Internal and external triage leading to delayed hospital admission (04HDC00658, 2 September 2005)

Medical officer ~ General practitioner ~ Emergency nurse ~ Community hospital ~ Ambulance service ~ Emergency department ~ Ischaemic heart disease ~ Diabetes ~ Pulmonary disease ~ Hypertension ~ Emphysema ~ Dyspnoea ~ Cardiopulmonary disease ~ Cardiac arrest ~ Rights 4(1), 4(2)

A 69-year-old man with a history of chronic lung disease, diabetes and angina visited his general practitioner with increasing shortness of breath, ankle swelling, a productive cough, and chest pain episodes thought to be angina. He was treated with antibiotics and prednisone.

A few days later he developed increased shortness of breath and anxiety and he was taken by ambulance to the emergency department (ED) at the local hospital. He was assessed by a medical officer and discharged an hour later with instructions and a prescription. Later that evening an ambulance was called again. The ambulance officer recorded that the man had panicked about his condition but had settled again.

The same evening the ambulance was called again. The ambulance officer called an emergency nurse at the hospital, who advised seeking assistance from the urgent doctor service. A doctor made a home visit, during which the man had a respiratory arrest, and subsequently a cardiac arrest and died.

It was held that the medical officer failed to properly assess and treat the man during his presentation to the ED. He should have considered cardiac causes for the shortness of breath, taken an appropriate cardiac history, conducted a cardiac examination and requested an ECG and chest X-ray. The man should have been observed for several more hours to fully assess the effectiveness of the medication, which initially resulted in a slight improvement in his condition. The medical officer did not provide an appropriate standard of care and breached Right 4(1). By failing to keep a proper record of the assessment, he breached Right 4(2).

It was held that the emergency nurse breached Right 4(1) by failing to respond appropriately to the telephone call from the ambulance officer about the man's condition, and breached Right 4(2) by failing to document the conversation.