT

Surname: CONNELLY
Given names: DOREEN
Permanent address (number, street, suburb, town): [redacted]
Postcode: 4670
Gender (M/F): F | Date of birth: 22/04/1932 | Est. age: 69
PCC / Senior / DVA: [redacted] | Patient telephone
Next of kin (name, relationship) | Next of kin telephone
Employer / group subscription / guardian name / occupation

INCIDENT/PATIENT LOCATION

Sub address (lot / unit / shop)
Place name (property / building / bridge)
Address (street number, name): [redacted]
Suburb / town: BUNDABERG
Postcode: 4670 | THIS TRANSPORT C: 4001 | TOTAL TRANSPORT Facility of origin

MULTI-STAGE TRANSPORT

TO

Destination / address: BASE HOSP
Postcode: 4670 | D THIS TRANSPORT: 1663 | Facility of destination

ADMINISTRATION

Billing address (if different from above)
Postcode
Subscriber number | Expiry date
Customer number | Date account raised
Chargeable km | Account type | Service charge: $

OFFICE USE ONLY

SIGN

ID number	Level	Station	Officer
17058	1	219	1 SHand
52714	A	719	2
			3
			4
			Checked by

CODE

E	F	H	J
05	25	01	000

K	L	M	O
073	000	0	5

R	S	T	X	Y	Z
4	6000	5	40		

OBSERVATION

Times	0258	0308	0321			
Pulse rate + regularity (Regular (R) Irregular (I))	71 R	69 R	71 R			
Respiratory rate + effort (Normal (N) Retractive (R))	36 R	36 R	36 R			
Oxygen saturation	98%	98%	98%			
Et CO_2						
BP Systolic	183	166	180			
BP Diastolic	95	96	93			
SKIN Temperature (Cold (C) Normal (N) Hot (H))	N	N	N			
SKIN Colour (Flushed (F) Normal (N) Pale (P) Cyanosed (C) Jaundiced (J))	N	N	N			
SKIN Moisture (Moist (M) Normal (N) Dry (D))	N	N	N			
ECG Rate	71	69	71			
ECG rhythm	SR	SR	SR			
Blood sugar level	—					
Pain level (0–10)	8	6	4			
PUPIL L (8 7 6 5 4 3 2 1)	5 / +	5 / +	5 / +	/	/	/
PUPIL R (size (mm) / reaction)	5 / +	5 / +	5 / +	/	/	/
GCS Eye opening (Spontaneous (4) To voice (3) To pain (2) None (1))	4	4	4			
GCS Verbal Response (Orientated (5) Confused (4) Inappropriate (3) Incomprehensible (2) None (1))	5	5	5			
GCS Motor Response (Obeys (6) Localized (5) Withdraw (4) Flexion (3) Extension (2) None (1))	6	6	6			
Total GCS	15	15	15			

Reacts (+) No reaction (-) Eyes closed (c)

0096

BUNDABERG BASE HOSPITAL

RMcB/ns

28 June 1995

Dr B Hartley
[redacted]
BUNDABERG 4670

Dear Dr Hartley

RE: DOREEN CONNELLY DOB 22.04.34 **UR 059241**

I have recently received this lady's thyroid function test results following her admission to the Base Hospital with an episode of atypical chest pain in mid-June this year. This shows that she is hypothyroid with Free T4 level of 8pmol/L (9-23) and a TSH of 35mIU/L (0.05-5.0). In addition her thyroid antibodies show she has an elevated thyroid microsomal level at 4490 and elevated thyroglobulin at 1733. In addition her speckled nuclear antigens are elevated at Titre 160.

I understand this lady has been previously told she is hypothyroid and commenced on Thyroxine some time ago however she elected to cease this herself. It would appear from these results that she certainly does need Thyroxine and I would be grateful if you could see her in order to go over this with her. As she has an outpatient appointment with Dr Strahan for an exercise tolerance test on 3 July this year I have sent a copy of this letter to him.

Yours sincerely

ROD MCBAIN
Medical PHO for Dr Strahan

Copy to Dr M Strahan

Signed by Dr C Swannell

BUNDABERG BASE HOSPITAL

GP/lm

10th September 1993

Dr J Joiner
[redacted]
BUNDABERG 4670

Dear Jon

RE: DOREEN CONNELLY DOB 22/4/34 **UR 059241**

This patient was admitted in my absence on leave in June having sustained a myocardial infarct.

There were no initial ECG changes and so Streptokinase was not given, CK subsequently peaked at around 700. She had a previous history of myocardial infarction in 1988 and had also been advised to take treatment for hypothyroidism but had discontinued. Clinically she was apparently not hypothyroid.

She was subsequently discharged on the 28th. June on treatment with Anginine PRN, Aspirin 150mgs, Atenolol 50mgs, Imdur 60mgs and Thyroxine 100 micrograms daily. When reviewed today she seemed still to have limited exercise capability and was having minor pains with exertion although not taking treatment.

Follow up thyroid function tests taken 2 weeks ago were within normal range. A fasting cholesterol was a little increased at 6.3 but with a low HDL at 0.99 indicating increased risk.

Today she was also complaining of some discomfort and numbness in the left thigh area which sounded like nerve compression symptomatology.

On examination she looked well, still moderately overweight at 75 kilos. Cardiovascular and respiratory examination normal with blood pressure 130/90. ECG showed that the previously noted changes in the inferior leads had recovered.

This patient should continue to recover as she loses weight and her thyroid recovers. Should she continue to have niggling pains onward referral to Brisbane for angiography may be necessary, for the moment as her ECG does seem to have improved I have not made any specific plans. I have asked her to come to see you for follow up.

Yours sincerely

GRAHAM PINN - VISITING PHYSICIAN

0093

BUNDABERG HEALTH SERVICE DISTF

Queensland Government Queensland Health

CLINICAL SUMMARY

CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph (H) [redacted]
Ph (B)
Catholic, nec

F

URN NO
059241

22-04-1934
M

HOME DUTIES

Usual GP.....
Address ..... Burrum St Med.....

Admission Date:	Discharge Date:	Follow-up Clinic:	Referral:
1/12/03	2/12/03	PMO	

Principal Diagnosis: (one only) The condition which after study, was found to be the main reason for the patients admission.

Chest pain

Secondary Conditions:

old MI
Hypothyroidism.

Principal Procedure:

Type of anaesthetic: ☐ Local ☐ Sedation ☐ General ☐ Spinal ☐ Epidural

Secondary Procedure/s and or Significant Non-Surgical Procedures:

Complications:

- ☐ Wound infection (include organism)
- ☐ Chest infection
- ☐ Haemorrhage/haematoma
- ☐ Pulmonary embolism
- ☐ Urinary tract infection (include organism)
- ☐ Adverse drug reaction
- ☐ DVT
- ☐ Others (please specify below)

External Cause of Injury/Poisoning:

Clinical Course and Significant Results:

Unstable angina / Non ST ↑ MI

Typed letter

Enclosed by Mail

Abnormal results

- ☐ ECG
- ☐ Radiology reports
- ☐ Haematology
- ☐ Histopathology
- ☐ MBA20
- ☐ Other

DISCHARGE MEDICATION/DOSAGE:

Thyroxine 100 mcg 1
Aspirin 100mg 1
Lipitor 20mg 1
Lasix 40mg 1

DISCHARGE MEDICATION/DOSAGE:

MO Signature: [signature] **Print name:** ABDUL KHAN
Designation: PMO **Date:** 2/12/03
Consultant: Graham

0091

CLINICAL SUMMARY

MR53

BUNDABERG BASE HOSPITAL

Doreen Connelly
22/4/1934

2/12/03 (ward round)

Dear Doctor

69 year old lady with prior history of silent MI presented with chest pain relieved by Nitroglycerin. Her Troponin was 0.6 with a flat CK curve. ECG shows old MI.

Past medical history
Prior MI (silent)
hypothyroidism

Meds
Aspirin 100mg OD
Lasix 40mg OD
Lipitor 20mg OD
Thyroxine 100mcg OD

Assessment
Unstable Angina/ Non ST Elevation MI

Plan
1. Booked for a stress sestamibi 8/12/03
2. Started on aspirin and lipid lowering agent.
3. Will hold off beta blockers until stress test performed to allow for an adequate study
4. Started on lasix. Will need to assess long term need based on EF and follow up exam.

Thank you

Abid Khan
Med PHO
4152 1222

BUNDABERG BASE HOSPITAL

PUBLIC | 059241-2

Title	Surname	Given Names	Date of Birth	Age
MR	CONNELLY	DOREEN	22 Apr 1934	69

Address: [redacted] ROAD
BUNDABERG 4670

Sex	M.S.	Country of Birth	Religion
F	M	AUSTRALIA	Cath

Ethnic Origin: NOT ABORIG. OR ENGLISH ONLY

Telephone - Home: [redacted] | Telephone - Business: | Occupation (Current or Last): HOME DUTIES

First Contact:
GEORGE CONNOLLY, HUSBAND
HUSBAND
AA
[redacted]

Alternative Contact:

If discharged in last 7 days, from which hospital	Date Admitted	Time Admitted	Admission Source
	01 Dec 2003	06:00	A & E

Referring Doctor/Person:
DR B HARTLEY
BURRUM STREET
BUNDABERG 4670

Unit	Ward	Bed	Treating Doctor
MED	10		STRAHAN

Account Class	Health Fund	Health Schedule
GPE		

Medicare Number: [redacted] | Pension Number: [redacted]

Date Discharged	Time Discharged	Discharge Status	
2/12/03	14.35	Home.	

Discharge planning should have a multidisciplinary approach.

Clinical management pathways improves the quality of care provided to patients

Educating patients regarding anticipated clinical interventions and expected outcomes and timeframes has been shown to improve outcomes and enhance patient satisfaction.

ICD9CM CODES

ADMISSION FRONT SHEET

059241 Bennum ST

Date: 02.12.03
Time: 12:05:44

Discharge Medication List-GP & Pharmacy

Script	Patient Name	Script label	
234408	DOREEN CONNELLY	ASPIRIN 100mg	Take ONE tablet each MORNING
		ATORVASTATIN 20mg(Lipitor)	Take ONE tablet DAILY
		FRUSEMIDE 40mg (Lasix eq)	Take ONE tablet each MORNING
		THYROXINE 100mcg (Oroxine)	Take ONE tablet each MORNING

KEEP OUT OF THE REACH OF CHILDREN
BUNDABERG BASE HOSPITAL PH: 07-4152 1222

This list of medication is the latest information the pharmacy can determine. There may be drugs which have been omitted as a pharmacist has not taken a full history.

BUNDABERG BASE HOSPITAL
No.
Date 2/12/03

8800 0088

Bundaberg HOSPIT/

BUNDABERG HOSPITAL SEX UR NO
CONNELLY F 059241
DOREEN
[redacted] 22-04-1934
BUNDABERG 4670 M
Ph(H) [redacted]
Ph(B)
Catholic, nec HOME DUTIES

GENERAL OBSERVATION SHEET

DATE	1/12/03	2	3	4	5	6		
TIME	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	

TEMPERATURE ° C

41.5 41 40.5 40 39.5 39 38.5 38 37.5 37 36.5 36 35.5

PULSE ° V
BLOOD PRESSURE ^

260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

RESPIRATIONS

120 115 110 105 100 95 90 85 80 75 70 65 60 55 50 45 40 35 30 25 20 15

BOWELS		IDUT - NAD						
WEIGHT								
FOETAL HEART								
URINE PROTEIN	ALBUSTIK							
	BOIL							

0087

GENERAL OBSERVATION SHEET

NKA HOSPITAL

Bundaberg Hospital
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph (H) [redacted]
Ph (B)
Catholic, nec

SEX F

UR NO 059241

22-04-19

HOME DUTIE

SPECIFIC OBSERVATION SHEET

EXAMPLES:

– FINGERS/TOES – Colour, temp, movement, swelling, pain, numbness. Remarks

– URINE – Vol, colour, reaction. SG. Albumen, Blood, sugar, bile, Remarks

OBSERVATIONS RECORDED: URINE ☐ FINGERS/TOES ☐ OTHER .....

INDICATE OBSERVATIONS IN SEPARATE COLUMNS

0330 Chest Pain

DATE	TIME	T	P	R	S/P	O2	Satr.		Pain			REMARKS
1/12/03	0446		90	18	145/85	RA	94%		0/10			Central - radiating j 5/10 in ball.
	0452		ECG	(1)			O_2 reapplied via Hudson @ 6L/min.					1/1 Anginine ↓ 0/1 1/1 Alpin
	0455		IV	Cannula inserted & Bld collected.								BSL. 7·3mmol/l
	0500		82		125/94	6L	99%		0/10			
	0515	37·2	136	20	116/78	6L	99%		0/10			Periods of Tachycardia & Arrhythmia
	0530		76-131	20	121/75	6L	99%		0/10			
	0545		95		129/95	6L	100%		0/10			68·2 Kgs Wt.
	0605		86-135	20	135/90	6L	99%		0/10			

SPECIFIC OBSERVATION SHEET

0086

W 64—GOPRINT®

BUNDABERG HEALTH SERVICE DISTRIC

BUNDABERG HOSPITAL
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph(H) [redacted]
Ph(B)
Catholic, nec

SEX
F

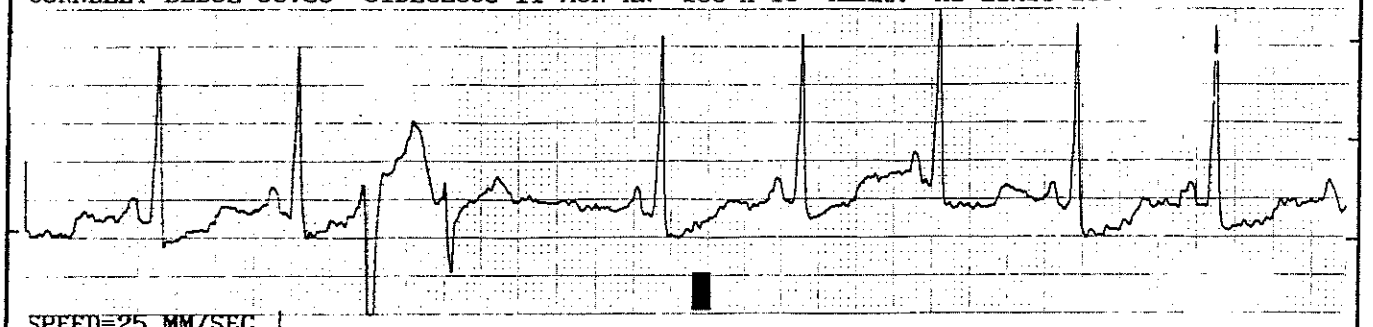
UR NO
059241

22-04-1934
M

HOME DUTIES

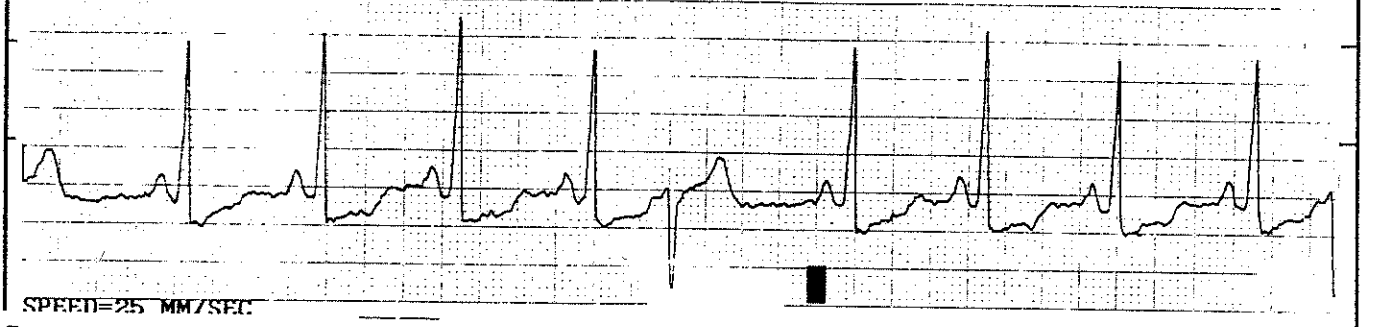
RADIOMETER PRINTOUTS

CONNELLY BED02 08:30 01DEC2003 II MON HR =138 A=10 *ALARM* HI LIMIT=130



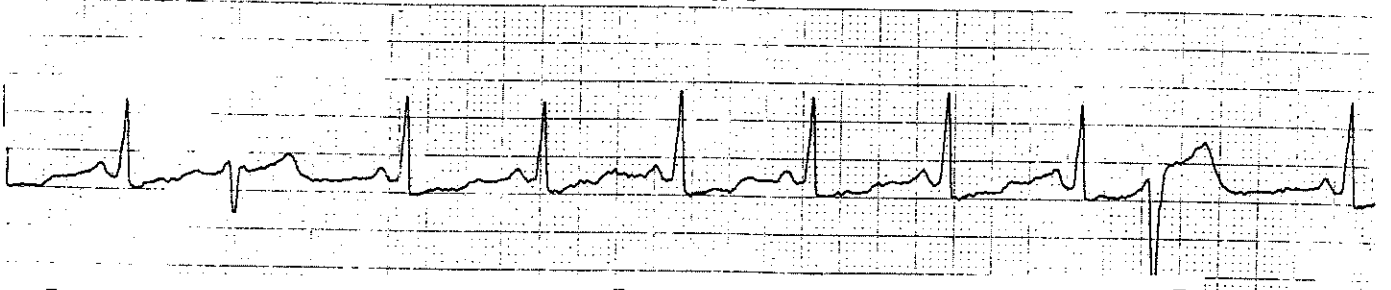
SPEED=25 MM/SEC

CONNELLY BED02 12:22 01DEC2003 II MON HR =89 A=14

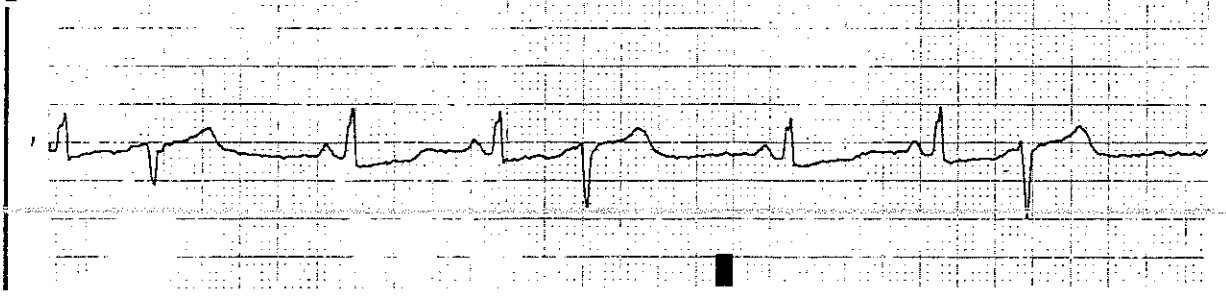


SPEED=25 MM/SEC

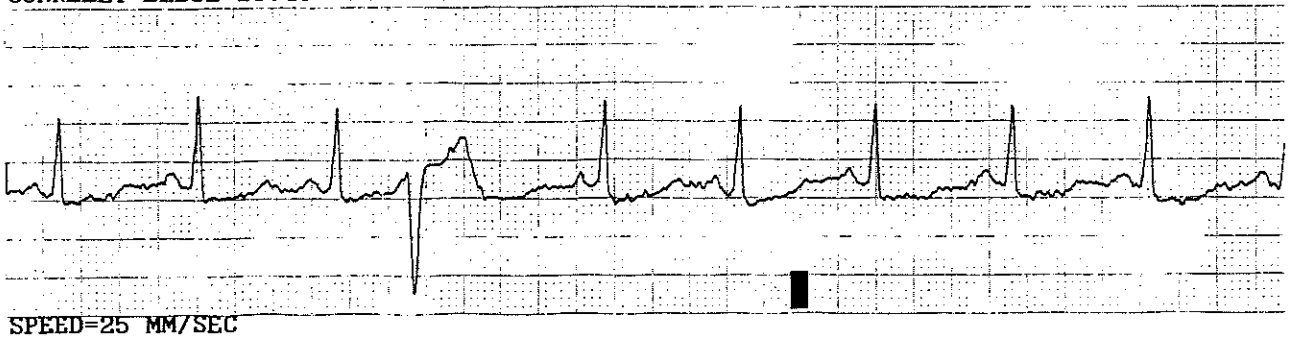
CONNELLY BED02 13:28 01DEC2003 II MON HR =84 A=4



CONNELLY BED02 14:58 01DEC2003 II MON HR =144 A=40 *ALARM* HI LIMIT=130



CONNELLY BED02 18:40 01DEC2003 II MON HR =83 A=11



SPEED=25 MM/SEC

MR62G

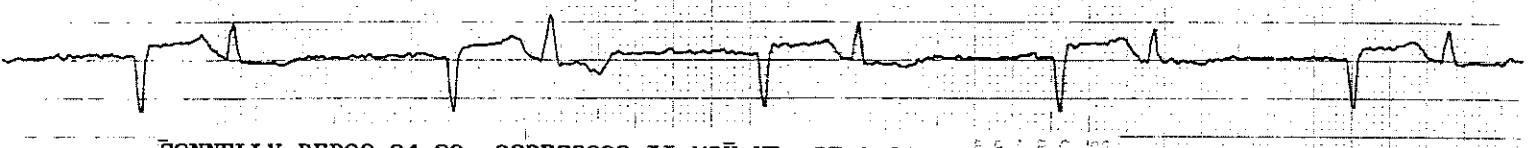
BUNDABERG HEALTH SERVICE DISTRICT

RADIOMETER PRINTOUTS

Surname:	CONNELLY
First Names:	Doreen
U.R. No:	059241
Date of Birth:	22/04/54

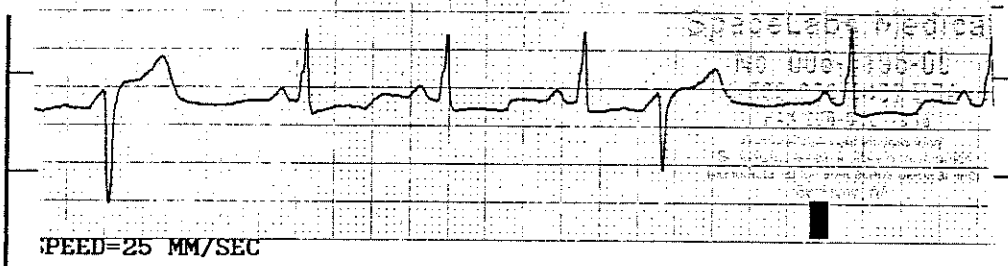
(Please affix Patient ID label here if available)

CONNELLY BED02 03:29 02DEC2003 V1 MON HR =74 A=36



CONNELLY BED02 04:30 02DEC2003 II MON HR =87 A=21

PEED=25 MM



PEED=25 MM/SEC

0083

MR62G

Queensland Government
Queensland Health

BUNDABERG HEALTH SERVICE DISTRICT

PATIENT PROFILE

Date: 1.1.12.03 Time Admitted to Ward: 6pm hrs

BUNDABERG HOSPITAL
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph(H) [redacted]
Ph(B)
Catholic, nec

SEX F
UR NO 059241
22-04-1934
M
HOME DUTIES

Information given by: Patient ☐ Relative ☐ Other:

Presenting Problem/Illness/Reason for Admission: Chest pain.

Preferred name: Doreen.
Correct name band in place: Yes ☑ No ☐
Relatives aware of admission: Yes ☑ No ☐

Allergies or Reactions: (include accident/injury details) Nil

Is patient on any medication: Yes ☑ No ☐
Medication brought in: Yes ☑ No ☐ N/A ☐
Polypharmacy > 5 drugs: Yes ☐ No ☐ N/A ☐

Communication:
Coherent: Yes ☑ No ☐
Incoherent: Yes ☐ No ☐
English spoken: Yes ☑ No ☐
English understood: Yes ☑ No ☐
Interpreter needed: Yes ☐ No ☐
Other language preferred:

Impairment:
Speech: Yes ☐ No ☑ Speech pathology notified Yes ☐ No ☐
Hearing: Yes ☐ No ☑ Hearing aid Yes ☐ No ☐
Retained by patient Yes ☐ No ☐
Sight: Yes ☐ No ☐ (Glasses)/contact lenses Yes ☐ No ☐
Retained by patient Yes ☐ No ☐

Social History:
Does patient smoke: Yes ☐ No ☑ Notes:
Did patient smoke: Yes ☑ No ☐
Does patient drink alcohol: Yes ☐ No ☑
Does patient have problems sleeping: Yes ☐ No ☑ ... Sleep pattern

Does patient live alone: Yes ☑ No ☐
Family support: Yes ☑ No ☐
Whom and what support: husband.

Prior to admission was patient receiving:

			Notified: (if applicable)
Meals on Wheels	Yes ☐	No ☑	Yes ☐ No ☐
Home Help	Yes ☐	No ☑	Yes ☐ No ☐
Domiciliary Nursing	Yes ☐	No ☑	Yes ☐ No ☐
St Vincent	Yes ☐	No ☑	Yes ☐ No ☐
Blue Care	Yes ☐	No ☑	Yes ☐ No ☐
Community Health	Yes ☐	No ☑	Yes ☐ No ☐
Oxygen therapy	Yes ☐	No ☑	Yes ☐ No ☐

Personal care status:

	Independent	Assist	Dependant
Hygiene/shower/bath	☑	☐	☐
Mobility/transfer	☑	☐	☐
Meals/feeding	☑	☐	☐
Dressing	☑	☐	☐
Toileting	☑	☐	☐

Does the patient have any concerns regarding hospitalization:
Spouse Yes ☐ No ☐
Children Yes ☐ No ☐
Transport Yes ☐ No ☐

Accomodation:
Lives in own home Yes ☐ No ☐
Lives in nursing home Yes ☐ No ☐
Lives in hostel Yes ☐ No ☐
Other:

Someone to care for them Yes ☐ No ☐
Special needs:

Medical History
Chest infection Yes ☐ No ☑
Asthma Yes ☐ No ☑
Pneumonia Yes ☐ No ☑
Cardiac problems Yes ☑ No ☐

Diabetes Yes ☐ No ☑ Which type (1 or 2)
Epilepsy or fits Yes ☐ No ☑
Previous operations/illness:
MI x3.

General appearance:

Skin: General condition:
Pressure areas: Yes ☐ No ☐ Sacrum:
Heels: Other:

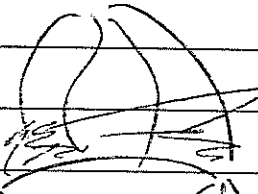
0082
MR69

Bundaberg Base HOSPITAL

Bundaberg Hospital
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph (H) [redacted]
Ph (B)
Catholic, nec

SEX F
UR NO 059241
22-04-1934
M
HOME DUTIES

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
01/12/03 0555 SISIelo	Hx See on D.E.M Record. DX CCF/unstable Angina DDX? MI Summary
	(S) SOB on minimal exertion / weeks. Orthopnoea/slight dry cough/ Recurrent central chest pain for 2/52 Chest pain relieved by GTN/Asprin MI history in '93/'95. Thyroid disease — on Thyroxine On regular GTN spray at home.
	(O) Vitals Normal wt 68-2kg SaO2 94(air) SaO2 99% (O2 at 6L/m) Bilateral chest crepts at base (A) - CXR  Bilateral basal opacity - Troponin 0.52 (A) -) RSC/~~HSCT~~ ⇒ Normal -) CVS/RAT ⇒ ~~Pending~~ ⇒ Normal (P) -) Lasix 60mg IV stat. -) MI screen at Ward 10
	1/5

0080

INPATIENT PROGRESS NOTES

147714—GOPRINT ©

MR70

Bundaberg Base Hospital

Bundaberg Hospital
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph (H) [redacted]
Ph (B)
Catholic, nec

SEX F
UR NO 059241
22-04-1934
M
HOME DUTIES

CONTINUATION SHEET

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
01/12/03 0555	FBC ⇒ Normal
	LFT ⇒ Normal ; CXR Basal opacity of base.
	UEC ⇒ Normal
	CK
	Troponin ⇒ 0.052 ↑
	 Basal opacity
	DIW STRATTANI :
	→ for Admission and put on lasix.
	(P) → Admit
	→ Lasix 60mg IV stat
	→ Prop-up
	→ O2 at 6L/min
	→ for M.I screen in Ward.
	→ NO Telemetry available LS in ward 10 - To wait for medical team to Rev. at 0800hr.
	→ Thyroxin 100mcg PO Daily
	→ GTN 3 spray PO PRN. LS
1/12/03 0725hrs	Nursing: Pt settled into bed. Placed on telemetry. informed of RIB policy. WTU-med. PU ✓ Shannon RN (Nurse)
1/12/03 1045.	Heard that Nurse states Pt "Regard attaks" not interested in further information at this time. Shannon RN (TRIAGE)

0079

Bundaberg HOSPITAL

BUNDABERG HOSPITAL
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph(H) [redacted]
Ph(B)
Catholic, nec

SEX F
UR NO 059241
22-04-1934
M
HOME DUTIES

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
2/12/03	0500hrs Rested quietly o/n. Telemetry
	cont'. Eg/Urea o/n.
2/12/03	mobile & SOBOW. Nil Qs required.
1430hrs	Discharged home — Education RN (Nil)

0077

INPATIENT PROGRESS NOTES

CARE PATH ACTIONS (Formatted)

Care Path: MED-MI
Myocardial Infarction

Page: 1

CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph (H) [redacted]
Ph (B)
Catholic, nct

SEX F
UR NO 059241
22-04-1934
M
HOME DUTIES

INDICATOR	D.E.M. 1 / 12 / 03	Day 0 (First 24 Hrs) 1 / 12 / 03	Day 1 / /
DOCTORS	☑ Medical assessment ☐ Physician notified ☐ .	☐ Medical review ☐ .	☐ Medical review ☐ Heartstart referral ☐ .
TESTS	☑ FBC, Urea & Electrolytes, LFT's, Creatinine, Glucose, ESR ☑ CRP, Troponin, Coagulation profile ☑ Ck no.1 @.....0500.....hrs ☑ Troponin No 1 @.0500.....hrs ☑ 12 lead ECG ☑ CXR ☑ BSL (if applicable) ☐ .	☐ CK post presentation ☑ 6hrs @.....1100.....hrs,(Rpt Troponin if - ve) ☑ Troponin No 2 @.....1700 hrs (if -ve) ☐ 12 hrs @.....hrs ☐ 18 hrs@.....hrs (if indicated) ☐ 24 hrs @.....hrs (if indicated) ☐ Fasting Lipids & Glucose ☐ ECG on admission to CCU ☐ ECG pre Thrombolytic therapy ☐ ECG 1/2 hr post Thrombolytic therapy ☐ CXR (if not attended in DEM) ☐ APPT 4 hrs post thrombolytic therapy ☐ APPT 8 hrs post Thrombolytic therapy ☐ APPT 4 hrly if Heparin infusion given	☐ ECG ☐ APPT BD if heparin infusion given ☐ . ☐ .
OBSERVATIONS	☑ TPR, BP & SaO2 ☑ Cardiac monitoring ☐ Urinalysis (if pt voids)	☐ Norton Scale..... ☐ TPR, BP SaO2..... ☐ Cardiac Monitoring ☐ Fluid Balance Chart ☐ Urinalysis (if not attended in DEM) ☐ Observe IV cannula site Day..... Eve.....ND..... ☐ . ☐ .	☐ Norton scale..... ☐ TPR, BP, SaO2..... ☐ Cardiac monitoring ☐ Fluid balance chart ☐ Observe IV cannula site Day.... Eve.....ND..... ☐ Weight ☐ . ☐ .
MEDICATIONS	☐ Commence Thrombolysis agent if ICU bed unavailable within ☐ 15 - 20 minutes ☐ Tridal Infusion if indicated ☐ Medications as indicated:- ☑ Heparin / Anticoagulant ☑ Asprin ☐ Pain relief ☐ Antiemetic ☑ O2 4 ~~L/min~~ 6LPM	☐ Medications as indicated:- ☐ Thrombolytic agent ☐ GTN if indicated ☐ Anticoagulant ☐ Morphine ☐ Atenolol ☐ Nitrates ☐ Sedation ☐ Antiemetic Maxolon pw mane	☐ Medications as indicated:- ☐ Anticoagulant - Cease Heparin infusion at 48 hrs ☐ Asprin ☐ Morphine ☐ Atenolol ☐ Nitrates if indicated ☐ Sedation ☐ Aperient ☐ .
TREATMENTS	☑ IV access X 1 cannulas ☐	☐ Active limb exercises hrly ☐ Deep breathing exercises hrly ☐ .	☐ Active limb & breathing exercises hrly ☐ . ☐ .
MOBILITY		☐ Rest in bed ☐ Mandatory rest periods for 30 minutes post meals & afternoon rest period	☐ Sit out of bed 15 - 30 minutes AM..... PM..... ☐ Mandatory rest periods ☐ .

RN (Day)		Nicholson	
RN (Evening)		MHanson	
RN (Night)	LBray	L	
Allied Health			

Eg: √ RJD = Performed X RJD = Variance

Dundalk HOSPITAL

BBH 7795081

Time	INTAKE												OUTPUT											
	ORAL N/G			PERIPH. I.V.			PERIPH. I.V.			C.V.L.			URINE		DRAINS				DRAINS				BOWELS
	TYPE	HRLY. VOL.	TOTAL	TYPE	HRLY. VOL.	TOTAL	TYPE	HRLY. VOL.	TOTAL	TYPE	HRLY. VOL.	TOTAL	HRLY. URINE	TOTAL		TOTAL		TOTAL		TOTAL		TOTAL		
0100																								
0200																								
0300																								
0400																								
0500																								
0600																								
0700													100	100										
0800																								
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1900																								
2000																								
2100																								
2200																								
2300																								
2400																								
TOTALS																								

INTAKE: ORAL N/G ..... I/V ..... C.V.L. ..... TOTAL ..... MEASURED BALANCE ..... ± WEIGHT .....

OUTPUT: URINE ..... N/G ..... I.C.C. ..... DRAINS ..... TOTAL ..... TRUE BALANCE .....

DATE WARD N/ U.R. No.

CONNELLY DOREEN 059241 Collector

22-04-1934

MAR 8 2007

Bundaberg Health Service District

PRN MEDICATION CHART

Bundaberg Hospital
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
Ph (H) [redacted]
Ph (B)
Catholic, nec

SEX: F
UR NO: 0592[illegible]
2?-04-1934
M
HOME DUTIES

PRN ADMINISTRATION

DRUG: GTN

ROUTE	DOSE	FREQ.	START
sublingual	300mcg	PRN	1/12

DOCTOR: [signature] | Time check:

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days
Dr's Signature
Pharmacist

PRN ADMINISTRATION

DRUG:

ROUTE	DOSE	FREQ.	START

DOCTOR: | Time check:

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days
Dr's Signature
Pharmacist

PRN ADMINISTRATION

DRUG:

ROUTE	DOSE	FREQ.	START

DOCTOR: | Time check:

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days
Dr's Signature
Pharmacist

PRN ADMINISTRATION

DRUG:

ROUTE	DOSE	FREQ.	START

DOCTOR: | Time check:

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days
Dr's Signature
Pharmacist

DRUGS WITH VARIABLE DOSE

DRUG	ROUTE	Discharge supply .... days. Dr's signature:

DATE	TIME	DOSE	DOCTOR	NURSE

DRUG	ROUTE	Discharge supply .... days. Dr's signature:

DATE	TIME	DOSE	DOCTOR	NURSE

FOR DRUGS NOT GIVEN INSERT
(according to Hospital Policy)

R REFUSED
S STARVING
A ABSENT
W WITHHELD

Surname ..... U.R. No. .....

Given Names: .....

Sex ..... DOB .....

(Affix Patient Identification Label Here)

Record of Administration | Date → / ↓ Time

Drug | Route | Dose | Freq | Start | Doctor | Time check

Discharge Supply ☐ days Dr's Signature _____ Pharmacist

WIDE BAY REGION
Bundaberg HOSPITAL
DISCHARGE SUMMARY

Local Doctor Jones DR HARTLEY
Address Hinkler Place.
MARYBOROUGH ST
BUNDABERG

--ID---------SEX---
F 059241
CONNELLY
DOREEN [redacted]
BUNDABERG 4670
Ph(H) [redacted]
Ph(B)
CATHOLIC
22-04-1934
M

Admission Date: 12/6/95

Discharge to: Clinic: Appt. date: time:

Symptoms/signs on presentation 1 HR central chest pain.
Silent anteroseptal + inf. mi in past
PHx Hypothyroidism.
?MI
ADMITTING DIAGNOSIS

*** PRINCIPAL DIAGNOSIS**
Atypical Chest Pain.

Secondary Diagnoses

PRINCIPLE PROCEDURE

Secondary procedure/s

INVESTIGATIONS:

	Y	N	NAD	**WRITE ABNORMAL RESULTS**
F.B.C.	☐	☐	☐	Serial CEs (N)
BIOCHEM	☐	☐	☐	ECG - no new changes
L.F.T.'s	☐	☐	☐	FBC (N) MBA (N)
MICRO	☐	☐	☐	Awaiting TFT/Lipids — copy to LMO
HISTOLOGY	☐	☐	☐	
X-RAY	☐	☐	☐	
CT SCAN	☐	☐	☐	
E.C.G.	☐	☐	☐	
OTHER				

Clinical Course/Complications
Booked for ETT as outpt. — appt 3/7/95. 1.30pm

Cause of injury/poisoning (if applic.):
Place of Occurance:

Medication on Discharge
Aspirin 150mg daily
Angmire 1 S/L prn

R.M.O. (sign) C SWANNELL (print) DATE 14-6-95
CONSULTANT (sign) STORTHAN (print) DATE

0068

* Definition : The condition which after study, was found to be chiefly responsible for occasioning the patient's admission to hospital

DISCHARGE SUMMARY

BUNDABERG BASE HOSPITAL

PUBLIC | 059241-1

Title	Surname	Given Names	Date of Birth	Age
MR	CONNELLY	DOREEN	22 APR 1934	61

Address
[redacted]
BUNDABERG 4670

Sex: F | M: F
Country of Birth: AUSTRALIA NOS
Religion: CAT
Ethnic Origin: CAUCASIAN

Telephone - Home: [redacted]
Telephone - Business:
Occupation (Current or Last): HOME DUTIES

First Contact
GEORGE CONNOLLY, HUSBAND
HUSBAND
[redacted]
BUNDABERG 4670
[redacted]

Alternative Contact:

If discharged in last 7 days, from which hospital:
Date Admitted: 12 JUN 1995
Time Admitted: 12:40
Admission Source: A & E

Referring Doctor/Person:

Unit	Ward	Bed	Treating Doctor
MED	10		STRAHAN

Account Class	Health Fund	Health Schedule
GPE		

Medicare Number: [redacted]
Pension Number:

Date Discharged	Time Discharged	Discharge Status
14.6.95	1300hrs	Home

ICD9CM CODES

P	7850		
	412		
	2720		
	2449		
	4149		

ADMISSION/DISCHARGE SHEET

Bundaberg HOSPITAL

GENERAL OBSERVATION SHEET

--ID----------SEX---UR NO--
CONNELLY F 059
DOREEN
[redacted] 22-04-1
BUNDABERG 4670
Ph(H) [redacted]
Ph(B)
CATHOLIC

DATE JUNE '95 | 12.6.95 | 13.6.95 | 14.6.95 | 15.6.95

TIME | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM

TEMPERATURE ° C

PULSE °

BLOOD PRESSURE

RESPIRATIONS

BOWELS				
WEIGHT	71.2 Kg.			
FOETAL HEART	WNL			
URINE PROTEIN — ALBUSTIK	NAD.			
URINE PROTEIN — BOIL				

GENERAL OBSERVATION SHEET

0066

DATE: 12-6-95

TIME: 1300

WARD: 10

KNOWN ALLERGIES (Record in red) Not Known

--ID---------SEX---UR NO--
CONNELLY F 059241
DOREEN
[redacted] 22-04-1934
BUNDABERG 4670 M
Ph(H) [redacted]
Ph(B)
CATHOLIC

PATIENT MEDICATIONS: YES/(NO)

NURSING OBSERVATIONS

Colour Pink Skin State Intact.

Discomfort/Pain Chest pain now resolved

Duration of Discomfort/Pain ½ hour

Communication Problems Nil

Visual Problems Reading glasses.

Other Problems —

ORIENTATION

Hospital and Ward routine explained ✓

Nursing Personnel ✓ Doctors visit ✓ Use of Buzzer ✓

VALUABLES

In Trust — To relatives — Retained by patient —

Articles entered into 'Clothes Book' Yes/(No)

Do you have glasses? (Yes)/No Retained by patient Yes/No Did not
Entered into 'Clothes Book' Yes/(No)

What do you understand is the reason for your admission to Hospital?
Chest pain.

Is your family aware of your admission? Yes.

Are you concerned about fulfillment of usual responsibilites? (Family, animals, work, etc.)
No problems.

Sleep and Rest habits. (Sedation, bed type, etc.) No problems.

Special Diet Healthy Heart

Bowel and Bladder Habits (Laxitives, bran, etc.) No problems

Do you have a responsible person at home to assist you following your hospitalisation? husband.

Do you receive any community service? Yes/(No)
If yes, state which service/s.

Ambulance Subscriber Yes/(No)

L Haeland (RN)

NURSES SIGNATURE & DESIGNATION

To be used for patients in hospital > 48 hours.

Revised October, 1993.

MR 69 A

STK NO. 7799069

0064

PATIENT PROFILE

MR69A

Bundaberg HOSPITAL

INPATIENT PROGRESS NOTES

--ID---------SEX---UR NO--
CONNELLY F 0592
DOREEN
[redacted] 22-04-19
BUNDABERG 4670
Ph(H) [redacted]
Ph(B)
CATHOLIC

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
12/6/95	
Gwamaf	
PHO	61 years o/
12.20	
PC	chest Pain
HPC	H/o MI x 2
	Last one 2 years ago
	No H/o Angina since
	Today sudden onset of central
	Chestpain whilst at rest; also between
	Burning Shoulder blades
	radiating across chest
	felt sob
	Nauseas &
	Vomited x 1
	Not clammy
	Pain worse than that of MI but of
	similar nature
	Not pleuritic
	No cough No haemaptysis
	RF
	Male Angina
	Nan Smoke
	Previous MI x2
	NOT BP
	NOT Diabetes

INPATIENT PROGRESS NOTES

0063

147714—GOPRINT ©

MR 70

Bundaberg HOSPITAL

Su.

--ID---------SEX---UR NO--
CONNELLY F 0592
DOREEN
[redacted]
BUNDABERG 4670 22-04-19
Ph(H) [redacted]
Ph(B)
CATHOLIC

(2)

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
12/6/95	
	Routine obs notify carers if frequency any further chest pain. Macleod SRN.
12-6-95	Nursing 1300 hrs. Admission via A+E as above. Settled into ward. Observations satisfactory. For CE no 2 this pm. No complaints of chest pain since arrival to ward. — J Harland RN
12/6/95	INTERN. 61 y.o. ♀. PC Chest pain – severe (7/10), dull, 'tight' feeling in centre of chest (retro-sternal) – pain radiated through to back at times. No radiation to neck/jaw/arms – pain lasted ~½ hr to 1 hour gradually resolved (didn't take anything for it) – felt nauseous, cold + clammy, vomited x 1 nausea passed as pain did. No dizziness/syncope – no acid reflux into mouth/throat. (Never suffered with heartburn/reflux)

INPATIENT PROGRESS NOTES

147714—GOPRINT ©

MP70

0061

Bundaberg HOSPITAL

--ID---------- SEX --- UR NO --
CONNELLY F 059241
DOREEN [redacted]
BUNDABERG 4670 22-04-1934
Ph (H) [redacted] M
Ph (B)
CATHOLIC

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
	O/E Afebrile, in no distress
	CVS HR = 60 BP = 110/70 JVP NE
	HS x 2, no murmurs
	Resp chest expansion fair
	breath sounds resonant B = C
	no crackles / wheezes
	Abdo soft, obese, non-tender
	no masses / organomegaly
	palpable
	CNS grossly intact
	ECG – no new Δs, no ST depression
	Impression: ? severe angina / MI
	? other
	Plan: · admit
	· serial CE's / ECG, bloods (as done in A+E), CXR FBE MSA
	· TFT's mane
	· (N) diet
	· routine obs
	· notify if further chest pain / if concerns
	· start aspirin 150mg daily (hold thyroxine until TFT's)
	~~· Patient~~
12.6.95	Unwell. No chest pain. 9/Counts patient.
2245	Obs satisfactory. Cr 262 collected. Bloods
13.6.95	0400 hrs. Observed to have rested well
nocte	Frequently checked. Nil pain. patient. S McKinlay

W 61—Govt. Printer, Qld.

MB70

INPATIENT PROGRESS NOTES

Bundaberg HOSPITAL

--ID---------- SEX--- UR NO--
CONNELLY F 059241
DOREEN
[redacted] 22-04-1934
BUNDABERG 4670 M
Ph(H) [redacted]
Ph(B)
CATHOLIC

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
14/6/95	JHO/SWANNEW
	UMO - Dr ~~Jones~~ (Hinkler Place) → no longer the G.P.
	— Dr Hartley Maryborough St.
	J. Roberts

BUNDABERG HEALTH SERVICE
NURSES DISCHARGE SUMMARY

	YES	N/A
Medications given to patient	✓	
Appointment given to patient If yes – Doctor _____ Date _____		✓
Community Support Service		✓
X-rays returned		✓
Valuables returned		✓
Relatives notified	✓	
Transport arranged Private ☑ Q.A.S. ☐ (must be a subscriber)	✓	
Letter given to patient		✓
Medical certificate given to patient		✓

Pearson
SIGNATURE OF REGISTERED NURSE

14.6.95
DATE

(Stk No. 7799079)

14.6.95	N/V c/o chest pain. D/C changed home
17 Clm	Pearson RN

INPATIENT PROGRESS NOTES

147714—GOPRINT ©

MR70
0057

B'Barra HOSPITAL

INPATIENT MEDICATION CHART

Admission

From 12/6/95 **To** ..../...../.....

Admission Weight.....**Kg**

--ID----------SEX---UR NO--
CONNELLY F 059241
DOREEN
[redacted] 22-04-1934
BUNDABERG 4670 M
Ph(H) [redacted]
Ph(B)
CATHOLIC

AVOID ERRORS: Drugs will not be administered without a written, legible, complete prescription.

ADVERSE DRUG REACTIONS	DRUG	MONTH/YEAR	NATURE OF REACTION
	N/K.		

ONCE ONLY (AND PREMEDICATION) DRUGS

DATE	TIME	DRUG	DOSE	ROUTE	DOCTOR	GIVEN BY	TIME GIVEN

DRUGS WITH VARIABLE DOSE

DRUG			**ROUTE**	
DATE	TIME	DOSE	DOCTOR	NURSE

DRUG			**ROUTE**	
DATE	TIME	DOSE	DOCTOR	NURSE

IN PATIENT PRESCRIPTION CHART

C 0056

REGULAR PRESCRIPTIONS	SURNAME	GIVEN NAMES
DRUG REACTIONS (See front of Sheet)	ADMINISTRATION TIMES (According to Hospital Policy)	FOR DRUGS NOT GIVEN INSERT (According to Hospital Policy) **R** REFUSED **A** ABSENT **S** STARVING **N** NO STOCK

RECORD OF ADMINISTRATION — Date → / Time ↓

DRUG

ROUTE | DOSE | FREQ. | START

DOCTOR | Pharmacist

DRUG

ROUTE | DOSE | FREQ. | START

DOCTOR | Pharmacist

DRUG

ROUTE | DOSE | FREQ. | START

DOCTOR | Pharmacist

DRUG

ROUTE | DOSE | FREQ. | START

DOCTOR | Pharmacist

DRUG

ROUTE | DOSE | FREQ. | START

DOCTOR | Pharmacist

DRUG

ROUTE | DOSE | FREQ. | START

DOCTOR | Pharmacist

DRUG

ROUTE | DOSE | FREQ. | START

DOCTOR | Pharmacist

BUNDABERG BASE HOSPITAL

NURSING CARE RECORD

MEDICAL DIAGNOSIS Chest pain

--ID----------SEX---UR NO--
CONNELLY F 059241
DOREEN
[redacted] 22-04-1934
BUNDABERG 4670 M
Ph(H) [redacted]
Ph(B)
CATHOLIC

DATE	SURGICAL / MEDICAL PROCEDURES
12/6.	IVC (A+E.

DATE	SPECIAL INSTRUCTIONS
12/6	H/24 TPR BD
	Admission weight
	Admission WTO.
14/6	TPR & BP – BD 1600 1600

DATE	PATHOLOGY / X-RAY REQUESTS
12/6	CE NO. 1, FBC, MBA (A+E).
	CE NO. 2
13/6	CE NO. 3. TFT. 0800.
14/6	Thyroid Antibodies
14/6	Fast. e. g Lipids.

DATE	SPECIAL NEEDS
	PHYSIO
	SOCIAL WORKER
	OCCUP. THERAPY
	OTHERS

DATE	DIET
12/6.	Healthy Heart
13/6	L.3.M 2400 (water to drink)

0052

MR 92

BBH 7780082

PLEASE ENSURE HOSPITAL NAME APPEARS ON ALL COPIES

Bundaberg. HOSPITAL

059241
CONNELLY F
DOREEN 22/04/1934
[redacted] 4670
BUNDABERG
GEORGE CONNOLLY, HUSBAND
[redacted]

(Affix Patient Identification Label Here)

SUMMARY ON DISCHARGE

A more detailed summary will be forwarded.

TO: Copy sent Dr Jones

☐ DOCTOR

No. & STREET

SUBURB POSTCODE

COPIES SENT TO:—

(1)

(2)

MORE INFORMATION AVAILABLE FROM MEDICAL SUPT'S OFFICE. ALWAYS QUOTE U.R. No. IN ALL CORRESPONDENCE.

DATE OF ADMISSION: 18/06/93 CONSULTANT: PINN

DATE OF DISCHARGE: 28/06/93 WARD: 10

DIAGNOSIS AT DISCHARGE (1) Inferior MI (2) Hypothyroid (3) Raised Cholesterol.

PRESENTING COMPLAINTS/CLINICAL FEATURES Chest pain, radiated into her back • SOB • nausea

RELEVANT INVESTIGATION RESULTS ECG – TWI inf leads.

CE's

	(1)	(2)	(3)	
AST	48	69	95	WBC 9·7
LDH	207	233	269	Hb 12·8
CK	635	752	689.	Plt 357.

TREATMENT/OPERATION patch CKMB 26 commenced – removed due to hypotension 21/38, Continue thyroxine

COMPLICATIONS/CLINICAL COURSE as TFT's revealed hypothyroidism Start Atenolol + Aspirin + Imdur

* Repeat TFT's in 4/52.

MEDICATION ON DISCHARGE Anginine S/L i prn
Aspirin ō 150 mg daily
Atenolol ō 50 mg mane
Imdur ō 60 mg mane
Thyroxine ō 100 µg daily
Miconazole top 1 squirt bd 1/52

DISCHARGE/FOLLOW-UP
☐ Care of referring doctor
☐ O.P.D. Clinic
☐ Other Hospital
☐ Nursing Home
☐ Other

CLINIC PINN OPD 6/52

APPT. DATE / / TIME am

Signature M Taylor TAYLOR

Status HHO

Date 28/6/93

0050

SUMMARY ON DISCHARGE

118928—H 860—GOPRINT 1/91 MR53

1 print firmly with ball point pen
2 for supplied answers, place code in appropriate box
3 if label is missing or incorrect complete PATIENT DETAILS
4 for a chargeable patient complete ACCOUNT DETAILS p3

059241
CONNELLY
DOREEN
[redacted]
BUNDABERG
GEORGE CONNOLLY. HUSBAND
[redacted]

F
22/04/1934
4670

PATIENT DETAILS

U.R. No.	
SURNAME	Connelly
FIRST NAME	Doreen
SECOND INITIAL	
USUAL ADDRESS — No. & Street	[redacted]
Suburb/Town	B'Berg
A.S.G.C.	
POSTCODE	
OCCUPATION	
SEX (M or F)	F
CONTACT NAME	George Connelly
CONTACT 'PHONE	[redacted]
RELATIONSHIP	Husband
MEDICARE No.	
AGE	59
D.O.B.	22/04/1934
RELIGION	R/C

ADMISSION DETAILS

DATE ADMITTED	18/06/93
TIME ADMITTED (24 hr clock)	1840
REGISTER? (G or M)	G
BOARDER? (Y or N)	N
MARITAL STATUS (1 single, 2 married/de facto, 3 widowed, 4 divorced, 5 separated)	2
PERMANENT AUSTRALIAN RESIDENT? (Y or N)	Y
MEDICARE ELIGIBILITY (1 eligible, 2 not eligible, 3 not identifiable)	1
COUNTRY OF BIRTH	SCOTLAND
ETHNIC ORIGIN (1 caucasian-european, 2 aboriginal, 3 Torres St. Is., 4 asian, 5 other)	1
INPATIENT TYPE (1 acute, 2 nursing home type)	1
COMPENSABLE STATUS (1 workers (Q'ld), 2 workers (other), 3 third party, 4 not compensable)	4
SOURCE OF ADMISSION (1 priv. med prac., 2 casualty, 3 outpatient, 4 other hospital, 5 nursing home transfer, 6 status transfer, 7 other)	2
PATIENT ACCOMMODATION (1 standard, 2 private shared, 3 private single)	1
HOSPITAL INSURANCE (1 insured, 2 not insured)	2
ADMITTING WARD	1 CU
Have you been discharged from any hospital in the last 7 days? (Y or N)	N
If YES, which hospital?	
total length of stay? (in days) without breaks of more than 7 days in previous hospitals	

PATIENT MOVEMENTS

WARD TRANSFERS—state ward transferred to and the date

TO		DATE	
TO		DATE	

STATUS TRANSFERS—INPATIENT TYPE 1 acute 2 L.S.N.H.T.

NEW STATUS		DATE	
NEW STATUS		DATE	

STATUS TRANSFERS—PATIENT ACCOMMODATION 1 standard 2 private shared 3 private single

NEW STATUS		DATE	
NEW STATUS		DATE	

OUT—ON—LEAVE

FROM		TO	
FROM		TO	

DISCHARGE DETAILS

DATE DISCHARGED	28/06/93
TIME DISCHARGED (24 hr clock)	1235
DISCHARGE STATUS (1 home, 2 other hospital, 3 nursing home, 4 other institution, 5 died, 6 status transfer, 7 discharged at own risk, 8 other)	1

DIAGNOSIS ON DISCHARGE

PRINCIPAL CONDITION TREATED (PLEASE PRINT)
(1) Inferior MI 4/04/93
2449.

OTHER CONDITIONS TREATED (PLEASE PRINT)
(2) Hypothyroid

OPERATION AND/OR PROCEDURE (PLEASE PRINT)
If no operation(s)/procedure(s) please tick box ☑
Principal
Others

EXTERNAL CAUSE OF INJURY/POISONING (PLEASE PRINT)
How it Happened
Place of Occurrence (e.g. home, street, work)

TREATING DOCTOR Name PINN
Signature

HOSPITAL USE ONLY

L.M.O. DR.
ADDRESS
LETTER TO DOCTOR/OTHER AGENCY
INFECTIOUS DISEASE NOTIFIED
SUMMARY DICTATED DATE / / 0049

PATIENT IDENTIFICATION AND DIAGNOSIS SHEET (MR 569) CHART SUMMARY

1702—Govt. Printer, Qld.

BUNDABERG BASE HOSPITAL

NURSING CARE RECORD

059241
CONNELLY
DOREEN [redacted] F 22/04/1934
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND [redacted]

MEDICAL DIAGNOSIS MI

DATE	SURGICAL/MEDICAL PROCEDURES
18/6/93	IV Jelco (R) hand
23/6/93	IV Removed.
	26/6 ECG please

DATE	SPECIAL INSTRUCTIONS
22/6	~~BID~~ TPR + BP BD
22/6	L + S BP 0600
22/6	Daily Weigh 0600
27/6	Listen to Cardiac Tapes.

DATE	PATHOLOGY/X-RAY REQUESTS
18/6/93	CXR
	FBC U+E CEX2 ~~CEX2~~ ✓ CEX3
26/6	E.C.G.

DATE	SPECIAL NEEDS
	PHYSIO
	SOCIAL WORKER
	OCCUP. THERAPY
	OTHERS

DATE	DIET
18/6/93	H. Heart

0025

BUNDABERG
BASE HOSPTIAL

NURSING TRANSFER / DISCHARGE SUMMARY

059241
CONNELLY F
DOREEN 22/04/1934
[redacted]
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]

Consultant Mr Connolly
P.H.O. Dr M. TAYLOR
Ward 10
ADMISSION DATE 18/6/93
DISCHARGE DATE 28/6/93

Address

Religion

Relatives contacted re Transfer: YES / NO Name

Discharge to Home Phone No.

Transport: Private ☐ Ambulance ☐ Ambulance Subscriber: YES / NO

ALLERGIES

DIET (HELP/FEED)

MOBILITY WALKING AIDS

PERSONAL HYGIENE DENTURES: UPPER ☐ LOWER ☐

PRESSURE AREA CARE

ELIMINATION

DRESSINGS

VISION GLASSES ☐ C/LENS ☐ PROSTHESIS ☐

HEARING HEARING AID ☐

COMMUNICATION

VALUABLES WALLET ☐ RINGS ☐ WATCH ☐ OTHER ☐

HOME ENVIRONMENT
HOUSE ☐ HIGH ☐ LOW ☐ No. OF STAIRS ☐
FLAT/VAN ☐ HIGH ☐ LOW ☐ No. OF STAIRS ☐
CARAVAN ☐

MEDICATIONS

APPOINTMENTS

0024

LETTER/REFERRAL

M.R. 93

Bundaberg HOSPITAL

059241
CONNELLY
DOREEN
F
22/04/1934
[redacted]
BUNDABERG
GEORGE CONNOLLY, HUSBAND
4670
[redacted]

GENERAL OBSERVATION SHEET

DATE: 18/6/93 | 19/6/93 | 20/6/93 | 21-6-93 | 22/6/93 | 23-6-93 | 24/6

TIME: AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM

TEMPERATURE ° C

PULSE °

BLOOD PRESSURE

RESPIRATIONS

BOWELS						
WEIGHT					67.5kg	
FOETAL HEART						
URINE PROTEIN	ALBUSTIK					
	BOIL					

GENERAL OBSERVATION SHEET

0048

W 62—Govt. Printer, Qld.

Bundaberg HOSPITAL P2

DAILY FLUID SUMMARY

059241
CONNELLY F
DOREEN 22/04/1934
[redacted]
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]

DATE	INTAKE			OUTPUT					MEASURED BALANCE
	ORAL	INFUSED	TOTAL	URINE	GASTRIC	DRAINS	BOWELS	TOTAL	
15/6	150	—	150	500	—	—	—	500	Neg pt
16/6	750	—	750	570	—	—	—	570	> 180

DAILY FLUID SUMMARY

Bundaberg HOSPITAL

SPECIFIC OBSERVATION SHEET

059241
CONNELLY F
DOREEN 22/04/1934
[redacted]
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]

EXAMPLES:

– FINGERS/TOES – Colour, temp, movement, swelling, pain, numbness, Remarks

– URINE – Vol, colour, reaction. SG. Albumen, Blood, sugar, bile, Remarks

OBSERVATIONS RECORDED: URINE ☐ FINGERS/TOES ☐ OTHER .....

INDICATE OBSERVATIONS IN SEPARATE COLUMNS

DATE	TIME	T	P	R	BP	FQa	SaQa	REMARKS
18/6/93	1850.		55	14.	127/61	3ℓ.		New (P) admitted to ICU. c/o chest pain 6/10 in severity between shoulder blades. ECG recorded
	1855				119/60			½ Anginine given. pain now 1/10
	1900		63	12	96/51	3ℓ.		pain 1/10 persisting
	1905		62	14	109/57	3ℓ		½ Anginine repeated. transiderm
	1915				108/56			2S applied. pain still 1/10 in
								severity.
	1930		60	18	112/68	3ℓ.		Pain 1/10 but getting better. Pain
								remains between shoulder blades
	1945		60	18	117/62	3ℓ		Pain now dull ache - no distress.
	2000		62	20.	122/63	3ℓ		IV Morphia 2.5mg + IV Maxolon
								10 mg given
	2005		61	20	113/53	3ℓ.		No pain now.
	2020		60	20.	104/48	3ℓ.		NO CAS pain Monitor SR
	~~2045~~		58	20	107/61	3ℓ.		NO CAS pain. Monitor SR.
	2200		56	18	95/52	3ℓ		Asleep Monitor SR.
	2300.		57	14	95/43	3ℓ		Asleep monitor SR
19/6/93	2400		59	10	91/49	3ℓ		2nd CE's taken Resting mild pain Monitor SR
	0100		53	17	94/53	3ℓ		Sleeping.
	0220		73	12	96/52	3ℓ		Mild pain, resting, Monitor SR
	0300		59	12	78/36	3ℓ		SB sleeping Gtn patch removed
	0305.				84/38			
	0315				81/38			SB no c/o pain.
	0325				85/42			

0044

BUNDABERG BASE HOSPITAL

PATIENT PROFILE

DATE 18/6/93

TIME 1840

WARD ICU

(Nursing History and Assessment Sheet)

SURNAME: CONNELLY GIVEN NAMES: DOREEN AGE: 59.

CONSULTANT DR DONNELLY M.O. DR. TAYLOR P/D MI

KNOWN ALLERGIES (record in red ink) NIL KNOWN

IS PATIENT ON MEDICATIONS? Yes/No

T..... P..... R..... B/P..... Weight .....

VITAL SIGNS:

Urinalysis .....

NURSING OBSERVATIONS

Colour: PINK *Skin State:* WARM/DRY

Discomfort/Pain: ?o central chest pain 6/10.

Communication Problems: –

Visual Problems: –

Other Problems: –

ORIENTATION

Hospital and Ward Routine explained: ✓

Nursing Personnel: ✓ *Doctor's Visit:* ✓ *Use of 'Call' Buzzer:* ✓

VALUABLES

In Trust: ..... *To Relatives:* ..... *Retained by Patient:* .....

Articles entered into 'Clothes Book': Yes/No

STUDENT OR ENROLLED NURSE'S SIGNATURE

.....

REGISTERED NURSE'S SIGNATURE:

.....

0042

MR69

Bundaberg HOSPITAL

INPATIENT PROGRESS NOTES

059241
CONNELLY F
DOREEN 22/04/1934
[redacted]
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
18·6·93.	59 y old ♀ pres c hx vague chest pain. Began this a.m. Has generally not changed - better at times. Goes into back. No other rad^{n}.
	nv̄ associated ~~c~~ SOB / weakness / ↓LOC.
	No assoc^{n} c food.
	Not ↑ c exertion. or ↓ c rest.
	Has "been just not feeling well".
	Nausea. 1x episode vomiting - water.
	No Hx URTI / cough.
	Central chest pain. Vague in nature.
	PMHx: ~~a~~MI 5y ago - no chest pain! CVA° DM° angina°. epilepsy° asthma° * Hypothyroidism - stopped thyroxine self.
	PSHx: nil
	Allergies: NIK.
	Medicat^{n}: nil.
	O/E: Looks well. a little confused. Well-oriented.
	PR 70. BP:
	JVP NE
	Carotids x 2
	AB → x
	HS x 2 I — II
	0040

W 61—Govt. Printer, Qld.

MR 20

Bundaberg HOSPITAL

059241
CONNELLY
DOREEN [redacted] F
22/04/1934
BUNDABERG 4670
GEORGE CONNOLLY. HUSBAND [redacted]

(Affix Patient Identification Label here)

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
~~2330~~	Pain settled.
	Angio.
	~~ECG~~ - inverts ~~in~~ leads.
	MCA / fronto-hypoid / CE: ②/③ ? in ~~a~~ -
	case
	C
14/8/93	ATSP re ↓ BP
0320	
	25 mg intra patch placed on at
	~ 2200.
	BP in A+E 125/61
	↓ gradually to 78/36
	patch removed at 0300
	BP now 87/38.
	~~plan~~ I: hypotensive response to
	transderm patch
	P: leave off patch
	B Mahe
	B Ritchie

0038

Bundaberg HOSPITAL

059241
CONNELLY
DOREEN
[redacted]
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]

F
22/04/1934

INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
19/6/93	CAK (P) relaxed and watching TV. Psychosocial (P) visited
2045	by her husband + son. C/S monitor in Sinus Rhythm T⁄
	i/v Jelco patent NO chest pain RESPS SaO2 g 95% on
	GIT Appetite fair Oral Fluids encouraged GOS. Output only
	270 mls Nico @ TOR. Continue (P)
20-6-93	Neuro :- No 4s overnight. (P) T° 37·3 at 0600.
0625	- Wt 67kg.
RN	CVS :- 66 - 91 BP 116/85 Lying 105/69 Stand.
	- Monitor in SR
	Resps - Nil Distress
	GUS - Voided 200 mls amb. NAD.
	IV - Cannula flushed + Patent
20/6/93	Pain - free.
	ECG - T-wave inversion all inf. leads.
	O/E/ P 80
	JVP ↔
	HS 1 -11 -1
	Chest - few basal crops.
	→ MI protocol.
	Start Atenolol 25 mg.
	Await IFTs.

0036

W 61—Govt. Printer, Qld.

INPATIENT PROGRESS NOTES

Bundaberg HOSPITAL

INPATIENT PROGRESS NOTES

059241
CONNELLY F
DOREEN 22/04/1934
[redacted]
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]
(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
21/6/93 - RP 1410 HRS.	NEURO: Showered self - no c/o SOB or chest pain.
	CVS: Monitor SR HR 54-62. BP 105/52. Afebrile.
	RESP: No SOB.
	GIT: Tolerating Healthy Heart diet
	GUS: Voiding good volumes.
	IV: Jelco patent. (RN).
21/6/93 1730.	CNS: Pain free. Mobilising to toilet c no ill effects.
	CVS: Monitor S/R. BP Rate 68-72. BP: 100/55. Colour pnt. Skin warm & dry.
	RS: Nil resp. distress. No O2 needed.
	GIT: Tolerating h.heart diet.
	GUS: VIT x 2 today.
	IV Jelco in situ (R) arm.
	SWABS taken Breast - commenced on topical cream at 1600
	Transferred to ward 10 @ 1730
21.6.93 0005hrs	Pt resting in bed. Nebulised x 1 & remains stable - experienced slight lightness in chest but eased when she returned to bed at DM(2) - instructed to ask for pm's overnight. Nil further episodes of chest pain. Pt remains patent. Medpro.
22/6/93	0440hrs rested quietly during the night. N/A c/o SOB/chest pain. IV line infiltrated & sited.

INPATIENT PROGRESS NOTES

W 61—Govt. Printer, Qld.

Bundaberg HOSPITAL

INPATIENT PROGRESS NOTES

059241
CONNELLY
DOREEN F
[redacted] 22/04/1934
BUNDABERG 4670
GEORGE CONNOLLY. HUSBAND
[redacted]

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
24.6.93	Hypothyroidism – start thyroxine 100 mcg Daily
	Dietry advice from dietician
	Enzymes confirm small MI
	No sign ECG changes
	For Cardiac post MI rehab
	? Home Sun / Mon
24.06.93	Pt has been RIB this shift;
1530hrs	mobilized around ward & assistance, has had
	n/c of chest pain or SOB has
	mainly been self caring (RN)
24/6/93 2200hrs	Ambulant around ward area only bathroom walk.
	not attended this shift due to business of ward.
	No complaints pain or S.O.B. (Nursing Assistant)
25.6.93	0430hrs Awake to yard only ne Qo offered.
25.6.93	Chest pains on mobilisation
	No sign LVF BP 110/60 P 60
	pains relieve O2 or GTN
	Add Imdur 60 mg Daily
	Try to achieve Once daily
	regime ? Home Sunday? Mon
	Sub max exercise ECG Next week.

0032

Bundaberg HOSPITAL

059241
CONNELLY F
DOREEN 22/04/1934
[redacted]
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]

(Affix Patient Identification Label Here)

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
28.6.93 0430hrs	Rested well, nil 4o overnight - [illegible]
28-6-93	Dr Pinn WR
	Inf NE.
	ho hypertension, ↑chol.
	Part Hx MI 5yrs ago
	OPD Dr Pinn 6/52
	R/t TFT 4/52.
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
28/6/93 O/P	Pt discharged to home ——— R.C.W.Ba

INPATIENT PROGRESS NOTES

0030

B'Berg HOSPITAL

INPATIENT MEDICATION CHART

Admission

From ..../...../..... **To** ..../...../.....

Admission Weight.....**Kg**

059241
CONNELLY F
DOREEN [redacted] 22/04/1934
BUNDABERG 4670
GEORGE CONNOLLY, HUSBAND
[redacted]

AVOID ERRORS: Drugs will not be administered without a written, legible, complete prescription.

ADVERSE DRUG REACTIONS	DRUG	MONTH/YEAR	NATURE OF REACTION
	N/K		

ONCE ONLY (AND PREMEDICATION) DRUGS

DATE	TIME	DRUG	DOSE	ROUTE	DOCTOR	GIVEN BY	TIME GIVEN
18/6	1840	Aspirin	300mg	PO	[signature]	[signature]	1840
24/6	Noon	THYROXINE	50mcg	PO	[signature]	[signature]	1510

DRUGS WITH VARIABLE DOSE

DRUG			ROUTE	
DATE	TIME	DOSE	DOCTOR	NURSE

DRUG			ROUTE	
DATE	TIME	DOSE	DOCTOR	NURSE

INPATIENT MEDICATION CHART

REGULAR PRESCRIPTIONS | **SURNAME** Connelly | **GIVEN NAMES** Doreen

DRUG REACTIONS

(See front of Sheet)

ADMINISTRATION TIMES
(According to Hospital Policy)

FOR DRUGS NOT GIVEN INSERT
(According to Hospital Policy)

R REFUSED **A** ABSENT
S STARVING **N** NO STOCK

1993

RECORD OF ADMINISTRATION

Date → / Time ↓	26/6	27/6	28/6	29	30
0800	[illegible]	[illegible]	[illegible]		

DRUG ATENOLOL

ROUTE	DOSE	FREQ.	START
PO	50mg	Mane	26.6.93

DOCTOR [signature] | Pharmacist [initials]

DRUG

ROUTE	DOSE	FREQ.	START

DOCTOR | Pharmacist

DRUG

ROUTE	DOSE	FREQ.	START

DOCTOR | Pharmacist

DRUG

ROUTE	DOSE	FREQ.	START

DOCTOR | Pharmacist

DRUG

ROUTE	DOSE	FREQ.	START

DOCTOR | Pharmacist

DRUG

ROUTE	DOSE	FREQ.	START

DOCTOR | Pharmacist

DRUG

ROUTE	DOSE	FREQ.	START

DOCTOR | Pharmacist

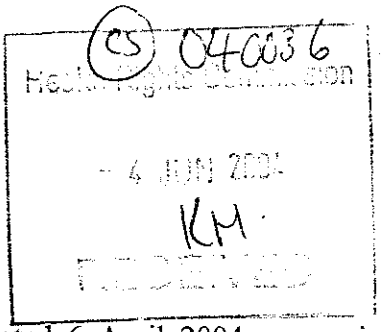
Queensland Government

Queensland **Health**

BUNDABERG HEALTH SERVICE DISTRICT
EXECUTIVE SERVICES

Enquiries to: Peter Leck, District Manager
Telephone: 4150 2020
Facsimile: 4150 2029
Our Ref:

Ms Karen Harbus
Intake Officer
Health Rights Commission
GPO Box 3089
BRISBANE Q. 4001



Dear Ms Harbus

I write in response to your letter dated 6 April 2004 concerning the complaint by Mr George Connelly about the health service provide to his late wife, Doreen.

Mrs Doreen Connelly presented to Bundaberg Base Hospital (BBH) at approximately 0450h on 1 December 2003. She had woken at 0330h with chest pain which lasted 30 minutes and completely resolved after she was administered oxygen, aspirin and GTN by QAS paramedics.

Upon arrival at BBH, Mrs Connelly was pain free and assessed by the duty medical practitioner, who noted Mrs Connelly's past history of an acute myocardial infarction and hypothyroidism. The medical practitioner also noted that Mrs Connelly complained of an increasing frequency of chest pain on exertion over the preceding days. Physical examination including vital sign monitoring revealed no major abnormality. Investigations including serial ECGs confirmed the previous myocardial infarction with some lateral 'T' wave changes, the chest x-ray was normal and blood tests showed a raised troponin value.

Mrs Connelly was admitted to a general ward and reviewed by the specialist medical team later in the morning. The medical team made a diagnosis of unstable angina with aspirin, a lipid lowering medication ('Lipitor') and frusemide ('Lasix') added to Mrs Connelly's medication. At that time Mr Connelly explained to the treating medical staff that their general practitioner had referred Mrs Connelly for a (sestamibi) stress test to be performed by North Coast Nuclear Medicine at Mater Hospital Bundaberg, which was booked for 7 December 2003. He explained he had notified the nuclear medicine service that Mrs Connelly was an inpatient at BBH and understood the booking would remain open until approximately 0930h, requiring confirmation from BBH staff before this time. The agreed management plan was that further blood tests be taken and if normal, the stress test occur, as planned. The blood was collected and marked urgent with the result checked by Dr Khan and arrangements begun to transfer Mrs Connelly for her stress test. The nursing staff member rang North Coast Nuclear Medicine to confirm the appointment however it had been reallocated with no further appointments available for one week. Arrangements were made for Mrs Connelly to undergo the test as an outpatient on 8 December 2003.

Mrs Connelly was stable throughout her admission, with no further complaints of pain or any requirements for any form of analgesia and was discharged home at 1430hr on 2 December 2003. Tragically Mrs Donnelly died in the early hours of the morning of 3 December 2003. One of Mr Donnelly's responses was to seek out the name of the nurse, who he believed hadn't rung the nuclear medicine service, therefore allegedly contributing to the untimely death of his wife. In a telephone call of 3 December 2003 with Mr Connelly, Ms Beryl Callanan Acting Director of Nursing explained that BHSD would review his concerns, but wouldn't release the name of the nurse to him, because the nurse was employed by BHSD and any complaint should be directed to the employing organisation.

An interview was conducted with the nurse caring for Mrs Connelly, who explained she had contacted North Coast Nuclear Medicine in an attempt to confirm the booking, after receiving confirmation from Dr Khan that Mrs Connelly could attend. However her phone call was made after the required confirmation time and the booking had been reallocated with no emergency appointments available. The timing of the latter booking was checked with the treating medical staff. BHSD believes the nurse performed her duties correctly within her overall workload allocation and can find no fault with her actions. It is noted that this nurse was very upset following Mr Connelly's return to BBH to complain about his wife's cancelled appointment, when he was reported to publicly remonstrate with a number of nursing staff in the ward area.

In reviewing this complaint, an internal review of the health care provided to Mrs Connelly was performed by Dr Keating, Director of Medical Services and Dr Peter Miach, Director of Medicine. This review confirms the above information including the ECG changes in Mrs Connelly's initial ECGs (as compared to previous ECGs in 2002), an elevated troponin on arrival which increased in value 8 ½ hours later, but with no rise in creatinine kinase. The raised troponin value is evidence of minor heart muscle damage. The combination of Mrs Connelly's past history, prolonged chest pain, ECG changes and raised troponin values indicates the diagnosis should have been acute coronary syndrome. Accordingly this lady should have remained in hospital for ongoing observation.

Based upon this information, I offer my profound apologies to Mr Connelly for the distress and anxiety relating to the unexpected death of Mrs Connelly. I would like to apologise to Mr Connelly in person and Mr Connelly can contact my office on 4150 2020 to arrange a time convenient to him. I have asked Drs Strahan and Khan to attend this meeting to provide further explanation and answer any questions that Mr Connelly may have.

As a health service, we wish to reduce these circumstances to a minimum and maintain a reputation for high quality care. I have directed Dr Keating and Dr Miach to review the care provided to all patients presenting with acute coronary syndrome to ensure these patients are managed appropriately. BBH has begun involvement with the Collaborative for Healthcare Improvement – Acute Coronary Syndrome, which will provide evidence based guidelines and systematic evaluation of the treatment of this condition in BBH with comparison on a statewide basis. An education session has been conducted at BBH for all medical staff involved in the care of such patients, with senior staff attending continuing education sessions on the specific topic of Acute Coronary Syndrome and the management of patients with raised troponin measurements.

I trust this information is of assistance.

Yours sincerely

Peter Leck
District Manager
01/06/04

Attention: Karen

FAX 32340333

News Mail 4/5/04

Wife's death questioned

THE plight of a Bundaberg man demanding an inquiry into his wife's death will land in the hands of Health Minister Gordon Nuttall today.

George Connelly has accused the Bundaberg Base Hospital of staff incompetence and ward crowding after his wife Doreen was discharged from their services in December, despite a suspected heart blockage.

She died less than 12 hours later from a heart attack.

Member for Burnett Rob Messenger has taken up Mr Connelly's cause, describing the hospital's actions as "disgraceful".

Late last week, Mr Messenger wrote a letter to Mr Nuttall, querying the hospital's actions.

The letter is expected to arrive on the Health Minister's desk today, if not sooner.

During a recent trip to Bundaberg, Mr Nuttall admitted the state government's past focus on hospital infrastructure rather than staff had been to the detriment of health services.

Mr Connelly said he was frustrated by a health system which would not even allow him access to his wife's medical files.

"They should have kept her in hospital," Mr Connelly said.

"They were short of beds — that's why they sent her home."

Mr Connelly is waiting for a reply from the Health Rights Commission in Brisbane.

"When I first talked to them, they said they had 200 or 300 cases like mine," he said.

However, Mr Connelly praised the efforts of Bundaberg Base Hospital's heart specialist Dr Strawn.

Mr Rob Messenger MP
Member for Burnett
Shadow Minister for Education and the Arts

Shop 7 Bargara Beach Plaza
15-19 See Street
(PO Box 8371)
Bargara Qld 4670

Office phone: (07) 4159 1988
Office fax: (07) 4159 2696
Mobile: 0427 179 839

COPY

Mr Gordon Nuttall
Member for Sandgate
Minister for Health
GPO Box 48
Brisbane Qld 4001

21 April 2004

Dear Mr Nuttall,

A Burnett constituent has contacted my office in regards to his wife's passing. Doreen Connelly was sixty-nine years old and had a prior history of silent MI and hypothyroidism.

On 2nd December 2003, Mrs Connelly was admitted to Bundaberg Base Hospital due to chest pains. She was discharged the same day, and past away that night.

Mr Connelly has since spoken with the Acting Director of Nursing and the Director of Medical Services, and has received letters from Patrick Martin, Acting Director of Nursing and little if nothing has been done to help Mr Connelly.

Mr Minister, I respectfully ask you:

- How does an elderly lady with a history of heart problems who medicates regularly with Asprin, Lasix, Lipitor and Thyroxine get admitted and discharged from hospital in a day, only to go home and never wake up?

I would like to ask again, Mr Minister, for a full comprehensive independent review into the Bundaberg and District Health Service.

A stream of Bundaberg hospital health professionals have contacted me and my office expressing concerns over bullying, unsafe working conditions, understaffing and overworking.

Mr Minister, I implore you to waste no time in establishing this comprehensive review.

Yours faithfully,

Mr Rob Messenger MP
Member for Burnett
Shadow Minister for Education and Arts

Health Rights Commission

Our Ref: 040036 S2/kh
Your Ref:

6 April 2004

Private & Confidential

Mr George Connelly
[redacted]
BUNDABERG QLD 4670

Dear Mr Connelly

Thank you for forwarding your complaint dated 12 February 2004, to the Health Rights Commission about a health service your late wife, Mrs Doreen Connelly, received from Bundaberg Base Hospital on 1 December 2003.

As required by the *Health Rights Commission Act 1991* (the Act), the Commissioner has asked me to assess the complaint to see whether we can obtain sufficient information to resolve it immediately or whether further action is appropriate. It is the Commissioner's hope that the complaint will be dealt with as informally and expediently as possible.

At the end of assessment, the Commissioner is required to determine whether the complaint has been satisfactorily explained or resolved, and can be closed. Alternatively, the Commissioner may decide to take further action to conciliate, investigate, and/or refer the complaint to another organisation which has the authority to deal with the complaint issues.

In your complaint and during subsequent telephone discussions, you stated that the main issue of your complaint is that a nurse at Bundaberg Base Hospital failed to ensure your wife attended a pre-booked stress test and x-ray. You stated that your wife was admitted to the hospital with a suspected heart attack but various tests were conducted which were "*negative*". You said that when your wife was checked by her heart specialist at 8.30 a.m. on 2 December 2003, you informed him that your wife was booked into a private hospital to have a stress test and x-ray conducted that day at 10.20 a.m. You stated that the specialist instructed the nurse to have the stress test and x-ray carried out "*straight away*". You informed me that at 10.30 a.m. the doctor advised you that the appointment had been reallocated and would now take place on 8 December 2003. You said you made enquiries at the private hospital and were informed that Bundaberg Base Hospital had not telephoned them. You were advised to take your wife home. Unfortunately, your wife passed away in the early hours of the morning of 3 December 2003. You believe that had your wife attended her stress test and x-ray appointment, the blockage in her heart would have been detected and she would have been operated on immediately. You believe she may well be alive today had this occurred.

You are seeking an explanation as to why your wife was not booked in for a stress test as a matter of urgency.

Before the Commissioner decides what action to take on your complaint, he is required to ensure that you have had the opportunity to resolve the complaint directly with Bundaberg Base Hospital.

As we discussed in our telephone conversation, you have agreed that I request Bundaberg Base Hospital to direct all communication through the Commission because your previous attempts to resolve the complaint with the hospital were unsuccessful.

Address: Level 19 288 Edward Street Brisbane Q 4000 **Postal:** GPO Box 3089 Brisbane Q 4001
Telephone: (07) 3234 0272 **Toll Free:** 1800 077 308 **Facsimile:** (07) 3234 0333 **Web Site:** www.hrc.qld.gov.au

Consequently, a copy of your complaint has been forwarded to Bundaberg Base Hospital with an invitation to provide a response directly to the Commission.

At this stage, provision of information by Bundaberg Base Hospital is voluntary and the early resolution of your complaint may depend on any advice we receive from them.

If you choose to initiate legal proceedings against the health service provider however, you should ensure that you are fully aware of the rights and obligations involved in making that decision. It is not the Commission's role to provide you with advice in relation to the claim itself or the procedural aspects of instituting proceedings. You should obtain independent advice in relation to these matters. The matters you need to consider include: -

1. the fact that, if you choose to initiate legal proceedings against a health service provider, you must normally do so within a period of 3 years from the date of the incident that led to your complaint; and

2. the *Personal Injuries Proceedings Act 2002* ("PIPA") which applies to claims for personal injuries and requires a number of procedures to be complied with prior to initiating legal proceedings, including strict provisions as to notice of your intention to proceed, which must be supplied within a short period of the incident complained of.

Your obligation to take steps in relation to the PIPA is deferred if you first make a complaint to the Health Rights Commission. There is no such deferral in respect of the 3 year requirement for the institution of proceedings referred to above.

There may be other matters to be considered. If you are not sure about your legal rights, you should seek advice as soon as possible.

I may be reached on 3234 0258 or Qld toll free 1800 077 308 (excl. Brisbane Metro) if you have any questions or further information about your complaint, or if you need to correct my understanding of the matter. I shall contact you when I have received and reviewed Bundaberg Base Hospital's response to your complaint. I look forward to helping you resolve this matter.

Yours sincerely

Karen Harbus.

Karen Harbus
Intake Officer

Health Rights Commission

Our Ref: 040036 S2/kh
Your Ref:

6 April 2004

Private & Confidential

Mr Peter Leck
District Manager
Bundaberg Base Hospital
PO Box 34
BUNDABERG QLD 4670

Dear Mr Leck

Mr George Connelly has approached the Commissioner about a health service his late wife, Mrs Doreen Connelly, received from Bundaberg Base Hospital on 1 December 2003. I enclose a copy of Mr Connelly's complaint.

As required by the *Health Rights Commission Act 1991* (the Act), the Commissioner has asked me to assess the complaint to see whether we can obtain sufficient information to resolve it immediately or whether further action is appropriate. It is the Commissioner's hope that the complaint will be dealt with as informally and expediently as possible.

At the end of assessment, the Commissioner is required to determine whether the complaint has been satisfactorily explained or resolved, and can be closed. Alternatively, the Commissioner may decide to take action to conciliate, and/or refer the matter to another entity for action, and/or in the case of non-registered providers, investigate the complaint.

In his complaint and during subsequent telephone discussions, Mr Connelly stated that the main issue of his complaint is that a nurse at Bundaberg Base Hospital failed to ensure his wife attended a pre-booked stress test and x-ray. Mr Connelly stated that his wife was admitted to the hospital with a suspected heart attack but various tests were conducted which were "*negative*". He said that when his wife was checked by her heart specialist at 8.30 a.m. on 2 December 2003, he informed the specialist that his wife was booked into a private hospital to have a stress test and x-ray conducted that day at 10.20 a.m. Mr Connelly stated that the specialist instructed the nurse to have the stress test and x-ray carried out "*straight away*". He informed me that at 10.30 a.m. the doctor advised him that the appointment had been reallocated and would now take place on 8 December 2003. Mr Connelly said he made enquiries at the private hospital and was informed that Bundaberg Base Hospital had not telephoned them. Mr Connelly was advised to take his wife home. Unfortunately, his wife passed away in the early hours of the morning of 3 December 2003. Mr Connelly believes that had his wife attended her stress test and x-ray appointment, the blockage in her heart would have been detected and she would have been operated on immediately. He believes she may well be alive today had this occurred.

Mr Connelly is seeking an explanation as to why his wife was not booked in for a stress test as a matter of urgency.

During the assessment, you are invited to provide the Commission with a response to Mr Connelly's complaint. In accordance with section 71(2) of the Act, the Commissioner has to decide if Mr Connelly

has had the opportunity to resolve the complaint with you. In this instance, the Commissioner is of the opinion that this complaint is unlikely to be informally resolved between you and Mr Connelly because previous attempts at direct resolution have not resolved the matter to Mr Connelly's satisfaction.

To enable the Commission to comply with the legislative requirements during assessment (section 70 of the Act), I will need the following information from you by 11 May 2004:

- Your intentions on whether or not you wish to make a submission to the Commission on the complaint.
- Your submission, if you intend to provide one. **Please indicate whether you are agreeable to having your response passed on to Mr Connelly.**

Information received by the Commission is used to examine the validity of the issues raised in the complaint. The type of information that may assist the Commission could include:

- copies of Mrs Connelly's medical records, notes and diagnostic reports;
- statements from any staff involved in the complaint issue;
- an explanation of the patient's symptoms, diagnosis and treatment;
- **an explanation as to why an urgent appointment for Mrs Connelly's stress test was not rebooked;**
- an outline of the investigations undertaken;
- copies of relevant documented policies; and
- any other information you think is relevant.

I have enclosed a copy of an Authority for Release of Information duly signed by Mr Connelly.

As our files are accessible under the *Freedom of Information Act 1992*, any comment you make may be accessible under that Act, subject to possible exemptions such as the confidentiality of information provided. You may wish to advise us when any comment you make is "Given in Confidence" for the purpose of that legislation. If a decision is made to refer the complaint to another body, for example a registration board, the Commissioner may decide to provide it with a copy of any submission you make.

Please do not hesitate to contact me on 3234 0258 if you wish to discuss the complaint or the Commission's processes.

Yours sincerely

Karen Harbus

Karen Harbus
Intake Officer

Enc.

cc. Dr Darren Keating
Director of Medical Services
Bundaberg Base Hospital

Ms Linda Mulligan
Director of Nursing

Queensland Government
Queensland Health

FAX MESSAGE

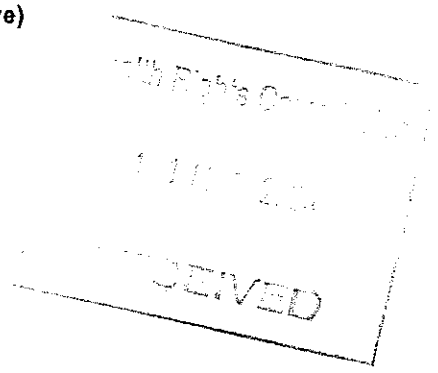
Bundaberg Health Service District
PO Box 34
BUNDBERG Q 4670

TO:		FROM:	
Fax:	07 3234 0258	**Fax:**	41502029
Name:	Karen Harb	**Phone:**	41502020
Organisation:	Health Rights Commission	**Name:**	Toni Hoffman
Date:	11/03/2004	**Position:**	Acting Director of Nursing Services Bundaberg Health Service District

CONFIDENTIAL COMMUNICATION

SUBJECT: George Connelly

Pages 3 **(Inclusive)**



CONFIDENTIAL

Karen,

Documents attached as per discussed.

Thanks.

Toni Hoffman

Toni Hoffman
Acting Director of Medical Services
11/03/2004

Enquiries to: Name and Branch/Unit Title
Telephone: Tel No.
Facsimile: Fax No.
File Ref: Ref. No.

Mr George Connelly
[redacted]
Bundaberg 4670

Dear Mr Connelly

Firstly, allow me on behalf of Bundaberg Health Service District (BHSD) to express my condolences at the passing of your wife late last year.

I understand that you have been in touch with the Health Rights Commission regarding events leading up to your wife's death at home following discharge from the Bundaberg Base Hospital on December 2nd, 2003. I have reviewed the notes taken by the then acting Director of Nursing, Ms Beryl Callanan, regarding her investigations of your concerns.

Her investigations have shown that the nurse allocated to your late wife was to rebook your wife's stress test, which had been cancelled as she was at the time an inpatient of this hospital. This nurse did contact the Mater Hospital, however the initial appointment had been reallocated. With respect to your late wife's condition at the time, there was no urgency to undertake the stress test as confirmed with the medical specialist team treating your wife. This team was happy to accept the early appointment date if available, but preferred the later date as is normal practice in such circumstances.

Unfortunately BHSD is not at liberty to provide you with the name of the nurse who was involved with the care of your wife as you request. Staff are employed by Queensland Health and are covered by vicarious liability, and as such the organisation is responsible for the care provided either collectively or individually by the staff. BHSD supports this staff member and can find no fault with her actions in relation to this case.

Whilst I am aware that you have spoken to both the then acting Director of Nursing and the Director of Medical Services by phone and have had a face to face meeting with Ms Callanan, we would be pleased to meet with you again if you wish to discuss any matters pertaining to the care received by your late wife as an inpatient at this Hospital.

Once again, please accept my condolences at the passing of your wife. I am sorry that you feel as though you have been unable to resolve this painful episode surrounding your wife's death. Please feel free to contact us for an appointment if you wish to discuss this further.

Yours sincerely

Insert Name
Insert Position Title
/ /

C46237.

Queensland Government

Queensland Health

Enquiries to: Director of Nursing
Telephone: 4150 2025
Facsimile: 41502029
File Ref: 010304

Mr George Connelly
[redacted]
BUNDABERG QLD 4670

Dear Mr Connelly

Firstly, allow me on behalf of Bundaberg Health Service District (BHSD) to express my condolences at the passing of your wife late last year.

I understand that you have been in touch with the Health Rights commission regarding events leading up to your wife's death at home following discharge from the Bundaberg Base Hospital on December 2nd, 2003. I have reviewed the notes taken by the then acting Director of Nursing, Ms Beryl Callanan, regarding her investigations of your concerns.

Her investigations have shown that the nurse allocated to your late wife was to rebook your wife's stress test, which had been cancelled as she was at the time an inpatient of this hospital. This nurse did contact the Mater Hospital, however the initial appointment had been reallocated. With respect to your late wife's condition at the time, there was no urgency to undertake the stress test as confirmed with the medical specialist team treating your wife. This team was happy to accept the early appointment date if available, but preferred the later date as is normal practice in such circumstances.

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Whilst I am aware that you have spoken to both the then acting Director of Nursing and the Director of Medical Services by phone and have had a face to face meeting with Ms Callanan, we would be pleased to meet with you again if you wish to discuss any matters pertaining to the care received by your late wife as an inpatient at this Hospital.

Once again, please accept my condolences at the passing of your wife. I am sorry that you feel as though you have been unable to resolve this painful episode surrounding your wife's death. Please feel free to contact us for an appointment if you wish to discuss this further.

page 2. has Patrick Martins signature - no text - according to c...

HEALTH RIGHTS COMMISSION

AUTHORITY FOR RELEASE OF INFORMATION

I, George Alexander Connelly of [redacted] Bundaberg, 4670, authorise officers of the Health Rights Commission to contact my late wife's doctor/s and hospital about her medical treatment and to have access to my medical notes. Her name is Doreen Connelly and her date of birth is 22/04/1934.

G. A. Connelly
(Signature)

22-02-04
(Date)

6th January 1938
(Date of Birth)

Q00036.

Enquiry/Oral Complaint

Enquiry Number: 046237
Enquiry Received: 08/12/2003 10:16:00 AM
Enquiry Status: Open

Type Of Contact: Type: Complaint
Sub-Type: Oral Complaint

☐ Anonymous Caller

Caller

Type: Individual

Last Name: Connelly
Initials: G
First Name: George
Title: Mr

Gender: Male

Address 1: [redacted]
Address 2:
Address 3:

Suburb: BUNDABERG
State: QLD
Post Code: 4670

Business Hours Phone: [redacted]
Other Phone:
After Hours Phone:
Fax Number:

Email Address:

Consumer

☐ Caller Is Consumer

Last Name: Connelly (Dec'd)
Initials: D
First Name: Doreen
Title: Mrs

Gender: Female
Mode: Telephone

Non-English Speaking Background (NESB): ○ Yes ○ No
Interpreter Required: ○ Yes ○ No
Aboriginality:
Preferred Language:

Type Of Provider

Type: Organisation
Speciality:
Classification: Hospital Public General
Sub-Speciality:

District: Bundaberg

Organisation: Bundaberg Base Hospital

Last Name: Leck
Initials: P
Official Title: District Manager
First Name: Peter
Title: Mr

Address 1: PO Box 34
Address 2:
Address 3:
Suburb: BUNDABERG
State: QLD
Post Code: 4670

Named Provider

Last Name: First Name:

Initials: Title:

Primary Issue: Diagnosis

Outcome:
Closure Reasons: Enquiry Only
Scale: Substantial

Date Of Health Service: 02/01/03
HRC Process Explained: ○ Yes ● No
HRC Info Sent: ○ Yes ● No
Permission To Send Complaint: ○ Yes ○ No
Provider Known To HRC: ● Yes ○ No

Case Officer(s): Karen Harbus/HRC

Comments: A man telephoned to complain that when he took his wife to A&E of a public hospital, she was told that she had suffered a heart attack and would need to have x-rays carried out at the nearby private hospital. He said the appointment was made for 11.30 a.m. but the nurse did not get her there in time. The man said the appointment was therefore cancelled and his wife was discharged. He stated that she died at 5.30 a.m. the next day. He said he believed that if she had undergone the x-rays, she might still be alive. I asked him about the cause of death and he stated that he did not have the Death Certificate as yet. I asked him if he had a good relationship with his GP and he said yes. I advised him to await the Death Certificate and then take it to his GP and ask the GP whether or not his wife's death could have been prevented. I suggested to him that if the GP told him his wife's death could have been prevented, that he write to the hospital with a complaint, including any outcomes he was seeking such as an apology or explanation. I advised the man that if he was unhappy with the response he received from the hospital, that he contact the HRC again. The man stated that he would ring his solicitors and I said that was a good idea. I asked him if he wished me to ring the hospital on his behalf and he told me that he had already spoken to them. I asked him if he wished me to talk to the friends who were now at his house. The man put me onto Lorrain. I reiterated the above advice to her. She stated that the man was very angry about the nurse for not getting his wife to the x-rays on time and that the nurse had failed in her duty of care. I asked her if she could assist the man in writing to the hospital now about this aspect of the complaint, seeking an explanation as to what happened. She said she could. I advised her that if the man was unable to resolve the matter, that he call again as HRC would hold details on the database.

Duration Of Call: 10 minutes

File Note

Consumer: Provider:

Encryption Key:
Date Composed: 01/03/2004 11:03 AM Composed By: Karen Harbus/HRC

Body Text:
C attended at the HRC on 16/02/04 in order to return the signed Authority. He was accompanied by his daughter, Ms Kim Schmidt, 16 Senior Crt, Windaroo, 4207 (ph 3804 0705 (h) - 0409 900 880 or 3804 0422 (w). I asked C if he had as yet had a meeting with P and he said he had met with the DON. He became very distressed and said that the nurse had killed his wife. He said he knew there was a "big cover up" going on because P would not release his wife's records. I advised him that under the FOI Act I did not think they were obliged to. He said he wanted the HRC to investigate the matter even though P had not finished their investigation. I advised him that under HRC legislation, he was obliged to try and resolve the complaint directly with P. I explained that now that I had received his signed Authority I could fax it through to P and they would know that he had given me permission to speak to them on his behalf. The man stated that this was not good enough. His daughter explained to him that he had followed correct procedures in signing the Authority and generally tried to reassure him. He explained that he is going to Greenslopes Hospital for tests and an operation and would be there for a few weeks. I said I would keep in touch with his daughter as events arose. I asked him to clarify his outcome and he said "That nurse should not be practising. She is murdering more people".

MY HEALTH SERVICE COMPLAINT

An Optional Complaint Form: Please write your own if preferred
I wish to lodge a complaint, and my name is:

MC KH
@ 034246
JC 237

Name George Alexander Connelly

Address [redacted]
Bundaberg 4670 Qld

Phone H) [redacted] W) —

Date of Birth 6-01-38

Aboriginal or Torres Strait Islander? ☐ Yes ☑ No Non-English Speaking Background? ☐ Yes ☑ No

I am complaining on behalf of (if relevant):

Name Doreen Connelly (My wife deceased)

Address for — as above

Phone H) _____ W) _____

Date of Birth 22-04-34

Aboriginal or Torres Strait Islander? ☐ Yes ☑ No Non-English Speaking Background? ☐ Yes ☑ No

The person (or place) I want to complain about is: Doctor/Hospital/Other Health Care Provider

Name Hospital (Bundaberg Base Nurses name unknown)

Address Bourbong St Bundaberg 4670 PO Box 34 Qld

Phone 07-41521222

WHEN IT HAPPENED (Date) 02,03-02-04

On Separate sheets please outline your complaint with reference to the attached "Guide to Writing a Complaint".

SIGNED: G. A. Connelly DATE: 12-02-04

Any further queries, contact the *Health Rights Commission* on (07) 3234 0272 or Qld Toll Free 1800 077 308 (excl. Brisbane Metro)

◆*It is an offence to threaten, punish, harass, discriminate or intimidate a person who has made a complaint to the Health Rights Commission*

Please return this completed form to the ***Health Rights Commission, GPO Box 3089, BRISBANE Q 4001***

046237

Doreen Connelly
22/4/1934

2/12/03

Dear Doctor

69 year old lady with prior history of silent MI presented with chest pain relieved by Nitroglycerin. Her Troponin was 0.6 with a flat CK curve. ECG shows old MI.

Past medical history
Prior MI (silent)
hypothyroidism

Meds
Aspirin 100mg OD
Lasix 40mg OD
Lipitor 20mg OD
Thyroxine 100mcg OD

Assessment
Unstable Angina/ Non ST Elevation MI

Plan
1. Booked for a stress sestamibi 8/12/03
2. Started on aspirin and lipid lowering agent.
3. Will hold off beta blockers until stress test performed to allow for an adequate study
4. Started on lasix. Will need to assess long term need based on EF and follow up exam.

Thank you

Abid Khan
Med PHO
4152 1222

NURSE

On late the 1st or early the 02-12-03 my wife Doreen Connolly was taken by Ambulance to Braidelbury Base Hospital with a suspected heart attack after several checks which turned out negative my wife was admitted to hospital and in she had been given several pain killing tablets and strong sedatives for Tuesday she was now feeling no pain as suggested that I go and pick up our son Paul and take him to work, she had been booked in for a stress dectamide at 10.20 AM on the 2-12-03 by her doctor Dr Morgard she asked me to let them know that she was in hospital this was at the Mater Hospital I did this and told them that I did not know if the Base Hospital was going to run her down or not they told me that they would have to know early as the time would have to be rearranged. The heart specialist was suppost to see her at 8 AM he did not arrive till aprox 8.30 AM I told him about the x ray at the Mater hospital he turned to the nurse and said I want this x ray done and strait away he then left. I gave the nurse all the particulars including the appointment form which included the telephone number for the Mater hospital and told her she had to phone them strait away. She walked of without saying a word. At 10 AM the ward doctor came up with the nurse and said we will send you up for that x ray now are you feeling any pain of course she wasn't she had been given medication to stop the pain he then started to work out how he was going to get her to the Mater Hospital I said do you want me to run her down he said yes, the nurse then intervened

you are taking a risk she should go by ambulance
he agreed and said I will phone the Mater
and let them know she is on the way down
and headed off I followed him as I thought there
was something they were not telling us. He told
me that we think she has a blockage in the heart
and this x ray will show us where it is and we
will be able to give her something for it and send her
to Brisbane to be operated on strait away to clear
it. I went back and told my wife. At 10-30 the doctor
came back and said the appointment had been recelocated
and he had booked her in for monday 8-12-03.
On hearing this I went strait down to the Mater Hospital
I was told that the Base Hospital had not phoned it
so they relocated the x ray at 9:30 AM. I then went back to the
base hospital and complained to the ward doctor
he said it was to late and there was nothing they could
do about it. (I have since found out that the hospital
could have requested an emergency x Ray) I then
asked the doctor what happens now he said she can
go home and that the Mater will send the results back
to them, I went back to my wife she had been told she was
going home, the nurse was attending another patient I
asked the reason she did not phone the Mater she
said in a huff its not my job the doctor should have
phoned, as she was walking off I said you should
have given all the information to the doctor then. The
hospital refused to give me the nurses name.
My wife passed away between 4:30 AM and 6 AM on the 3-12-03.
It is my opinion the the nurse should never be allowed
to continue in her trade again and put other lives
at risk

G. J. Connelly

0002