Nursing care provided following heart attack (09HDC02146, 28 June 2012)

Public hospital ~ District health board ~ Registered nurse ~ Coronary care ~ Intracerebral haemorrhage ~ Early Warning Score ~ Communication with family ~ Documentation ~ Standard of care ~ Rights 4(1), 4(2), 4(5)

Two women complained about the standard of care provided to their father at a public hospital. The man, aged 71 years, was admitted to the Coronary Care Unit (CCU) at the hospital for thrombolytic treatment after suffering a heart attack. After two days in the CCU, he was transferred to a general medical ward for acute patients. The next day the family became concerned about his condition and thought he may be having an intracerebral haemorrhage (bleeding on the brain), noting that he was complaining of a headache, was drowsy, and was showing signs of confusion. The man's daughter communicated her concerns to the registered nurse (RN) on duty that morning. The RN reviewed the man and had no concerns. The daughter remained concerned about her father and expressed this to the RNs on duty that evening. After taking the man's observations and speaking to him, neither RN had any concerns. However, they contacted a house surgeon at 6.42pm and requested a family meeting to address the daughter's concerns.

At approximately 7pm, the man vomited, and an RN contacted the house surgeon again. At approximately 8.30pm, a house surgeon reviewed the man. He considered the possibility of an intracerebral haemorrhage, but thought that the more likely cause for the man's symptoms was an infection, and ordered tests to investigate. The house surgeon also requested that the RNs carry out neurological observations every four hours, and record these on the Neurological Observations chart.

At 9.45pm the man's blood pressure was noted to be increasing, his heart rate was dropping, and he had an episode of apnoea (a pause in breathing). At 10.30pm an RN requested a review from the house surgeon as the man's blood pressure was continuing to increase. A CT scan of the man's head revealed that he had an intracerebral haemorrhage. Unfortunately, the man's condition continued to deteriorate and he died five days later.

It was held that the medical care provided to the man was appropriate, and no individual doctors were investigated. However, both RNs breached Right 4(1) by failing to take the man's observations after he vomited given his symptoms, including a headache. They also breached Right 4(2) for failing to complete documentation to an adequate standard.

One of the RNs breached Right 4(1) for signing off medication for the man without ensuring he had taken it, and failing to complete a full set of neurological observations as directed by the house surgeon. She also breached Right 4(5) by failing to contact a house surgeon in a timely manner following a significant change in the man's condition at 9.45pm.

The DHB had an Early Warning Score chart to assist in the early detection of potentially unstable patients and to give guidance on the appropriate response. In this case, there was a widespread failure by the RNs to use this Early Warning Score chart. The DHB breached Right 4(1) by failing to take reasonably practicable steps to

ensure its staff were using the Early Warning Score chart correctly in their everyday practice, including taking adequate observations. Comment was also made in relation to the DHB's responsibility to foster a culture where staff communicate effectively with families and acknowledge their concerns.