Death after delay in receiving treatment for DVT in an Emergency Department (01HDC11475, 4 March 2003)

Public hospital ~ Emergency Department ~ Triage times ~ Referral from GP with diagnosis of DVT ~ Death from pulmonary embolism ~ Resource constraints ~ Right 4(1)

A 64-year-old patient was referred to a public hospital by his GP, with a diagnosis of deep vein thrombosis (DVT) confirmed by ultrasound imaging. The patient died of a pulmonary embolus after waiting in the Emergency Department for several hours without being seen. The patient's wife complained that:

1 the junior doctor did not adequately ascertain the patient's referral status or consult with staff regarding appropriate management, or communicate this to the appropriate staff;
2 a staff nurse did not triage the patient correctly or take observations and review his triage category appropriately;
3 another staff nurse did not adequately assess and review the patient's triage notes or alter his triage status appropriately, or call for additional assistance when triage guidelines were not being met;
4 the nurse manager did not ensure that triage nursing staff were adequately trained; and
5 the Director of Emergency Medicine did not ensure that the referral and consultation systems were adequate or that the Medical Admitting Officer was adequately trained.

The Commissioner reasoned that:

1 it is extremely important that the team that has taken information from a GP communicate this information to the Emergency Department doctors and nurses;
2 when the patient was not seen by a doctor within the triage time frame his case should have been discussed with the emergency doctor because he was being denied access to appropriate medical care; and
3 triage should be prompt and patients should be seen by a doctor within a certain time according to their triage categorisation.

Individual staff did not breach Right 4(1) of the Code because:

1 it was reasonable for the junior doctor to rely on the GP's advice that the patient was being referred with an uncomplicated DVT;
2 the initial triage assessment was appropriate even though the triage nurse had not read the radiology report;
3 the triage nurse acted appropriately when she saw the patient later, even though no observations were taken, as his medical condition gave her no reason to alter his triage category;
4 the nurse co-ordinator responded appropriately as the patient was perceived to have an uncomplicated DVT, and she was powerless to cope with the overwhelming patient demand;
5 the nurse manager carried out her responsibilities appropriately in endeavouring to ensure that nurses were appropriately trained in triage assessment; and
6 the clinical director of emergency services was not responsible for the adequacy of training of junior admitting doctors, or ensuring that GP referrals to the Emergency

Department functioned effectively — he had attempted to improve the process for patient admission, and responded appropriately in a difficult situation.

The public hospital breached Right 4(1) of the Code, as the response of the Emergency Department was substandard. The Commissioner recommended that the Ministry of Health undertake an audit of the Emergency Department.