General Practitioner, Dr C

General Practitioner, Dr D

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 05HDC00985)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms	Consumer
Ms B	Friend of consumer
Dr C	Provider/General practitioner
Dr D	Provider/General practitioner
Ms E	Registered nurse
Ms F	Registered nurse
A Medical Centre	Provider/Employer

Complaint

On 24 January 2005, the Commissioner received a complaint from Ms A through a Health and Disability consumer advocacy service trust, about the services provided by Dr C and Dr D. The issues identified for investigation were:

Dr C

- *The appropriateness of the care and treatment provided by Dr C, General Practitioner, to Ms A in July and October 2004.*

Dr D

- *The appropriateness of the care and treatment provided by Dr D, General Practitioner, to Ms A in September and October 2004.*

A Medical Centre

The appropriateness of the care and treatment provided by a medical centre in October 2004.

An investigation commenced on 9 May 2005.

Information reviewed

Information from:

- Ms A
- Ms B
- Dr C

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- Dr D
- The General Manager, the medical centre
- Ms E
- Ms F

Ms A's
- medical records from the medical centre
- medical records from the District Health Board

Independent expert advice was obtained from Dr Simon Brokenshire, a general practitioner and accident and medical practitioner.

Information gathered during investigation

Introduction
Ms A, aged 36, attended a medical centre on four separate occasions between July and October 2004. The medical centre is an ACC endorsed level 2 Accident and Medical Clinic, open from 8am until 9pm, with over 15,000 regular patients. Ms A was seen twice by her regular general practitioner, Dr C, and twice in an after-hours capacity by Dr D, a general practitioner and senior doctor in emergency medicine.

Consultation on 20 July 2004
On 20 July 2004, Ms A presented to Dr C with dysmenorrhoea (difficult and painful menstruation) and menorrhagia (excessive uterine bleeding). Ms A had been experiencing these symptoms for four months.

During the consultation, Ms A was tearful and stated that she could not "handle [the] pain any more". Dr C noted that Ms A had had her last cervical smear and an intra-uterine device (IUD) inserted six years ago. Her follow-up plan included removing the IUD[1] and carrying out a cervical smear when Ms A returned in a fortnight's time. Ms A was agreeable to the plan and an appointment was booked for 5.15pm on 3 August 2004.

Although it is not recorded in her clinical notes, Dr C advised my Office during the investigation that she did perform an abdominal examination as part of the consultation. She recalled that there were no lumps or specific areas of abdominal tenderness, and that Ms A had normal bowel sounds. She explained that the consultation did not include a vaginal examination, and vaginal and cervical swabs were not taken as Ms A was experiencing heavy vaginal bleeding and refused internal investigations.

[1] The recommended duration for an IUD to remain in the uterus is between five to eight years depending on the material the IUD is made from.

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To alleviate her symptoms, Dr C prescribed Synflex (an anti-inflammatory medication), and Marvelon (a combined oral contraceptive pill). Dr C explained that, as well as helping to regulate her periods, the oral contraceptive pill would provide contraceptive protection following the removal of her IUD. She also prescribed metronidazole (an antibiotic) and Micreme (an antifungal cream) to treat Ms A's thrush-like symptoms.

Ms A did not attend the follow-up appointment with Dr C in early August 2004.

Consultation on 25 September 2004

Ms A next presented to the medical centre two months later at approximately 7pm on Saturday 25 September 2004 with lower abdominal pain. She had an initial triage assessment with the nurse on duty, who recorded Ms A's temperature as 37.7°C. While Ms A's vaginal bleeding had ceased, the nurse noted that she had a yellowish, smelly vaginal discharge. Ms A was concerned that her symptoms were caused by the IUD.

Ms A was seen on this occasion by Dr D. During the consultation, Ms A complained of lower abdominal pain, vaginal bleeding with discharge, vomiting, diarrhoea and a general feeling of discomfort. She was concerned about her state of health, and told Dr D about her family history of ovarian and cervical cancer. (Dr D recalled that it was not until Ms A's second consultation on 5 October 2004 that he was informed of her family history of cancer.)

Dr D documented that Ms A was feeling teary, and that she had been experiencing abdominal pain with smelly and yellow-coloured vaginal discharge. She did not have any pain when urinating. On examination, she was afebrile, and her abdomen was normal (not distended), although she had generalised pain in her lower abdominal area. Dr D wanted to perform a vaginal examination but Ms A declined an internal investigation. He documented in his notes that "she is pushing my hand away".

A urine sample showed a trace of protein. Dr D did not consider it necessary to order blood tests that night as there was no after-hours pick-up of blood samples, and he had not detected anything abnormal from his abdominal examination.

Dr D made a provisional diagnosis of pelvic inflammatory disease (PID). He advised Ms A to return to Dr C in the next one to two days to have her IUD removed, and to have a cervical smear and cervical and vaginal swabs taken. He documented his follow-up plan as "she also needs smears and swabs and was told about that". To alleviate her vomiting and pain, Dr D gave her intramuscular injections of Maxolon and Voltaren. She was also prescribed oral analgesics, antibiotics and Maxolon.

Ms A did not return to Dr C as advised. Over the following week, she continued having diarrhoea and vomiting. According to her, the symptoms worsened "after each dose of the prescribed medicines".

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Consultation on 1 October 2004
Six days later, at approximately 2.30pm on 1 October 2004, Ms A presented again to Dr C. Ms A complained of abdominal pain, irregular menstrual bleeding and vaginal discharge. She stated that she felt "terrible [and could] not remember ever feeling so unwell". She informed Dr C of her decision to stop the oral contraceptive pill as she was still having irregular periods, and did not believe that the prescription was effective. Ms A also told Dr C that she had stopped taking the medication Dr D prescribed as it did not alleviate her diarrhoea and vomiting.

After reviewing Ms A's clinical records, Dr C noted that she had presented to Dr D six days earlier, and had been prescribed antibiotics for probable PID. Dr C also noted that Dr D had advised Ms A to attend a follow-up appointment with her in relation to the smear, swabs and IUD removal.

Although it is not documented in Dr C's notes, she informed my Office that she did examine Ms A's abdomen. She observed a generalised tenderness without any abnormal organ enlargement or rebound tenderness. Internal examination of Ms A's vagina and cervix did not reveal any infection or unusual discharge. Her uterus was tender but not acute. Dr C removed her IUD without any difficulty and took a cervical smear. She explained that cervical and vaginal swabs were not done as she did not observe any smelly discharge during the IUD removal.

From her observations and examination, Dr C did not consider Ms A to be dehydrated, jaundiced or anaemic. Dr C prescribed medication to alleviate Ms A's abdominal pain, diarrhoea and vomiting, and advised her to return if her symptoms did not settle or the pain worsened.

Pre-consultation events on 5 October 2004
On 5 October 2004, Ms A sought medical attention from the medical centre as she had difficulty breathing, and had "excruciating pain" in her abdominal area. Her friend, Ms B, drove her to the medical centre. On arrival at 6.13pm, the receptionist gave Ms A a Triage Assessment Form to complete (see Appendix 1). Ms A indicated on the form that she was having severe pain/headache, and was directed to the triage area for an initial nursing assessment.

Ms E was one of two nurses on duty that evening. She recalled that the medical centre was particularly busy as several patients had presented with injuries and emergency medical conditions. Ms E was attending another patient in the plaster bay when she saw Ms A in one of the nurses' stations. According to Ms E, Ms A "did not appear to be in severe pain" and "nothing in her appearance [was of] concern at that time". When Ms E indicated to Ms A that she would be attended to shortly, Ms B replied, "We're fine, we can see you are really busy." Ms E informed them that they could approach her sooner if the need arose.

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Ms B has a different recollection. According to her, when she asked about Ms A's expected waiting time before being triaged, Ms E explained that the clinic was very busy and that she would have to "wait [her] turn". Although Ms B recalled waiting for approximately 15 minutes before Ms A was triaged, it was documented on the triage form that Ms A was assessed at 6.20[pm], approximately seven minutes after her arrival (see Appendix 1).

During the triage assessment, Ms E explained that she needed to record some baseline observations including Ms A's blood pressure. After two unsuccessful attempts with an automatic machine, Ms A's blood pressure was recorded at 100/70mmHg using a manual machine. Her pulse was 80 beats per minute and temperature 36.8°C.

Ms E recalled being told that Ms A's pain was "coming in waves" and that "she was getting another wave". She tried helping Ms A onto the examination bed but was pushed away, as Ms A preferred Ms B to assist her. As lying horizontally aggravated Ms A's abdominal pain, the back of the bed was put in an upright position.

Ms A was assessed as triage category 4 using the Australasian Triage Scale. Patients in this category are considered to have a semi-urgent medical condition, and should be seen by a doctor within 60 minutes. Ms E explained that her assessment was based on Ms A's complaint, appearance, demeanour, and the clinical observations taken. Although she was aware that Ms A was experiencing pain, she did not observe any pallor (pale appearance to the skin) or sweating, and did not recall the pain being described as "excruciating". According to Ms E, there were no acute factors indicating that Ms A needed to be seen by a doctor immediately. Ms E said that she would have arranged for medical assistance sooner if Ms A's pain had appeared severe, or Ms A had requested it.

While waiting for a doctor, Ms A requested pain relief. Ms E explained that as there were no "standing orders", nurses were unable to administer pain relief before a patient was seen by a doctor. She checked on Ms A in between assessing other patients. On one of these checks, approximately 15 minutes after the triage assessment, Ms A complained that her pain was worsening. Ms E told Ms A that she would inform Dr D accordingly and request pain relief be charted.

Immediately after Dr D finished with a patient, Ms E went into his consultation room and asked him to attend Ms A. He indicated that he would see her. According to Ms E, Dr D "poked his head briefly" into the cubicle where Ms A was, but she could not hear what he was saying. Ms E observed him returning to his consultation room without charting any pain relief.

Ms B said that Dr D made a remark along the lines of "Oh, you again. Didn't I see you the other day?" He then left to attend to another patient. Ms B considered his comment inappropriate. Dr D clarified:

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"What I really meant and tried to say was that I was very surprised to see her a week later, just as unwell and not being seen earlier or being admitted by now. I did not mean for this to be interpreted as it was."

Consultation on 5 October 2004

Ms A was seen by Dr D at 6.57pm. She was not brought to his surgery room but remained in the triage cubicle for this consultation. Ms A did not present with any diarrhoea or vomiting but complained of pain "all over" her abdominal area. Dr D noted that she had recurring abdominal pain which was "coming in waves", and experienced back pain when lying horizontally. He documented that her IUD had been removed, and that she did not experience any abnormal symptoms when urinating.

On examination, Ms A was afebrile and there was nothing abnormal detected in her ears, nose, throat, chest or cardiovascular system. Her abdomen was normal and not distended. Dr D observed that she had generalised pain in her abdomen, which was more acute in the upper right area. While palpating her abdomen, Ms A pushed Dr D's hand away. He explained to Ms A that he did not intend to order a blood test as there was no collection of routine blood samples after hours. Dr D was unable to perform CT and ultrasound scans during the consultation, and advised Ms A to return to Dr C for further investigations.

Ms B found Dr D's basic demeanour towards Ms A to be "abrupt and condescending". Her impression was that Dr D considered Ms A to be wasting his time when he had other patients to see.

Dr D queried whether Ms A's abdominal pain resulted from using an IUD beyond the recommended duration, or could be explained by a diagnosis of cholecystitis or diverticulitis. Although he considered admitting Ms A to the Emergency Department of a public hospital, he did not do so as he was uncertain about her expected waiting time. Dr D advised Ms A to self-admit or to return to the medical centre that evening if her condition worsened. Alternatively, she was advised to see Dr C the following day. Dr D recalled that Ms A "was happy with going home on pain medication and to see her doctor the next day". In contrast, Ms A expressed amazement that she "would be sent home in this much pain".

To alleviate Ms A's symptoms, Dr D prescribed Tramal (an analgesic) and Buscopan (an antispasmodic medication). She was also given intramuscular injections of Buscopan and Tilcotil (anti-inflammatory analgesic) by Ms F, registered nurse, who explained that Ms A needed to remain for about 20 minutes for further observation. According to Ms F, Ms A's pain appeared to be intermittent as she was able to converse with Ms B. While waiting for Dr D, Ms A complained about his decision to send her home.

Dr D returned to see Ms A. She reiterated her dissatisfaction with being sent home. According to Ms B, Dr D "did not seem interested" and advised her to have blood tests and

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CT and ultrasound scans when she saw Dr C the following day. The consultation concluded at 7.03pm.

As they were leaving the medical centre, Ms B informed Ms F about Ms A's "lack of improvement". Ms B recalled Ms F advising them to call an ambulance or to go to a second medical centre, which had a triage nurse on duty all night. Ms B interpreted this to mean that Ms A would receive better medical care at another medical centre. Ms F clarified that she had mentioned the second medical centre as she was aware that Ms B was dissatisfied with the care Ms A had received from the medical centre that evening.

Post-consultation events on 5 October 2004

On the way home, Ms A and Ms B stopped to get the prescription filled. As Ms A did not experience any improvement 50 minutes after taking the medication, Ms B contacted the second medical centre on her behalf. The nurse on duty advised her to return to the medical centre or to call an ambulance.

Ms B telephoned Ms E to complain that the prescribed medication was ineffective. Ms E said that she would convey Ms B's concerns to Dr D.

Dr D recommended hospital admission. This was relayed to Ms B. Ms E offered to arrange for an ambulance and to fax Ms A's clinical records to the public hospital. Ms B indicated that she would call the ambulance herself.

Ms A was transferred by ambulance to the public hospital that evening. She was reviewed by a gynaecologist the following day, and a decision was made to perform a laparotomy. The operation on 6 October revealed peritonitis secondary to the rupture of a tubo-ovarian abscess. Approximately 1.3 litres of pus was drained from the peritoneal cavity. Ms A remained in the high dependency unit for eight days as she developed bilateral plural effusion (excessive fluid surrounding the lungs). On 15 October, her condition stabilised, and she was transferred to the general ward. Ms A had a slow recovery and was discharged from hospital on 31 October 2004.

The medical centre's triage system

The medical centre's triage guidelines applicable at the time Ms A received care were issued on 15 December 2002 and reviewed on 20 December 2003. The guidelines describe the initial assessment process and the triage scale used. The guidelines define triage as:

> "… the process by which walk-in or acute patients are allocated a priority of care and area of treatment."

On arrival at reception, patients are requested to answer questions on the Triage Assessment Form. If a patient circles "yes" to having any of the acute symptoms listed on the form, the receptionist is required to alert the triage nurse or to take the patient to the

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treatment room to be seen by a doctor. The guidelines place responsibility on the nurse to triage patients and to assign a triage scale, and on the doctor to see the patient within the waiting time corresponding to the assigned triage scale.

The triage scale used by the medical centre is based on the Australasian College of Emergency Medicine's recommendations. The five levels of acuity (priority for assessment according to the severity of presenting symptoms), corresponding codes and response times for a patient to be seen by a doctor are:

Triage Category	Description of Category	Numeric Code	Colour Code	Maximum waiting time before medical intervention
Resuscitation	Immediately life threatening	1	Red	Seen immediately
Emergency	Imminently life threatening or important time critical treatment	2	Orange	Seen within 10 minutes
Urgent	Potentially life threatening or situational urgency	3	Green	Seen within 30 minutes
Semi-urgent	Potentially serious, situational urgency, significantly complex or severe	4	Blue	Seen within 60 minutes
Non-urgent	Less urgent	5	White	Seen within 120 minutes

The medical centre has a check system to ensure that new staff are not rostered together. On the evening of 5 October 2004, the medical and nursing staff on duty were all senior staff. They also have a system of "call-back" doctors who are available to work at short notice from 6pm on weekdays, all weekends and public holidays. It is initiated by the doctor on duty or the senior nurse, and is used on occasions when a junior doctor is on duty, or when the waiting room is extremely busy. The call-back system was not used on the evening of 5 October 2004 when Dr D was the only doctor on duty.

The medical centre has since designed an electronic triage form, which was implemented following a trial in May 2005. Their new system enables all triage assessments to be recorded electronically and audits to be conducted on the information recorded.

The medical centre's patient recall system

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The medical centre had a patient recall system in place in 2004, which staff continue to use in several ways. This includes the doctor writing on the consultation notes "recall in 'x'-amount of time". Following the return of test results, the doctor may forward the report to a nurse and ask for the patient to be recalled within a certain timeframe. Where a patient is advised to attend a follow-up appointment, the patient is offered an appointment time by the receptionist following his/her consultation with the doctor.

At the time Ms A consulted Dr C in July 2004, the medical centre's recall system was not programmed to record "DNAs" (did not attend — missed appointments). Since then, improvements have been implemented. The medical centre now document electronically in the patient's notes, the patient's reason(s) for missing appointments, along with any cancellations or rescheduled appointments. In addition, the computerised system enables the medical centre to audit staff members who cancel patients' appointments.

Independent advice to Commissioner

The following expert advice was obtained from Dr Simon Brokenshire, a general practitioner and senior medical officer in an accident and medical centre:

> "**Statement of objectives:**
>
> I have been asked to provide independent advice and comment to the Commissioner on a number of aspects related to case 05/00985 which involved two separate doctors, covering four separate consultations. I have also been asked to comment on the triage processes of the clinic from where this complaint arose.
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> **Declaration of possible conflict of interest:**
>
> I am unaware of any conflict of interest that I may have regarding this case.
>
> **Qualifications:**
>
> MB ChB (Otago, 1984), Dip Obs (Akld,); Dip Com A&E (Akld, 1995)
>
> FRNZCGP; FAMPA
>
> **Experience:** I graduated in 1984 and went into General Practice in 1990.
>
> Over the following 10 years I worked in city, rural and provincial settings.

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With the increasing trend for general practice after-hours care to be conducted out of an A&M setting, I chose to do further training in this area of medicine obtaining my diploma in community accident and medical practice, followed by my fellowship with AMPA.

Over the last five years, I have devoted my time solely to Accident and Medical care, working as a senior medical officer in a busy A&M centre which sees some 60,000 patients a year.

Questions to be addressed:

These are multiple, and so to be concise and avoid repetition, they will be outlined in the bulk of my response, heading up each section.

Documents reviewed:

- Complaint letters
- Notification letters
- Correspondence from [Ms A]
- GP records
- Correspondence from [Dr D]
- Correspondence from [Dr C]
- Correspondence from [the medical centre], including responses from registered nurses [Ms F and Ms E].

Other documents reviewed/ information sought

- Personal communication with AMPA executive.
- 24hours Surgery triage training course document (2004); A. Higgins.
- Guidelines for Triage Education and Practice;
  Considine, J., LeVasseur. SA. & Charles, A. 'Consistency of Triage in Victoria's Emergency Departments: Guidelines for Triage Education and Practice'. Monash Institute of Health Services Research. Report to the Victorian Department of Human Services, 2001
  http://www.med.monash.edu.au/healthservices/CNR/Education
- Policy Document — The Australasian Triage Scale
  http://www.acem.org.au/open/documents/triage.htm
- Tubo-ovarian abscess. Livengood. C. www.uptodate.com. 2005 Uptodate.
- PID Livengood.C, Chacko.M. www.uptodate.com. 2005 Uptodate.
- Guide to Pathogens and antibiotic treatment 7th ed, Selwyn Lang et al.

Summary of events:

This has been provided by the Health and Disability Commissioner's Office and will not be repeated here.

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SPECIFIC QUESTIONS AND ADVICE:

[Dr C]

1. Was [Dr C's] care and treatment of [Ms A] on 20 July 2004 adequate and appropriate?

I believe the care here was of *an adequate standard*.

The presenting complaint was that of dysmenorrhoea, menorrhagia and possibly irregular bleeding (recorded by [Ms A] in the [letter] of 19/05/05).

The length of time of this problem is recorded as four months and so appears not to be an acute problem. The notes record some patient distress or frustration of such symptoms. There is also reference to her concerns regarding her family history of ovarian cancer.

Two positive issues of perceived importance by [Dr C] were the IUD which was overdue for removal and may be a contributing factor for her symptoms, and an overdue smear.

Negatives in the history not recorded are any inter-menstrual bleeding or post-coital bleeding, no pregnancy symptoms, nor mention of discharge even though treatment of such appeared in the plan.

No examination was recorded, but in the plan the patient was to return for further examination and removal of the IUD.

No baseline observations were recorded eg temperature, pulse, or blood pressure. Nor was an abdominal examination recorded. No pregnancy test was recorded.

Follow-up correspondence confirms that a number of these issues were covered in the consultation but not recorded.

The plan included the return of the patient for full exam in two weeks; but also involved the prescription of antibiotics, analgesics and the combined oral contraceptive pill.

The reasoning for the antibiotics from subsequent correspondence appears to be because there were some symptoms of a discharge and it appears she was covering thrush and gardnerella. Also, it appears that [Dr C] wished to provide some antibiotic cover prior to the removal of the IUD (presumably covering the possibility of a low-grade endometriosis or pelvic inflammatory disease. (Although the metronidazole would also cover anaerobes, full cover of possible bacteria (if one is concerned with pelvic inflammatory disease) would not be covered by this

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combination eg chlamydia is not covered.) Some practitioners I believe would not prescribe antibiotics at this point (some would opt for the taking of swabs prior to such and would not necessarily routinely cover with antibiotics for the procedure of IUD removal).

The logic of the pill prescription is reasonable as it may provide cycle control and ongoing contraceptive cover if this is needed post removal of IUD. (Although high dose oestrogen may have got more rapid bleeding control.)

The prescribing of the combined pill would require the checking and informing of the safety profile of this drug in this particular woman. No documentation of such is present in the notes but this would be one's usual practice. This risk assessment I would regard as being important especially as this patient was 37 years old and who may possibly be overweight. There was no recorded blood pressure reading.

Subsequent communication inferred that the patient had been on an oral contraceptive before and it is implied that a risk assessment occurred.

To proceed from here, the doctor might remove the IUD and take swabs, cover with antibiotics if clinically indicated, and arrange follow up where a repeat pelvic exam would occur and a smear taken (when bleeding had stopped).

Or treatment may be instituted to obtain cycle control and follow-up for IUD removal and smear at the next appointment.

Both options have their pros and cons.

There is some mention in the communications that there was some patient reluctance to have an exam at that point in time.

The doctor may have been under time constraints as I would imagine this consultation may well have been long up to the point of considering a pelvic examination.

With these considerations, it seems reasonable to delay a full exam for a future appointment if no acute signs had been elicited. Also gaining control of bleeding is needed to perform an adequate smear.

It was documented that the patient returns in 2 weeks for a full exam, smear and IUD removal.

This is an important point.

In the patient's recall of events, she says she was to return when the bleeding stopped which may not have occurred with any degree of certainty.

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The patient re-presented 2 months following this initial consultation.

Either way, if the implied outcome was control of periods and this did not occur, I would expect the patient to seek clarification or present earlier.

Earlier follow up with the same practitioner may have resulted in a different outcome.

The record of this consultation can be critiqued as all consult[ation] records can be.

There appears to be some gaps, omissions, and some differences in practice to that of the adviser's practice; however this consultation is a complex one which involves a number of issues all difficult to cover in an initial GP consult due to various constraints.

These include the initial presenting complaints which require some skill and time in teasing out and have a wide differential diagnosis. There are issues around the IUD, an overdue smear, possible discharge, the safe prescribing of the pill and consideration of ongoing contraception post removal of the IUD, along with the safe prescribing of a non-steroidal anti-inflammatory analgesic. Also there are the issues of patient's fears, concerns and frustrations as they have often put up with symptoms for some time prior to seeking assistance. They come with significant expectation and often a wish for a rapid resolution of the problem.

On reflection therefore the standard of care within this consultation is deemed to be of an acceptable standard.

2. Was [Dr C's] care and treatment of [Ms A] on 1 October 2004 adequate and appropriate?

My conclusion was that on this occasion care and treatment did *not reach an acceptable standard* to a *mild – moderate* degree but it was complicated by a number of confounding factors.

This consult reflects a follow-up and carrying out of the initial plan of 20/07/04; as well as a review of a more acute presentation to another doctor 6 days earlier (25/09/04).

It appears that there is an assumption that this consult[ation] **six days** earlier was a more acute presentation of the chronic problem.

I assume these notes were fully available. The consulting doctor of 6 days earlier suggested this current follow up and to continue with the plan of removal of the IUD and smear and had started antibiotics to cover possible pelvic inflammatory disease

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or endometriosis. These however had been discontinued due to nausea and diarrhoea.

The consultation notes on this occasion are legible yet brief.

They allude to a possible intolerance (nausea and vomiting) to medication prescribed 6 days earlier at her more acute presentation.

The only other documentation is that of the IUD removal and taking of the smear.

A medical certificate is issued.

Details are entered for the smear register.

A prescription for an anti-inflammatory analgesic, Imodium and Stemetil were given for presumptive ongoing pain, and intolerance to previous medications prescribed six days earlier (to counter by the above anti-nausea and anti-diarrhoeal medication).

Important Issues:

- **The timing of representation (3rd consultation)**

The timing of this re-presentation places a further strain on the provision of medical services in a timely fashion, it being on a Friday. A further weekend is coming. Doctors are generally busier and under more pressure on a Friday so time and communication may not be as optimal as it may be earlier in the week. Notes may not be as good due to these factors. Investigations on a semi-acute basis are more difficult to arrange along with the obtaining of the results of such.

Patient factors, perceptions and concerns re finances are accepted as barriers to timely review and intervention. These are difficult and fraught issues.

However again I find there to be an anomaly between [Ms A's] degree of perceived illness and discomfort (eg in her being unable to attend work), yet seeking medical assistance some 6 days after a more acute presentation despite being advised to do so earlier.

- **Brevity of notes which are not of acceptable standard and reflect some omissions of practice.**

Audit of the notes of this consultation in isolation is critical of the brevity.

Important omissions were:

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– Clarification and expansion of the more acute history over the preceding 7 to 10 days;

– A lack of observations noted.

– Lack of documentation of the abdominal, rectal and pelvic exams.

– No swabs taken or IUD sent for microbiological examination.

– No pregnancy test or urine analysis.

– Although this patient may have been a difficult historian and difficult to examine, full cognisance of her discomfort, her re-presentation, and the previous doctor's assessment were needed, so consideration of other possible diagnoses to account for her symptom complex could be made.

- **Assessment of acuity and degree of illness**

This is at times very difficult for all practitioners especially primary care physicians who are seeing the progression of disease from its early stages.

The notes do not appear to take cognisance of the earlier acute presentation on the prior weekend in terms of patient discomfort and malaise. [Dr C] upon follow-up did not feel the patient was acutely unwell. This appears to be based on her general impression which is valuable but is not backed up by baseline observations nor documented abdominal findings. I understand that this patient was obese which makes abdominal findings especially pelvic findings more difficult. The converse of this is that a higher index of suspicion is needed. No comment was made of adnexal masses nor cervical excitation. (Either positive or negative.)

- **Full consideration of patient's perceived distress, other possible differential diagnoses and the need for further investigation?**

I think swabs and the sending of the IUD for microbiological exam should have been done. This has been my standard practice.

[Dr C] at her initial consultation chose to put this patient on antibiotics due to the possibility of a low grade infection. It follows then to carry through and send samples away, particularly in someone who has re-presented in abdominal discomfort. (Third presentation albeit somewhat delayed.) Also at the preceding consultation six days prior, pelvic inflammatory disease was a possible diagnosis. The prescribed antibiotics of 6 days earlier were seemingly poorly tolerated and they had been discontinued prior to this current consultation. No further antibiotics were prescribed apparently as there was no discharge present; there was not the perception of being acutely unwell, and because of the perceived intolerance to the recent antibiotics.

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Faeces for culture and clostridium difficile may have been considered.

Blood [tests] at this point are arguable but based on chronicity of illness and perceived increasing acuteness of presentation, blood [tests] may have assisted or reassured.

Note that obtaining the results in a timely fashion on a busy Friday is often difficult in primary care.

I doubt that either swabs or blood [tests] would in the short term have assisted greatly in a change of treatment or plan, but may have assisted future consults should this occur eg over the upcoming weekend. (Unless for example, a very high white count or CRP [C-reactive protein] were returned suggesting infection rather than dysmenorrhoea due to [the] IUD.)

A pelvic ultrasound would probably not have been indicated on the documented findings at this point in time unless the suspicion was raised that something else was happening here. However one might have been considering this in view of the previous working diagnosis of PID, where antibiotics were not being tolerated and although there were no acute abdominal signs, there appeared to be some generalised discomfort and comment was made of a tender uterus.

If one was considering other tubo-ovarian problems, retroperitoneal or possibly bowel pathology eg a diverticular abscess or appendicitis, then it may have assisted.

Access to such may have been difficult especially so on a Friday and would generally be requested if there was a perception of a higher acuity or becoming more unwell.

If the only way to get an ultrasound in this locality at this time of presentation was admission to hospital, I do not believe this was warranted at this point in time, but would be considered if rapid improvement did not occur.

One must remember that it was the working assumption that the removal of the IUD was going to reduce symptoms.

Were there signs of other pathology, sepsis or acute illness at this point in time? It appears not.

3. Are [Dr C's] clinical records of an appropriate standard? If not, why not? Please also comment on the appropriateness of the notes in terms of communicating to other providers involved in [Ms A's] care.

The clinical records are legible as they are computerised in this practice.

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The clinical records on the 20 July 2004 are of *an acceptable standard* albeit with the comments made in my reply to question 1.

The clinical records on the 1 October 2004 are *not of an acceptable standard* and my reasons for this conclusion are outlined in question 2.

In terms of communicating to other providers involved in [Ms A's] care, the consult of 1 October 2004 is lacking.

Examples of why I feel the notes of the consultation of 1/10/04 are not up to standard include the following:

- *Audit of the notes of this consultation in isolation is critical of the brevity.*
- *Little in the way of clarifying and documenting the history of this illness eg to clarify the onset of the gastrointestinal symptoms which probably predated the scripting of antibiotics six days earlier.*
- *Clarification and documentation of the problem which appeared to have changed from dysmenorrhoea and menorrhagia to more generalised abdominal discomfort with associated diarrhoea and vomiting.*
- *No comment is made of baseline observations, general appearance or impression of the patient's wellness, abdominal examination findings, speculum findings, pelvic examination findings, whether swabs were taken (antibiotics were possibly still being taken — this is not documented positively or negatively), the sending of the IUD for microbiological examination.*
- *A further plan may have been outlined but this was not documented and therefore not communicated to future medical staff.*

In terms of communicating to future providers the notes of this consultation would leave a future doctor unclear of [Dr C's] impression and in fact leaves me with an impression of a routine consult for a smear and removal of an IUD rather than a somewhat more acute [and] chronic problem.

There is no conveyance of impression of the degree of illness.

Nor, more importantly, is there a full documentation of intimate exams of which there are sometimes some reluctance to be repeated on behalf of the patient or future doctor.

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On a number of occasions in the notes, there has been an expression of patient reluctance to have a pelvic exam making it more important to have this information communicated for other doctors when it was done.

4. Should any other investigations or tests have been ordered by [Dr C] at the consultation on 20 July 2004? If yes, please explain.

In the context of the consultation and plan, I do not believe any other investigations or tests were crucial at this point.

The appropriate excerpt from question 1 is as follows:

It was documented that the patient returns for a full exam, smear and IUD removal.

An MSU dip stick and pregnancy test may have been considered but the complaint was not of general abdominal pain but rather dysmenorrhoea and menorrhagia although irregular periods may prompt this test.

5. Should any other investigations or tests have been ordered by [Dr C] at the consultation on 1 October 2004? If yes, please explain.

- I think swabs and the sending of the IUD for microbiological exam should have been done.

- Faeces for culture and clostridium difficle should have been considered.

- Bloods at this point are arguable and based on chronicity of illness and perceived acuteness of this presentation. Due to the protracted history bloods may have assisted or reassured.

- A pelvic ultrasound might have been considered, but it is arguable as to [whether] it was definitely indicated at this point. On consideration of symptoms and protracted history, an abdominal ultrasound might have been reassuring but on signs, there appeared little to justify it acutely, unless the suspicion was raised that something else was happening here. *See comments re[garding] ultrasound in my reply to question 2.*

Note — A confounding factor here was the timing of seeking advice and assistance. Had [Ms A] presented earlier in the week as opposed to the following Friday, the IUD could have been removed, then if she had not improved, blood [tests] and an ultrasound may have been considered on a semi-acute basis prior to the weekend.

I do not expect patients to take these factors into account but they are confounding factors affecting the provision of a good medical service.

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6. Should [Dr C] have referred [Ms A] for assessment by a gynaecologist?

[Dr C] saw this woman on two occasions.

On the first occasion, there were no indications to refer at this point.

On the second occasion, 1 October 2004, this was the third consultation for this problem but was also the completion of the initial plan of removal of the IUD.

Her condition was assessed as not being acute although the problem was developing some chronicity.

Examination revealed no indications for referral at this point.

Also note that this second consultation of [Dr C] was on a Friday and the most likely only option for referral was acutely to hospital.

It is my opinion that this was not indicated at this point in time.

[Dr D]

1. Was [Dr D's] care and treatment of [Ms A] on 25 September 2004 adequate and appropriate?

My conclusion was that on this occasion *care and treatment reached an acceptable standard*.

There are some points of discussion that I would raise in critiquing the record of the consult.

This consultation was complicated by a number of confounding factors.

I have some concern as to the assessment of acuity and degree of illness with a lack of recording of specific baseline observations yet documentation of general observations eg malaise and pallor.

This was confounded by annotation of the abdominal examination in a non-standard manner.

There was no documentation of a pregnancy test having been done.

The failure to conduct a pelvic exam due to the patient's lack of consent compounded the sequence of events.

It is unknown if the importance of this exam was impressed upon the patient.

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Swabs would have been useful to confirm the working diagnosis of PID and the IUD could have been removed.

The prescribed antibiotic treatment would not have covered chlamydia.

This consultation took place on a Saturday (no time recorded on notes).

It appears to be an acute or acute and chronic presentation of lower abdominal pain. This is the second visit to this clinic, her first being to her GP some two months earlier. The plan then was to be seen two weeks following this first consultation for removal of IUD and smear. These notes I assume were available.

The history and review of systems appears adequate although there are some gaps in documentation.

Baseline observations were recorded as normal but the only specific one documented was that of a temperature of 37.7°C.

General observations of 'pallor, miserable and sick and teary' [were] made.

These strike me as important comments. 'Pallor' used medically is a significant observation. The other observations are subjective but imply some degree of empathy given by the doctor but also a degree of distress imparted by the patient.

Follow-up comment was made of an apparent lack of distress or marked discomfort with the patient lying semi-recumbent and talking easily. People in marked distress often do not verbalise well.

Urine exam reveals a trace of protein, there is no mention of pregnancy test result.

Documentation of the abdominal exam appears ambiguous and leaves the reader with some uncertainty. [For example,] 'Sore all over, more so lower and is pushing my hand away.'

'Pushing my hand away' gives an impression that the patient was in reasonable discomfort and possibly not understanding the importance of such an exam and the need for some co-operation.

The documentation is not standard and so the communication of the signs to another doctor and the impression that [Dr D] had is unclear.

Explanations for such are many, and can take in patient and doctor factors.

Generally speaking, it is difficult to establish if this examination met the required standard. Documentation should be relatively standard and outline any difficulty in obtaining the information due to eg patient discomfort or compliance.

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Standard notation should outline if the abdomen was soft, tender, any masses, any organomegaly, bowel sound quality, any signs of peritonism eg percussive tenderness, rebound and guarding; along with rectal and pelvic exams.

It was documented that the patient refused a pelvic examination which I regard as significant. As to how hard this issue was pushed by [Dr D] is unknown.

I regard this exam along with a rectal examination as important in a woman of reproductive age with lower abdominal pain.

I note in the patient's recall of events she comments that 'he did say the IUD had to come out but did not suggest it be done then'.

With a working diagnosis of PID swabs are important.

Ideally this patient should have had a full pelvic examination with swabs, removal of IUD, palpation for masses and attempt to illicit cervical excitation, along with a smear.

(Note however that even if a pelvic exam had been done, signs of pelvic pathology are often difficult to detect especially in a woman of larger habitus, particularly the palpation of masses, however obtaining the samples would assist subsequent consultations.)

[Dr D] on follow-up communication discusses the issue of blood [tests] and that he felt they were unlikely to add significantly to his clinical assessment. Also, he commented on the apparent difficulty in obtaining semi-acute blood results in his setting out of normal working hours.

It is easy in retrospect, but if there was some uncertainty as to the diagnosis, chronicity or acuteness of this presentation a FBC [full blood count] and CRP [C-reactive protein] may have given a pointer or alert toward this.

If a pelvic examination had elicited any signs of concern, then consideration of an ultrasound may have occurred at this time.

The ability to get semi-urgent investigations may not have been easy after-hours in this setting.

[Dr D] is regarded as a senior doctor who had done his training in Accident and Medical practice. I would assume that there were no acute signs that caused him concern.

Also the fact that it was not [considered] necessary to do any bloods, refer for observation, a second opinion or ultrasound it is the impression that the degree of

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assessed illness and acuity was not acute and that analgesia and antibiotics may well contain the illness if not solve the problem.

The documented refusal to have a pelvic exam meant that the doctor had to make an educated guess as to possible pathology.

[Dr D] outlined his differential diagnosis of PID, IUD causing problems, abdo[minal] pain of other origin; and his plan was for clinical review by her GP following the weekend, possibly the next day. Analgesia and an antiemetic were provided.

Antibiotics to cover possible PID was given. Note this combination would not cover all possible causes. eg chlamydia would not be covered.

[Dr D] outlined in his follow-up notes that he had mentioned possible hospital review if she did not improve.

On balance in spite of the reservations outlined, I feel that overall care and treatment here was of an acceptable standard.

2. Was [Dr D's] care and treatment of [Ms A] on 5 October 2004 adequate and appropriate?

My conclusion is that on this occasion care and treatment *did not reach an acceptable standard* but only failed to a *minor* degree.

This consultation was complicated by a number of confounding factors.

The principal issue here is the recognition of how unwell the patient was perceived to be, the acuity of such, and need for tertiary service referral in someone where the disease process is evolving with time.

I believe [on] balance, it would have been more prudent to have admitted this woman for ongoing observation and a second opinion.

I do not believe that the protracted history (this being the fourth consultation) was given enough weight; the notes documenting her abdominal signs were not of a reasonable standard and cast some concern over the adequacy of the examination.

Non-standard terminology was used similar to that used in this doctor's previous consultation.

There is no documentation of any abdominal masses, guarding, rebound or percussive tenderness. Bowel sounds are recorded as normal. These later signs, if present, would be indicative of acute pathology and possible peritoneal inflammation and would suggest that hospital review would be prudent.

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Rectal and pelvic exam were not performed. A pregnancy test was not documented.

In view of the re-presentation of this patient, the lack of a firm diagnosis and the discomfort the patient appeared to be in, further observation and investigation may have been prudent to initiate.

These depend on what is available in the setting.

Urgent bloods, imaging (an ultrasound or CT) or referral for a second opinion with view to possible laparoscopy/laparotomy would be considerations.

This however depends on the assessment of acuity and degree of current illness, and the need for urgent investigation as opposed to semi-urgent investigation during normal working hours. Referral may be dependent on local knowledge of the likelihood of these investigations occurring on an acute basis.

The documented plan was to provide analgesia, admission to hospital overnight if no better or GP review in the morning.

Analgesia was provided, the initial choice of such seemingly appropriate.

Despite this, the patient reportedly remained distressed. However I feel there is conflicting evidence of the patient's condition and I believe it was difficult at this point in time to identify her developing illness.

It appears that the baseline observations showed no evidence of severe illness, that the triage nurse's opinion was not that of someone markedly unwell, (the initial triage nurse assessment was carried out by an experienced nurse of over 10 years standing).

The second nurse to be involved who provided the patient with IM [intramuscular] analgesia made no comment in her notes to allow objective or subjective conclusions to be drawn as to concerns re[garding] [Ms A's] continuing condition or the need for further review or observation.

It appears there was some concern being voiced by [Ms A's] friend as to the care provided and [Ms A's] continued discomfort. Second opinion options were given and the complaint procedure was outlined.

There appears to be some debate as to what was meant or inferred by these comments.

The doctor's notes are ambiguous re[garding] these issues.

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However, a period of observation beyond the routine 20 minutes may have been warranted if there were any concerns from medical, nursing, patient or patient's advocate as to persisting discomfort or distress.

If inadequate response to analgesia had resulted then narcotic analgesia may have been an option.

The plan elected was to return home which may have been reasonable if social supports were adequate and that the patient and her carer were on board with this plan. Also, they needed to be clear as to what to do if things did not improve. One solution that sometimes satisfies a patient is access to the doctor should problems occur ie being given permission to phone back and talking directly to the doctor.

Social issues may preclude returning home and such a plan and again, ongoing observation in hospital or in the clinic may have been elected.

These suggestions are very easy to make in retrospect and may be entirely impractical to the setting in question.

The decision by the doctor not to admit, it seems, was partly made on the past experience of long delays for patients seen in the hospital's Emergency Department.

This I believe [the above] is an erroneous assumption and should not be considered if ideally the patient would be better investigated and observed [in a hospital setting].

If hospital review was considered, the pressures the hospital system is under is of no real concern to primary care.

However I do *not* believe the course of action that was chosen altered the outcome of the disease or its progress. Had this woman been seen and admitted directly, I do not believe that her outcome and subsequent experience would have been significantly different.

In reality, there was no significant time delay in reaching hospital care in this case when she communicated that she was not improving.

(She was in the clinic for just under two hours, departed at 2000hrs and rang the clinic at 2030[hrs] to convey that she was no better. She was advised to go to hospital at this point.)

Transportation issues are said to have been discussed suggesting an ambulance be called.

Notes were faxed to the hospital.

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Note that admission observations to the Emergency Department showed [Ms A] to be febrile, tachycardic, and in moderate distress.

I believe that this patient suffered considerable distress from a significant illness that resulted in peritonitis and possible generalised sepsis. She required some time to recuperate and rehabilitate from her illness.

It appears her experience of the care received on the night of admission was below her expectations.

This was in the context of pain, distress, anxiety and reflection after such an ordeal that this complaint was made.

Some of this complaint related to how she perceived she was dealt with on a human level and the manner in which she perceived her care was delivered.

These issues are always fraught and related to memory of events, opinion, conjecture, interpretation and misinterpretation. They have not on this occasion been part of the assessment for this complaint, but I am mentioning them as I believe they formed a significant basis for the complaint.

My analysis of the notes, processes and procedures conclude that [Ms A] did not receive care to a reasonable standard from a medical point of view, but due to confounding factors, I believe this deviation from an acceptable standard is of a minor nature and probably did not affect the outcome of the disease process.

3. Are [Dr D's] clinical records of an appropriate standard? If not, why not? Please also comment on the appropriateness of the notes in terms of communicating with other providers involved in [Ms A's] care.

Generally [Dr D's] notes are of a reasonable standard and provide a reasonable record to communicate his thoughts to future members of the health team.

[Dr D's] notes are legible and relatively full with reasonable documentation of review of systems.

I have made past comment on some *non-standard annotation of his examination findings* regarding important negatives and generalised acceptable nomenclature.

Specifically, his notes relating to abdominal examination were not what I regard as standard and left the reader uncertain as to the exact findings.

I think doctors working in A&M settings or GPs seeing other doctors' patients need to be even more vigilant re[garding] their documentation of baseline observations and general impressions of [a] patient's acuity and degree of illness.

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A clear plan needs to be outlined often with an expected time scale.

This obviously needs to be communicated to the patient.

In some settings, patients would be given a copy of the notes.

4. Should [Dr D] have referred [Ms A] to a gynaecologist on 25 September 2004?

No, I do not believe such referral was indicated at this point in time.

It was reasonable to assume the original plan of removal of IUD and clinical review at this point. It was assumed that review would occur in the subsequent few days.

5. Were [Dr D's] follow-up arrangements for [Ms A] on 25 September 2004 appropriate? If not, why not?

Yes, I believe that having assessed [Ms A] as not being acutely unwell, and her having refused a vaginal exam, (that would have enabled further assessment and hastened the removal of the IUD), then early review by her own GP was appropriate. (Assuming no rapid deterioration in her condition occurred.)

Ideally, this should have been early in the week following this weekend consultation.

In reality it took place some 6 days later (on a Friday).

As to whether the suggested plan of early review was clearly communicated is uncertain, but certainly this is documented in the medical plan.

6. Was [Dr D's] assessment of [Ms A] on 5 October 2004 appropriate? If not, why not?

As already outlined, the issue was an assessment of acuity and the degree of illness.

A firm or confident diagnosis was not made at this point.

Although I think the specific diagnosis of a pelvic abscess may have been difficult to make, it bothered me that this was the fourth presentation and a firm diagnosis was still uncertain.

Secondly, the diagnosis as such was not necessary as long as one could be confident of the assessment of acuity and developing illness.

It is easy to say in retrospect that the assessment by the health team was wrong and that the patient warranted admission to hospital.

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However, there were minimal documented objective signs of high acuity at the time of assessment.

One must also consider the fact that primary care is seeing illness in progress and often sees more subtle, early signs that then develop.

The observations made 1–2 hours later showed evidence of developing illness with more acute signs (fever, tachycardia, and increasing distress).

Factors that in retrospect may have swayed the decision to admit:

- The degree of discomfort and distress that [Ms A] appeared to be in which did not abate with analgesia after a short period of observation.
- The possible associated chronicity of events.
- The absence of a confident diagnosis.
- The possible need to observe for longer and do some baseline investigations that may assist in clarifying the clinical picture.
- Psycho-social issues eg support, patient or carer anxiety and concern etc that would make admission a more viable option.
- Patient's previous demonstration of not being followed up as requested.

The impression I got from the notes was that admission was going to be likely. This should have then been expedited.

Note — Each patient's situation must be assessed uniquely but other confounding factors are always at play.

It appears from all people's notes that the clinic was busy with other unwell patients.

There would have been some pressure on limited staff.

A review of the appointment list on the night in question showed [that] in the half hour that [Ms A] presented (15 minutes either side), five other people presented and these included a person with a laceration to the head and a person with chest pain.

In each specific setting in New Zealand, there are different degrees of threshold to admit.

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These involve many issues surrounding what investigations or services will be provided at certain hours of the day. These factors may also influence one's decision.

We do not as primary care physicians wish to place secondary care under undue pressure dealing with things that may be better sorted out on a semi-acute basis.

These are all confounding factors but not excuses.

I think in balance that this patient warranted further observation and admission was prudent.

This however is not black and white and I do not regard the decision not to admit as a major departure in standard of care.

Advice was given to be admitted if any deterioration occurred. This happened 30–60 minutes after leaving the clinic. Admission occurred.

This short period of delay, I believe would not have affected the clinical outcome.

7. Should [Dr D] have referred [Ms A] to a gynaecologist on 5 October 2005?

This has been largely dealt with in [the] preceding questions.

The time of day and referral services available would dictate what was possible, but most likely the only choice was acute hospital assessment.

Specific gynaecological referral I believe was not the issue as a firm diagnosis was not at this point made.

The issue was tertiary acute assessment – as opposed to gynaecological or surgical referral.

This question has been dealt with.

8. Were [Dr D's] follow-up arrangements for [Ms A] on the evening of 5 October 2004 appropriate? If not, why not?

The plan for the subsequent 24 hours appears clearly documented in the notes.

It appears however, that this plan was not well communicated or accepted by the patient or her carer.

A clearer plan with the patient in agreement may well have made her feel listened to, and a more active participant in the options that may have been available.

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Some patients are reluctant to go to hospital when it is felt to be highly indicated by medical staff.

Others are keener to be reviewed even if medical staff feels there is no absolute need for such at a certain point in time.

Discussion of the options which were relatively limited may have assisted this situation. Namely:

- Home and review if no better after 'x' amount of time by phone or in person.
- Further observation in the clinic (if time, staff and space allowed).
- Admission to hospital.

[The medical centre]

1. Does [the medical centre's] triage system comply with relevant standards for Accident and Medical clinics? If not, why not?

[The medical centre] is an ACC endorsed level 2 Accident and Medical clinic.

Yes, I believe '[the medical centre's]' triage system does comply with the Accident & Medical Clinic Standard NZS 8151:2004.

They have the appropriate procedures and policies documented.

I think that the paper system used in this case could be improved upon, especially in documenting evidence to justify the assigned triage code.

For example, documentation of observations and a brief history, exam or nurse initiated investigations and interventions including pain relief (standing orders).

Such a system, I understand, was in the process of development and a computerised system has now been trialled.

The computerised annotation of time on the daily record of *all* documentation from triage, to consultation, to the administration of medication, I think would be an improvement in the system, but this is dictated in part by the computer system and IT company.

[The medical centre] have I believe, satisfied the requirements of the standard and would have had their systems audited to have obtained an ACC endorsement as a Level 2 A&M clinic along with the associated A&M contract.

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2. Was [Ms A] adequately and appropriately triaged on the evening of 5 October 2004? If not, why not?

Yes, I believe that [Ms A] was adequately and appropriately triaged on the 5/10/05.

The time line recorded showed that she was seen within acceptable time limits, she was assessed and a triage code was allocated that would fit with the Australasian College for Emergency Medicine's triage scale.

One could argue that she may fit into category 3 or 4 but she was seen within an acceptable time either way.

My comments regarding documentation of triage as per question 1 are relevant here. Baseline observations, a brief history along with general appearance, distress and perceived acuity and degree of illness are important aspects to effective triage.

These I believe were done on this occasion."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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Relevant standards

The Medical Council of New Zealand's publication *Good Medical Practice — A Guide for Doctors* (2003) states that doctors must:

> "keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed."

The New Zealand Standard *Accident and Medical Clinic Standard* NZS 8151:2004 states:

> "3 Consumer Assessment, Diagnosis, Treatment and Follow-up
>
> 3.1 Triage of Consumers
>
> Outcome: Triage occurs in a timely and effective manner in line with current best practice.
>
> Note: For the purpose of this Standard, triage is defined as an initial assessment of the severity of the consumer's condition, in order to determine priority of treatment."[2]

Opinion: Breach — Dr C

Care and treatment

Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that patients have the right to have services provided with reasonable care and skill. Ms A consulted Dr C on two occasions: on Tuesday 20 July 2004 when she first presented with dysmenorrhoea and menorrhagia; and on Friday 1 October 2004 when she continued to be troubled by abdominal pain, irregular menstrual bleeding and smelly vaginal discharge. Between these consultations, Ms A had also presented after-hours to Dr D on 25 September 2004, with similar symptoms.

Care and treatment on 20 July 2004
My expert, Dr Simon Brokenshire, considered the visit on 20 July to be a complex consultation involving a number of issues that were difficult to cover adequately in an initial consultation. Ms A presented with dysmenorrhoea, menorrhagia and possibly irregular

[2] See Appendix 2 for further information on this section of the Standard.

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bleeding of four months' duration, all of which require skill and time to investigate further, with several possible diagnoses. There were issues concerning the removal of her IUD, overdue cervical smear, safe prescription of the oral contraceptive pill, ongoing contraception following the IUD removal, along with the safe prescribing of a non-steroidal anti-inflammatory analgesic. Given the duration Ms A had put up with her symptoms prior to seeking medical attention, it is likely that she came with fears, concerns, frustrations and an expectation that her symptoms would be rapidly resolved. Dr C described her as "very tearful" and noted that she had exceeded her threshold for handling the pain.

Dr C's examination focused on Ms A's abdominal area. There were no lumps or areas of tenderness, and she had normal bowel sounds. However, Dr C did not document the findings in her clinical records (a matter commented on separately below). I note her explanation that Ms A was experiencing heavy menstrual bleeding and was reluctant to have an internal pelvic investigation or vaginal and cervical swabs. Dr C's plan was to schedule the internal pelvic examination and swabs a fortnight later when Ms A returned to have her cervical smear and IUD removed. An appointment was made for 3 August 2004.

Although postponing the internal pelvic examination and swabs was reasonable in the circumstances, Dr C needed to emphasise the urgency of an internal pelvic investigation (given Ms A's symptoms and IUD of six years' duration) and to document that she had done so. Dr C should also have documented Ms A's refusal to have swabs and a pelvic examination. Such notes serve as a follow-up reminder during the next consultation and are useful in the event Ms A is subsequently seen by another doctor (as eventuated). There is no indication from Dr C's clinical records that she advised Ms A about the importance of swabs and a pelvic investigation.

My expert pointed out that there were several gaps and omissions during this consultation. While oral contraceptives are appropriate for treating dysmenorrhoea and menorrhagia, Dr C should have assessed and discussed the risks and benefits of taking Marvelon (a third generation combined oral contraceptive) before prescribing it. A risk assessment was especially important as Ms A was in her late thirties and was overweight. A woman with a personal or family history of blood clots or severe varicose veins, or who is overweight, has a higher risk of developing blood clots if prescribed the oral contraceptive pill, and the risk is greater with third generation pills such as Marvelon.[3] It is unclear whether a risk assessment took place or whether the risks were discussed with Ms A,[4] as Dr C did not record any discussion on this matter.

[3] Ministry of Health, *Ministry of Health Renews Oral Contraceptive Advice* (Media Release, 21 December 1998).

[4] See Opinion 99HDC01756 on www.hdc.org.nz.

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My expert commented that some practitioners would not prescribe antibiotics and antifungal cream to treat gardnerella and thrush-like symptoms without taking vaginal and cervical swabs. Given that Dr C was attempting to treat a possible infection in the genital area, it would have been prudent for her to take vaginal and cervical swabs before prescribing Ms A with antibiotics and antifungal cream. The swabs would have confirmed the type of organisms present in Ms A's vagina and/or cervix and enabled Dr C to treat her symptoms more effectively. However, as noted above, Ms A was reluctant to have swabs taken.

Notwithstanding the gaps and omissions, I accept my expert's view that Dr C provided a satisfactory standard of care on 20 July 2004 and did not breach Right 4(1) of the Code. I accept that this was a complex consultation, which placed Dr C under tight time constraints, and that it was difficult examining and treating a distressed patient.

Care and treatment on 1 October 2004

Ms A did not attend the booked follow-up appointment a fortnight later (in early August 2004) but returned to see a doctor two months later on 25 September 2004. I note Dr C's comment that if Ms A had presented earlier, the outcome may not have been as severe. My expert also commented that earlier follow-up with Dr C could have led to a different outcome. It is unclear why Ms A did not attend her scheduled appointment with Dr C. It may have been prudent for Dr C to have taken steps to follow up with Ms A after the two-week period and to document her actions, although the procedures were not urgent. If the medical centre had an efficient patient recall system in place, the practice nurse or the receptionist could have been prompted to contact Ms A to remind her that she had missed her appointment and needed to make another appointment for IUD removal and a cervical smear. However, I accept that patients have some responsibility for their own care, and that this includes attending booked appointments for follow-up procedures.

When Ms A returned for a second consultation on 25 September, she saw Dr D. I agree with Dr C's comment that continuity of care is compromised when a patient receives care from different doctors. Dr D advised Ms A to return to Dr C within the next one to two days, but she did not present again until six days later on 1 October 2004. Whatever her reasons, Ms A delayed seeking medical attention despite being advised to do so.

On 1 October, Dr C removed Ms A's IUD and carried out a cervical smear according to the follow-up plan of 20 July. She also performed an abdominal and internal pelvic examination, although her findings were not documented. During the consultation, Ms A complained that she experienced diarrhoea and vomiting after taking the medication Dr D prescribed. She also felt very unwell. Although Dr C was aware from reviewing the treatment records that Ms A had seen another doctor on 25 September, her notes do not appear to take into account the acute symptoms with which Ms A had presented to Dr D.

Dr C did not consider Ms A to be acutely unwell after examining her abdomen and pelvis. My expert commented that it is more difficult to detect abnormalities from performing

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abdominal and pelvic examinations in overweight patients. I agree with my expert that Dr C should have adopted a higher degree of suspicion during her examination. While Ms A may have been a reluctant patient, Dr C should have been more attentive to Ms A's complaints and discomfort, and queried the reasons for her recent visit to Dr D. Taking these steps would have assisted her in considering other possible diagnoses for Ms A's multiple symptoms.

Dr C advised that she did not take vaginal and cervical swabs as there was no smelly discharge present when Ms A's IUD was removed. Given that Dr C had previously considered the possibility of a low-grade genital infection, and Ms A had re-presented with ongoing abdominal discomfort on 1 October, my expert advised that swabs should have been taken. Dr Brokenshire also considered that blood and stool tests for microbiological organisms would have been appropriate given Ms A's acute ongoing symptoms. While these investigations may not have led to a change of treatment, the results would have been beneficial for subsequent follow-up care. It would have been prudent for Dr C to investigate Dr D's provisional diagnosis of pelvic inflammatory disease by sending Ms A's IUD for microbiological examination. Dr C should also have considered the need for a pelvic ultrasound since Ms A's uterus was tender on examination, and she had complained of a generalised abdominal discomfort. Her adverse reactions to antibiotics should have alerted Dr C to the fact that the pelvic infection was not responding to Dr D's prescription, and necessitated additional investigation on her part, such as ordering an ESR (erythrocyte sedimentation rate). In my view, Dr C did not investigate Ms A's symptoms adequately on 1 October.

Dr Brokenshire advised that a hospital referral was not warranted based on Dr C's findings from the pelvic and abdominal examination. Dr C's working assumption was that the IUD removal would reduce Ms A's symptoms. I accept my expert's view that Dr C made an appropriate decision in the circumstances. Dr C told Ms A to return for reassessment if her pain and vomiting worsened, and if she was unable to take fluids. However, Dr C did not document her follow-up advice. Given that Ms A was presenting for the third time with ongoing symptoms, Dr C should have ensured that her notes provided a comprehensive picture of the consultation.

In mitigation, my expert noted that the consultation occurred on a Friday when doctors are generally busier and under greater pressure. However, patients rely on their doctors to be attentive to their concerns and to provide appropriate care regardless of the day of the week on which they present.

Taking into account all of these factors, I conclude that Dr C did not provide an appropriate standard of care on 1 October 2004 and breached Right 4(1) of the Code.

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Documentation

Right 4(2) of the Code states that patients have the right to have services that comply with relevant legal, professional, ethical, and other relevant standards. This includes the responsibility on providers to adequately document their consultations, since accurate documentation and record-keeping form a fundamental part of good quality care.

20 July 2004
Dr Brokenshire commented that Dr C's notes were barely of an acceptable standard. I note that it was only when my Office asked for clarification that Dr C confirmed that she did examine Ms A during both consultations. However, she did not document the findings of her abdominal examination and other baseline observations, including Ms A's weight, pulse, temperature and blood pressure. There is no record of any pregnancy test. Dr C also omitted to document the risk factors that may have been taken into account in her decision to prescribe the combined oral contraceptive, or any discussion of the risks. Although Dr C considered taking a vaginal and cervical swab at the next consultation (when Ms A returned for her cervical smear and IUD removal), this was not recorded in her notes.

1 October 2004
The documentation on 1 October 2004 was brief. Dr C omitted the history of Ms A's gastrointestinal symptoms (vomiting and diarrhoea), and gave the impression that her problem had changed from dysmenorrhoea and menorrhagia to a more generalised abdominal discomfort with associated diarrhoea and vomiting. Dr Brokenshire noted that Dr C failed to record any baseline observations (such as Ms A's temperature, pulse and blood pressure), and the findings from her cervical, pelvic and abdominal investigations. Given that Ms A was reluctant to have an internal pelvic examination during the first consultation, it was important to document that it had been carried out during this consultation. Such records are useful for guiding other doctors in follow-up care. My expert pointed out that there was no comment in Dr C's notes of her impression of Ms A's general wellness and appearance, and whether Ms A was still taking antibiotics. In addition, Dr C did not record whether she had sent Ms A's IUD for microbiological examination or her rationale for not taking vaginal and cervical swabs.

The severity of Ms A's condition was not reflected in Dr C's documentation. Nor was any follow-up plan documented. This omission left future doctors unclear about any follow-up required. Dr Brokenshire noted that another provider could be left with the impression that the consultation on 1 October was for a routine smear and removal of IUD, rather than "an acute and chronic problem".

Where a patient receives care from two or more doctors, it is particularly important that the documentation is as clear and comprehensive as possible. Good records help ensure quality and continuity of care, which is a patient's right, affirmed by Right 4(5) of the Code. Dr Brokenshire pointed out that doctors working in accident and medical settings need to be

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even more vigilant in recording their patient's baseline observations and their general impression of the patient's acuity and degree of illness. Dr C's failure to record vital information relevant to Ms A's history, care and treatment placed Ms A at risk of having her care compromised when she consulted Dr D after-hours on two occasions. In my view, Dr C's documentation of Ms A's consultations on 20 July and 1 October 2004 did not comply with professional standards and breached Right 4(2) of the Code.

Opinion: Breach — Dr D

Care and treatment

Ms A presented twice after-hours to Dr D: on Saturday evening 25 September 2004 with acute abdominal pain, and on Tuesday evening 5 October 2004 when she continued to be troubled by increased abdominal pain.

Care and treatment on 25 September 2004
Dr Brokenshire had some reservations about Dr D's care and treatment on 25 September 2004 but advised that it reached an acceptable standard. Ms A was noted to be "pale, miserable, sick and teary". However, aside from recording her body temperature at 37.7°C (a reading indicative of fever[5]), there were no other baseline observations to support Dr D's statement that she was "afebrile" and her "observation normal". As Dr D was uncertain of Ms A's actual diagnosis, chronicity and acuity, he should have ordered blood tests even if the results were not immediately available for after-hours consultations. By not investigating further, Dr D gave the impression that Ms A's degree of illness was not acute. While Dr D responded appropriately by conducting an abdominal examination, Dr Brokenshire was uncertain from Dr D's non-standard notes whether the examination was of an acceptable standard. I comment on Dr D's documentation below.

Given that Ms A was of reproductive age, a rectal and full pelvic examination should also have been offered. Ms A's refusal to have a pelvic examination (by pushing away Dr D's hand) suggests that she was in considerable pain. It is not clear that Ms A had understood the importance of such an investigation or the need for co-operation on her part. It is impossible to tell from Dr D's notes what information he had given Ms A about the pelvic examination. It would have been prudent for him to record that she refused such an investigation, despite having been advised of its importance. Ideally, Dr D would have taken pelvic swabs. The absence of a pelvic examination meant that Dr D had to make an educated guess as to Ms A's possible pathology.

Dr D was aware that the removal of Ms A's IUD was overdue, and that she had an abnormal vaginal discharge. While it would have been preferable for Dr D to remove Ms

[5] The normal body temperature is between 36°C and 37°C. A person has fever when the body temperature rises above 37.2°C.

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A's IUD and take vaginal and cervical swabs during this consultation, it was reasonable for him not to do so, and to document his advice that Ms A would see her regular GP, Dr C, during the coming week.

To cover the likelihood of PID, Dr D prescribed metronidazole and Augmentin. Dr D advised Ms A to admit herself to hospital overnight if she became more unwell. Dr Brokenshire considered Dr D's follow-up arrangements appropriate although Dr D's notes do not indicate whether clear advice was given to Ms A.

Overall, Dr D's care and treatment on 25 September 2004 was satisfactory and did not breach Right 4(1) of the Code. I agree with Dr Brokenshire's view that this consultation was complicated given Ms A'S issues and symptoms, and late presentation.

Care and treatment on 5 October 2004

Dr Brokenshire advised that the care Dr D provided on 5 October 2004 did not reach an acceptable standard. Although this was Ms A's fourth visit to the medical centre, and second consultation with Dr D, he was unable to make a firm diagnosis. Dr D did not give sufficient consideration to Ms A's protracted medical history or to the acuity of her presenting illness. Ms A looked "sore and miserable" and was re-presenting with ongoing acute symptoms. Rectal and pelvic examinations were not performed, nor a pregnancy test. My expert advised that Dr D should have considered abdominal imaging (ultrasound or CT scan), ordering urgent blood tests, and a specialist referral with the view to possible laparoscopy or laparotomy. Although the outcome may not have differed, it would have been prudent for Dr D to initiate further investigations.

Dr D noted that Ms A was "sore all over", "pushed his hand away [during the abdominal examination]", and was also sore in her upper right abdominal area. Her bowel sounds were normal. However, my expert was unable to conclude whether the abdominal examination was adequate because Dr D did not document whether Ms A had any abdominal masses or tenderness. In addition, Dr Brokenshire advised that Dr D should have investigated the bowel sounds further or referred Ms A to hospital. Normal bowel sounds in a person with ongoing acute symptoms are often indicative of acute pathology and possible peritoneal inflammation.

Dr Brokenshire commented that Dr D should have expedited Ms A's referral to hospital. It was inappropriate for him to send her home that evening with the follow-up advice that she either admit herself to hospital, or return to the medical centre if her condition did not improve. His decision was imprudent given that he had made a probable diagnosis of pelvic inflammatory disease 10 days earlier, and was aware that Ms A had not completed her course of antibiotics. In addition, Dr D should have given greater consideration to Ms A'S unhappiness at being sent home. His decision not to admit to hospital may have been based on past experience of long delays at the hospital's emergency department. In fact, Ms A did

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not experience any significant delay in accessing hospital care later that evening when her condition had not improved.

In summary, in a number of respects, the care and treatment Dr D provided on 5 October was not of an appropriate standard, and he therefore breached Right 4(1) of the Code.

Documentation

Dr D's notes are generally legible and relatively comprehensive. Dr Brokenshire commented that his documentation is a reasonable record of the care he provided, despite containing some non-standard annotation in relation to Ms A's abdominal signs. However, while Dr D's notes of 25 September were adequate, his records of 5 October fell short of the standard expected of a doctor working in an accident and medical setting. Dr D failed to document any abdominal masses, rebound, tenderness and enlargement of organs that may have been observed during the examination. Consequently, my expert was unable to ascertain whether Dr D's abdominal examination was adequate, and commented that it "left the reader uncertain as to [his] exact findings".

I accept Dr Brokenshire's advice. In my opinion, Dr D breached Right 4(2) of the Code in relation to his record-keeping on 5 October 2004.

Opinion: No Breach — The Medical Centre

Complaint
Ms A complained about the length of time she waited to be assessed after arriving at the medical centre on 5 October 2004.

Ms A's complaint raises two issues about the medical centre's triage system. The first is whether Ms A was adequately triaged by relevant staff on 5 October 2004 (a care and treatment issue involving Right 4(1) of the Code), and the second is whether the medical centre had a triage system in place that complies with the relevant standards for Accident and Medical clinics (a standards issue involving Right 4(2) of the Code).

Care and treatment
My expert advised that Ms A was adequately and appropriately triaged on 5 October 2004. She was assessed by a registered nurse, Ms E, within seven minutes of her arrival at the medical centre, which was an acceptable time frame. During the triage assessment, Ms E recorded Ms A's blood pressure, pulse, temperature and observed behavioural indicators of her pain. My expert commented that the important aspects of triage (such as baseline observations, brief history of the complaint, patient's general appearance, distress and perceived unwellness) were completed. In addition, Ms E checked Ms A regularly while

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she waited to see a doctor, and acted promptly when she complained of worsening pain. Although it was appropriate to triage Ms A as category 4, Dr Brokenshire advised that she could also have fitted into triage category 3 based on her presentation and baseline observations.

It is clear that Ms A experienced pain and discomfort when she presented on 5 October 2004. Despite her symptoms and acute discomfort, she was appropriately assessed and triaged that evening. Therefore, in my opinion, the medical centre did not breach Right 4(1) of the Code.

Standards

The medical centre is an ACC-endorsed level 2 Accident and Medical Clinic. As such, it is required to comply with the New Zealand Standards for Accident and Medical Clinics NZS 8151:2004 (Standards) in place at the time Ms A received care.[6] Triage is defined in the Standards as:

> "… an initial assessment of the severity of the consumer's condition, in order to determine priority of treatment".

Dr Brokenshire advised that the medical centre's triage system complies with the Standards. The medical centre has a written policy for triaging patients that is well understood and adhered to by nursing and medical staff. My expert commented that the triage codes adopted by the medical centre fit the Australasian College for Emergency Medicine's triage scale.

Accordingly, I conclude that the medical centre did not breach Right 4(2) of the Code in relation to the care they provided Ms A.

Dr Brokenshire commented on the medical centre's paper-based triage system in place at the time Ms A received care. He indicated that there is room for improvement in the documentation of assessments and baseline observations, which form the basis of the triage category assigned to a patient. My expert suggested incorporating into the triage form a section for recording the nurse's/doctor's observations, a brief history of the presenting complaint(s), examinations carried out, and nurse-initiated investigations and interventions (such as the administration of pain relief according to standing orders). The medical centre advised that in 2005, a computerised system for triage was implemented, which enables all triage assessments to be documented electronically and audits to be conducted.

[6] Since 1998, Accident and Medical Clinics have had the option of seeking ACC accreditation. In the accreditation process, clinics are audited against a written Standard, administered by Standards New Zealand. The Standard addresses a number of areas fundamental to good Accident and Medical Practice, including triage systems.

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This case also highlights the importance of a patient recall system. Although the medical centre had a recall system in place when Ms A consulted Dr C in July 2004, it was not computerised to record missed appointments. Since then, changes have been introduced allowing missed appointments, cancellations and rescheduled appointments to be recorded online in the patient's notes, and audits to be conducted where staff members cancel appointments. These changes will encourage timely follow-up by relevant staff when patients miss appointments and fail to re-present within the advised timeframe.

Vicarious liability

In addition to any direct liability for a breach of the Code, employers may be vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an employee. Under section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the act or omission leading to an employee's breach of the Code.

Both Dr C and Dr D were employed by the medical centre at the time of the events in question. Dr C provided inadequate care and treatment on 1 October 2004 and breached Right 4(1) of the Code. Her standard of documentation fell short of the standard expected of a general practitioner working in an accident and medical setting, and breached Right 4(2) of the Code. Similarly, Dr D's care and treatment on 5 October 2004 was inadequate and breached Right 4(1) of the Code, and his record-keeping for that consultation was deficient, breaching Right 4(2) of the Code.

I am satisfied that Dr C's and Dr D's omissions reflected individual clinical judgement. Accordingly, the medical centre is not vicariously liable for their breaches of the Code.

Actions taken

Drs C and D

In response to my provisional opinion, Dr C and Dr D each provided a written apology for their breach of Rights 4(1) and 4(2) of the Code, and confirmed that they have reviewed their practice.

The Medical Centre

The general manager advised that in 2005 improvements were implemented to the medical centre's triage system and patient recall system. Both systems are now computerised enabling a greater amount of information to be recorded and audited electronically.

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Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.

- A copy of my final report, with details identifying the parties removed, will be sent to the New Zealand Accident and Medical Practitioners Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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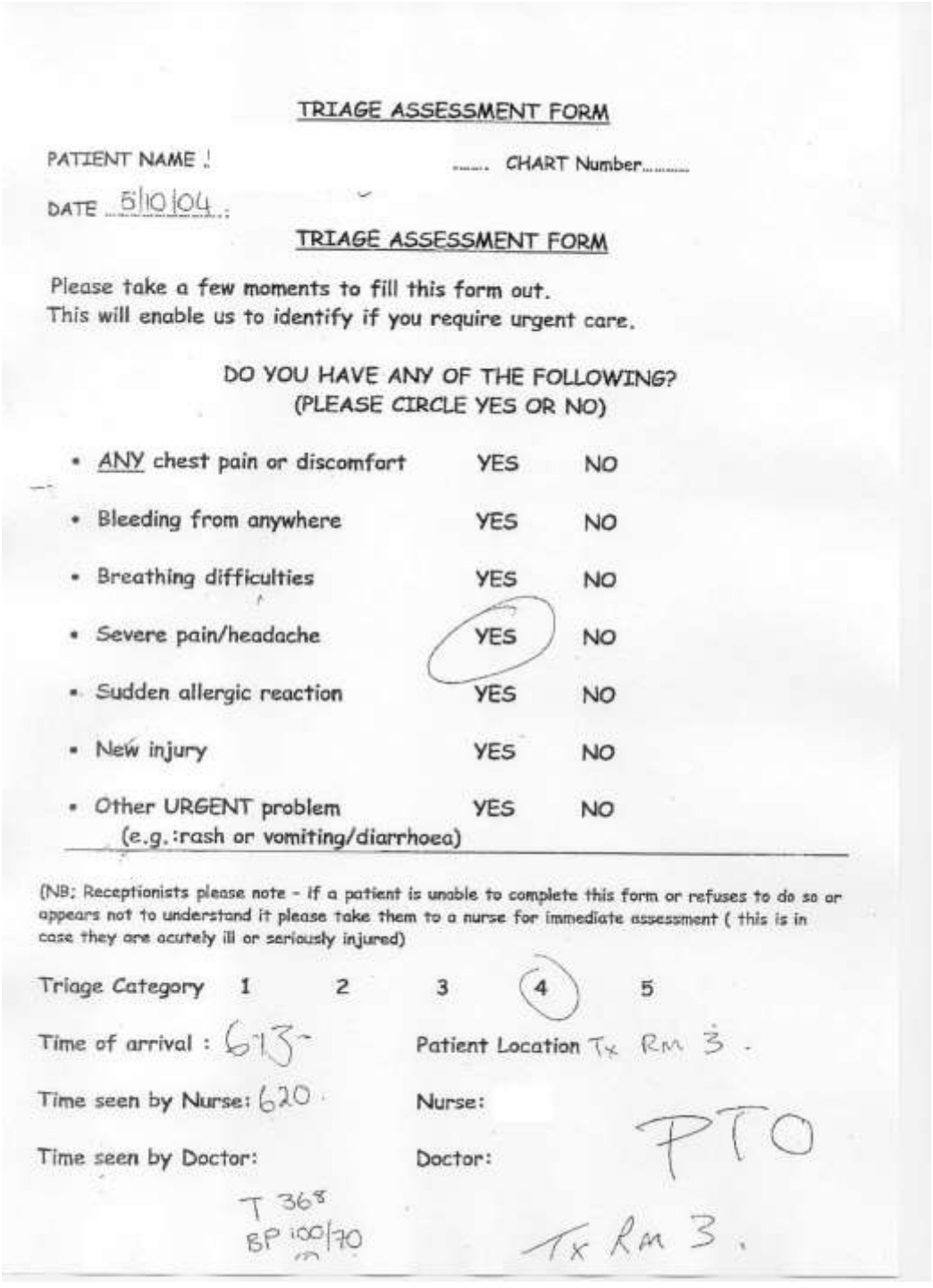
Appendix 1[7]



TRIAGE ASSESSMENT FORM

PATIENT NAME : ..... CHART Number.....

DATE 5/10/04.

TRIAGE ASSESSMENT FORM

Please take a few moments to fill this form out.
This will enable us to identify if you require urgent care.

DO YOU HAVE ANY OF THE FOLLOWING?
(PLEASE CIRCLE YES OR NO)

• ANY chest pain or discomfort	YES	NO
• Bleeding from anywhere	YES	NO
• Breathing difficulties	YES	NO
• Severe pain/headache	YES	NO
• Sudden allergic reaction	YES	NO
• New injury	YES	NO
• Other URGENT problem (e.g.:rash or vomiting/diarrhoea)	YES	NO

(NB: Receptionists please note - if a patient is unable to complete this form or refuses to do so or appears not to understand it please take them to a nurse for immediate assessment (this is in case they are acutely ill or seriously injured)

Triage Category 1 2 3 4 5

Time of arrival : 613 Patient Location Tx Rm 3.

Time seen by Nurse: 620 Nurse:

Time seen by Doctor: Doctor: PTO

T 36.8
BP 100/70

Tx Rm 3.

[7] Registered Nurse Ms E, who completed the form, advised (via her lawyer) that the form is not double-sided, despite "PTO" appearing on the bottom right-hand corner.

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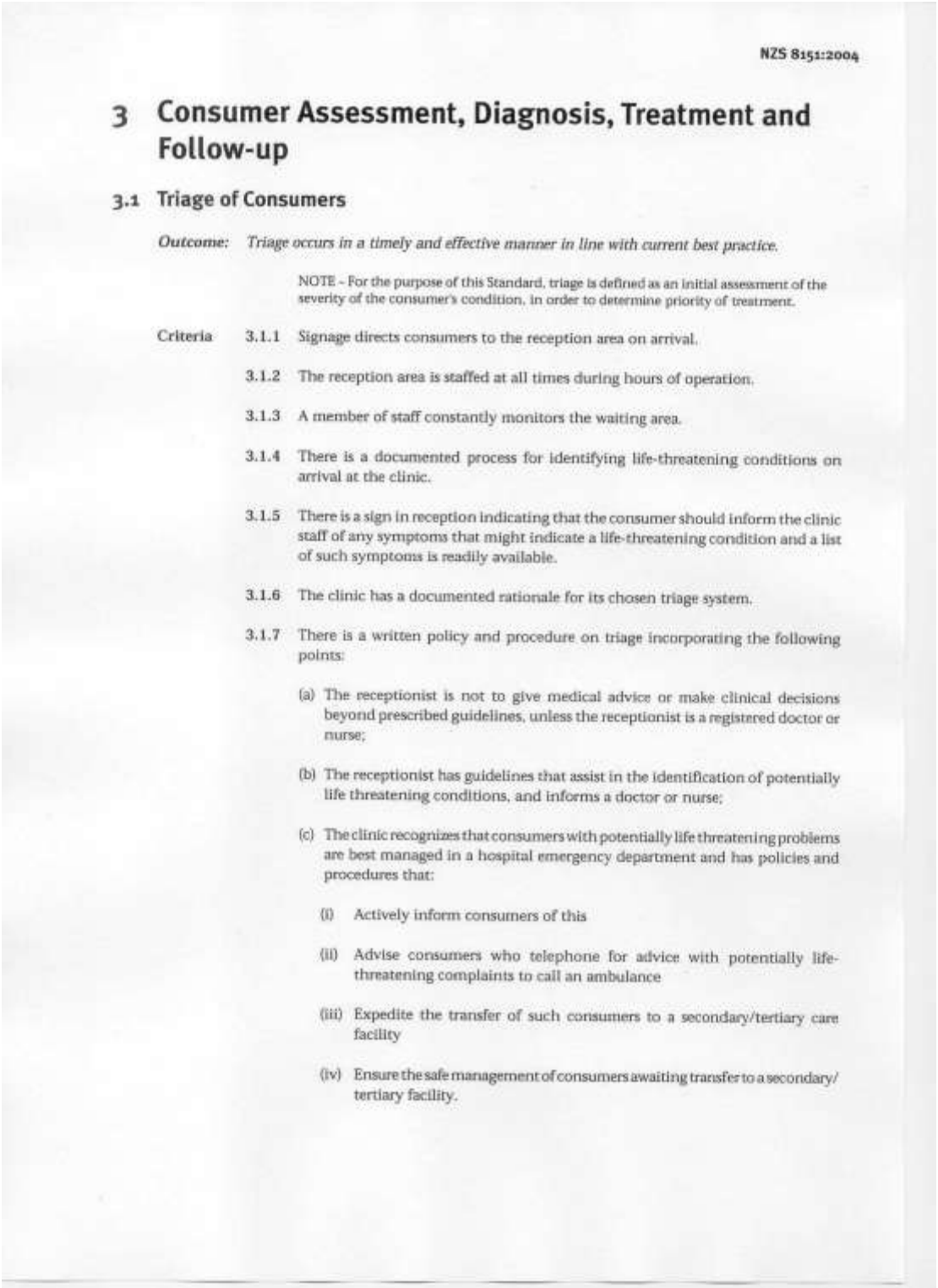
Appendix 2



NZS 8151:2004

3 Consumer Assessment, Diagnosis, Treatment and Follow-up

3.1 Triage of Consumers

Outcome: *Triage occurs in a timely and effective manner in line with current best practice.*

NOTE – For the purpose of this Standard, triage is defined as an initial assessment of the severity of the consumer's condition, in order to determine priority of treatment.

Criteria

3.1.1 Signage directs consumers to the reception area on arrival.

3.1.2 The reception area is staffed at all times during hours of operation.

3.1.3 A member of staff constantly monitors the waiting area.

3.1.4 There is a documented process for identifying life-threatening conditions on arrival at the clinic.

3.1.5 There is a sign in reception indicating that the consumer should inform the clinic staff of any symptoms that might indicate a life-threatening condition and a list of such symptoms is readily available.

3.1.6 The clinic has a documented rationale for its chosen triage system.

3.1.7 There is a written policy and procedure on triage incorporating the following points:

(a) The receptionist is not to give medical advice or make clinical decisions beyond prescribed guidelines, unless the receptionist is a registered doctor or nurse;

(b) The receptionist has guidelines that assist in the identification of potentially life threatening conditions, and informs a doctor or nurse;

(c) The clinic recognizes that consumers with potentially life threatening problems are best managed in a hospital emergency department and has policies and procedures that:

(i) Actively inform consumers of this

(ii) Advise consumers who telephone for advice with potentially life-threatening complaints to call an ambulance

(iii) Expedite the transfer of such consumers to a secondary/tertiary care facility

(iv) Ensure the safe management of consumers awaiting transfer to a secondary/tertiary facility.

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NZS 8151:2004

3.1.8 Consumers will be triaged into categories of priority. The basis for categorization is documented, and takes into account clinical risk, pain management and consumer expectation.

NOTE – This may be achieved by using the Australasian College for Emergency Medicine (ACEM) triage scale, the Manchester Triage Scale or similar.

3.1.9 The clinic informs consumers that there is a triage process that assesses and prioritises treatment for consumers.

3.1.10 On request, consumers are informed of the anticipated waiting time in relation to their triage category. Consumers should be kept informed of any changes to the indicated waiting time.

3.1.11 Triage decisions/categories and waiting times for initial assessment are monitored and reviewed periodically as a component of the internal audit programme.

NOTE – Triage accuracy and system evaluation may be undertaken in part by reviewing the triage allocation, sentinel diagnosis, average waiting time, admission rate and mortality rates in each triage category.

3.1.12 Staff and other resources should be deployed so consumers are seen in order of triage priority.

3.1.13 Where the chosen triage standards are not met, a review and corrective action process is implemented.

Compliance may be demonstrated by ensuring:

1. There are clear procedures for triage.
2. The receptionist's job description clearly defines the limits of the role in regard to triage.
3. Training for staff performing triage (including receptionists) on limits of the receptionist's role.
4. There is evidence of a periodic triage audit that evaluates compliance with the triage policy.
5. There is evidence of consumer feedback regarding waiting times and triage.

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