Auckland District Health Board

A Report by the

Health and Disability Commissioner

(Case 15HDC01560)

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Executive summary

1. Ms A, a first-year university student, had been unwell for four days with flu-like symptoms. Overnight on 13 September 2015, Ms A fainted twice. Ms A said that the second time she fell, she hit her face. She also hurt her right thumb.

2. Ms A was transported to the public hospital via ambulance and triaged. Notes made by the ambulance officer and by the triage nurse record that Ms A had fainted twice, had hit the left side of her face, and was complaining of pain in her face and right thumb. The ambulance notes also record that Ms A had a contusion on her left cheek bone.

3. Following triage, Ms A was examined by senior house officer Dr C. Dr C said that he read the ambulance and triage documentation "too quickly" or, from the history Ms A gave him, was too focused on the fact that she might have a head injury, and he did not pick up that there could be a possible facial injury. Dr C examined Ms A's cardiovascular, respiratory, abdominal, and neurological systems, which revealed no significant abnormalities except for dehydration. Dr C assessed Ms A's thumb as having a full range of motion with no swelling. An electrocardiogram (ECG) was performed, and Dr C assessed and signed it, but did not refer to the findings in the clinical notes. A urine pregnancy test was not done, and Dr C decided that a CT scan was not indicated. He recorded that his impression was syncope secondary to viral illness and dehydration.

4. Ms A remained in hospital overnight for observation. Dr C discharged Ms A at 8.03am that morning, as she was feeling much better and her observations were stable. Dr C did not discuss Ms A's case with a senior medical officer (SMO) prior to discharge, as was required by Auckland District Health Board (ADHB) of a house officer.

5. Ms A re-presented to the hospital that evening, as she felt unwell and thought that something was wrong with her face. Ms A spoke to an ADHB staff member at the front desk of the Emergency Department (ED), but no triage was completed. No documentation exists for Ms A's second presentation to ED except for a medical certificate issued by a medical officer.

6. Subsequently, Ms A was diagnosed with facial fractures, which were corrected by a maxillofacial surgeon.

Findings summary

7. Adverse comment is made about Dr C for not commenting on the ECG in Ms A's clinical notes, for not ordering a urine pregnancy test, and for missing a number of opportunities to elicit that Ms A had suffered a facial injury. Further criticism is made of Dr C for not suggesting follow-up or considering splinting for Ms A's thumb injury, and for not discussing Ms A's case with an SMO prior to discharge.

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8. ADHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[1] for failing to triage Ms A when she re-presented to ED. Criticism is also made about the absence of a record of her visit except for the medical certificate that was issued, and that ADHB is not able to identify the ADHB staff member who spoke with Ms A.

Recommendations

9. It is recommended that ADHB report to HDC on the implementation of its mentoring programme for junior staff, and on its review of the ED triage process, and provide evidence to HDC of the training sessions provided to triage and clerical staff on the triage process.

10. It is also recommended that Dr C and ADHB each provide written apologies to Ms A.

Complaint and investigation

11. The Commissioner received a complaint from Ms A about the services provided to her by Auckland District Health Board. The following issue was identified for investigation:

The appropriateness of the care provided to Ms A by Auckland District Health Board in September 2015.

12. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Auckland District Health Board	Provider

13. Information was also reviewed from:

Dr B	Chief Medical Officer, ADHB
Dr C	Senior House Officer
Dr D	Medical officer
Dr E	General practitioner
Mrs F	Consumer's mother
Ms G	Consumer's friend/witness
Ms H	Residential assistant/witness
Another District Health Board	Provider

14. Independent expert advice was obtained from an emergency medicine specialist, Dr Tom Jerram (**Appendix A**).

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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Information gathered during investigation

Background

15. Ms A, 19 years old at the time of events, was a first-year university student living in a hall of residence. She had been unwell for four days with flu-like symptoms.

16. Overnight on 13 September 2015, Ms A got out of bed to go to the bathroom, and fainted on the bathroom floor. She said that the back of her head was sore. When she stood up and tried to walk back to her room, she fainted again. Ms A said that she fell against a brick wall[2] and hit her face, causing pain. She said that her whole face felt numb, and that she had a bleeding nose. Ms A said that she also hurt her right thumb.

17. An ambulance was called at 2.48am. An ambulance officer recorded on the patient report form that Ms A's chief complaint was "Facial injury post Syncope[3] x 2 — Febrile". Ms A's history included that she was feeling unwell, that she had had two unwitnessed syncopal episodes and had hit her left cheek,[4] and that she complained of pain in her face and right thumb. It was also recorded that Ms A had a contusion to her left cheek bone. Ms A's observations were recorded at 3.25am. She was febrile[5] (39.3°C) and tachycardic[6] (pulse rate of 100), and had a GCS[7] of 15/15. Ms A was taken to the Emergency Department (ED).

First admission to ED

Triage

18. At 3.30am Ms A was seen by a triage nurse. Ms A's observations were recorded, and she was triaged as category 3 (recommended to be reviewed within 30 minutes). Ms A was transferred to the acute area of ED.

19. At 4.05am Ms A underwent an initial assessment by the same triage nurse, who noted that Ms A had been unwell for four days with an influenza-like illness, and recently had had two syncopal episodes. It was noted that she had pain in her right thumb and on the left side of her face. The nurse noted that Ms A's right thumb had a decreased range of motion, and queried whether an X-ray was required.

Examination by Dr C

20. At 4.43am Ms A was seen by senior house officer Dr C.[8] Dr C recorded on the admission note that Ms A had a four-day history of fever and a productive cough with green sputum. Dr C also recorded:

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[2] The corridors in her hall of residence were made of brick.
[3] The medical term for fainting.
[4] The ambulance records note that Ms A hit her left cheek bone on the corner of a desk. Ms A told HDC that this was recorded incorrectly, and she hit her left cheek on a brick wall.
[5] Raised temperature/fever.
[6] Abnormally rapid heart rate.
[7] Glasgow Coma Scale (GCS) is an objective means of recording a person's conscious state, and has value in predicting ultimate outcome. Motor, verbal, and eye responses are assessed independently and scored (lowest score of 1 reflects no response). The sum of these gives an overall GCS score out of 15, with 15 being fully conscious.
[8] Dr C has been registered in a general scope of practice since 2014.

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> "[F]elt hot and sweaty in middle of night, got up to go to the toilet and fell — reports [loss of consciousness]. Woke up and tried to walk back to room and had another syncopal episode … Feels very dehydrated, decreased oral intake all day yesterday … Hit [left] side of head on brick wall with second syncopal episode. Mild headache currently on [left] side … No vomiting. Nil previous syncope … Denies [abdominal] pain."

21. Dr C told HDC that after gaining a history from Ms A he then read the ambulance and triage documentation. He said: "I must have read them too quickly or was too focused on the fact that she might have a head injury from the history she gave me and did not pick up that there could be a possible facial injury."

22. Dr C examined Ms A's cardiovascular, respiratory, abdominal, and neurological systems, which revealed no significant abnormalities except for dehydration. An electrocardiogram (ECG)[9] taken was assessed and signed by Dr C, but he did not refer to the findings in the clinical notes. A urine test showed slightly elevated neutrophils.[10] A urine pregnancy test was not done. Dr C told HDC that this should have been done but, as Ms A had a lack of abdominal or gynaecological symptoms, he felt that it was an unlikely cause of her presentation.

23. Dr C said that his primary concern was a head injury rather than any facial injury, and that his subsequent examination was concerned with excluding an acute intracranial bleed.[11] He said that the history he had obtained from Ms A "was not that she had hit her cheekbone on the corner of the desk (as referenced in the ambulance notes)". Dr C stated: "This is why my subsequent history taking and examination focused on a potential head injury."

24. In response to the "information gathered" section of the provisional opinion, Ms A said that she definitely told Dr C about "hitting my whole face on the brick wall and how my whole face was numb …". Ms A told HDC that she made several requests to Dr C for an X-ray of her face. In contrast, Dr C said: "[There was] no discussion at any point regarding facial injuries. I was certainly not asked 'repeatedly' for a facial x-ray …" He said that it was he who raised the possibility of imaging with Ms A regarding her head injury and the concern around acute intracranial pathology.

25. Dr C said that he explained to Ms A that there was no indication for a CT head scan, but that she should remain in hospital overnight for observation. Dr C said that he decided not to do a CT scan because there was "no evidence of a depressed skull fracture, no episodes of vomiting, no evidence of retrograde amnesia, no worsening headache, [and] no scalp haematoma". Dr C told HDC that he explained to Ms A that to perform an unnecessary CT scan would expose her to unnecessary radiation, and that he had no immediate concerns regarding a head injury given his findings.

[9] A diagnostic tool that measures and records the electrical activity of the heart.
[10] Indicative of possible infection.
[11] Bleeding within the skull.

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26. Ms A told HDC that she also asked Dr C for her thumb to be X-rayed. She said: "[W]hen I fell [my thumb] was extremely sore, and they just brushed it off and said 'its probably fine'." Dr C recorded that he assessed Ms A's thumb as having a full range of motion with no swelling. He said that it seemed, therefore, that a fracture was unlikely and an X-ray was not indicated at the time.

27. Dr C recorded that his impression was syncope secondary to a viral illness and dehydration. He told HDC:

> "From the history given to me by [Ms A] and my examination finding, my initial impression of her presentation was that of a viral illness leading to decreased oral intake and subsequent dehydration resulting in two syncopal episodes the second of which involved a head injury against a brick wall in her University hostel."

No review by senior doctor

28. ADHB told HDC that a Senior Medical Officer (SMO) is in charge of house officers and is required to stay in ED until 2am, and that thereafter the SMO is available on call to provide advice or return to ED if required. If ED is busy, the SMO will stay overnight.

29. ADHB said that on the night Ms A presented, the department had on duty a medical officer, two registrars, and two house officers, and an SMO on call. It said that patients are transferred to the short-stay area overnight if clinically appropriate, to enable the SMO to review the patients at the 8am handover.

30. ADHB told HDC that all patients seen by a house officer have to be discussed with an SMO before being discharged. This is detailed in the electronic ED orientation handbook, and explained at the compulsory orientation session at the start of each house officer's three-month run. Dr C did not discuss Ms A's case with an SMO at any time prior to her discharge. Dr C stated: "I appreciate that I should have discussed this case with the senior staff member on at the time and that this process for me has now been rectified." He said that if patients are to be discharged, he now discusses them with the on-call consultant/senior staff member.

Discharge

31. Ms A was treated with intravenous fluids overnight. Following a review by Dr C at 7.17am, Ms A was discharged at 8.03am with a prescription for analgesics (paracetamol and ibuprofen). Dr C recorded on the discharge summary that Ms A was feeling much better, and her observations were stable. He told HDC that Ms A was discharged when her pain had improved and her initial tachycardia and fever had settled. He said that there were no ongoing concerns about a head injury.

32. Ms A's discharge summary advised her to seek medical attention if she was not improving over the next few days. The discharge summary did not suggest a review of Ms A's thumb injury.

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Deterioration

33. Ms A told HDC that she walked home from the hospital and felt very hot, nauseous, and dizzy, and her face and mouth felt "completely numb". She said that she had trouble standing up and walking owing to dizziness, and blood coming from her nose continuously.

34. Later that day, Ms A had a video call with her mother, Mrs F. Mrs F told HDC that her daughter looked really unwell, and she told her that she needed to go back to hospital to be reviewed. Mrs F said that she could tell that there was something not quite right about her daughter's face, but it was her daughter's flu symptoms she was concerned about most. Mrs F said that her daughter had no visible injuries and no blood was visible. Mrs F told HDC that she called and organised for a residential assistant,[12] Ms H, to drive Ms A back to ED to be re-examined.

35. Ms H told HDC that she cannot recall whether she spoke with Ms A's mother, but provided HDC with a copy of her Facebook Messenger messages with Ms A. At 5.54pm, Ms A wrote to Ms H: "Could someone please come see me I need help. Ive gone backward[.]" Ms H said that she went to see Ms A in her room and found her lying on her bed. Ms H told HDC that Ms A looked terrible, was pale, clammy, and "coherent but not by much". Ms H said that Ms A's main complaint was that her face was really sore. Ms H does not recall seeing any blood coming from Ms A's nose. Ms H said that she was not happy leaving Ms A at the hall of residence as she could not be supervised properly, and Ms H knew from her past experience with sick students that if they get worse, they should be taken back to hospital.

Second presentation to ED

36. Ms A told HDC that she returned to the hospital ED that evening because she was feeling really bad and could tell that there was something wrong with her face, as it looked lopsided. Ms H drove Ms A to the hospital. Ms A said that she was also accompanied by two friends.

37. Ms A said that she sat down in the waiting room, and recalls Ms H "explaining the situation to a nurse on the front desk". Ms H thinks that she told someone at the front desk that Ms A was worse. Ms A told HDC:

> "I remember going up to explain what I felt with [Ms H], to a woman who was a nurse … I explained that I had no feeling in my face and that I was concerned about the blood coming from my nose.[13] I explained that I asked for an X-ray the night before but no one carried through, so I asked if I could be X-rayed at this moment because I was still concerned. She told me that ED was 'very busy tonight' and that there was limited bed space so those in the worst conditions would be admitted first. She did not seem very much concerned or keen to follow through on my request for a facial X-ray, she put much emphasis [on the] fact that

[12] A residential assistant or resident advisor lives in the university accommodation and serves as a leader, helper, and resource person for students.

[13] Ms A told HDC that every time she blew her nose, blood came out.

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I had been diagnosed with flu symptoms … and told me to take paracetamol and 'not come back unless you start vomiting MULTIPLE TIMES'.

38. Ms A told HDC that she "asked to be looked at again" but that the nurse at the front desk told her that the department was very busy. Ms A said that after a lot of "nagging", the nurse told her that all they could do for her was to give her IV fluids. Ms A then asked for a medical certificate.

39. Ms G told HDC that she went with Ms A to ED as Ms A had been complaining of being in a lot of pain. Ms G recalls that Ms A spoke with a "lady at the front desk". Ms G cannot recall what Ms A told the lady, but recalls the lady telling Ms A that "they were really busy and that [Ms A] just had the flu and to take Panadol".

40. ADHB told HDC that it is unclear to whom Ms A spoke on arrival at ED, and ADHB is unable to identify who may have assisted her. It said that none of the nurses working in triage on the day recall speaking to Ms A. In response to the provisional opinion, ADHB told HDC that it took the following action to try to identify the triage nurse:

"1. We interviewed all the triage nurses working during the afternoon and night shift on the day [Ms A] presented to ED.

2. We reviewed access to the electronic clinical records of [Ms A] that evening. There was no access to patient's clinical record identified during this time.

3. Security footage of the waiting room is stored for a month and was unavailable for review."

41. ADHB told HDC that all patients who present to ED are triaged in accordance with the Australasian triage scale,[14] and that there are no exceptions to that rule.

42. In response to the provisional opinion, ADHB stated that the information from Ms A and her friends contained in this report "suggests that the triage nurse started the triage process". ADHB considers that the triage process was started by a triage nurse (but was "not completed/captured by the IT system"), with the following actions:

"1. Obtained a clinical history

2. Provided advice on the wait time to see a doctor and the triage process ('worst conditions would be seen first'). The ED was busy at the time with over 12 presentations per hour and the wait time would have been about 2 hours for lower triage categories.

3. Advised that there was limited bed capacity in the department

4. Declined a request for an X-ray to be done at triage. X-rays are not ordered by the triage nurse.

[14] The Australasian triage scale has five triage categories: triage category 1 patients are very urgent, while triage category 5 patients are less urgent. For each triage category there is a specified maximum clinically appropriate time within which medical assessment and treatment should commence.

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5. Gave the option of treatment with intravenous fluids
6. Agreed to a request for a medical certificate."

43. In response to the provisional opinion, ADHB told HDC that a patient can choose not to complete the triage and registration process after arrival in ED, but that this causes difficulties in documenting the patient's presentation and linking it with his or her clinical record (the electronic triage captures information only once triage is complete).

Medical certificate

44. No documentation exists for Ms A's second presentation to ED except for a medical certificate issued by medical officer Dr D. ADHB told HDC that a patient who presents for a medical certificate is triaged as category 5.[15] ADHB stated:

> "The only way that she could have avoided being triaged would be if she specifically requested that she did not wish to see a nurse or doctor to the triage nurse. The other possibility would be if she made the request for a medical certificate to one of the clerical staff at the information desk."

45. Dr D told HDC that she was approached by a triage nurse, who asked if she would provide a medical certificate for a patient who had been discharged earlier in the day. Dr D said she was told that Ms A had re-presented to the department specifically for a medical certificate, and that "it was made very clear to me that [Ms A] was at the department for the sole purpose of obtaining a medical certificate … and that she was NOT seeking further medical review". Dr C was not on duty at that time. Dr D said that she was happy to provide a certificate, but did not review Ms A or communicate directly with her. Dr D said that she provided the certificate on the basis of the clinical notes from Ms A's presentation earlier in the day.

46. ADHB told HDC that Dr D should have had some face-to-face contact with Ms A before issuing the medical certificate, and should have documented her contact with Ms A in the clinical notes.

47. In response to the "information gathered" section of the provisional opinion, Ms A told HDC: "[B]ecause no one would help me, I felt so helpless and I had an assignment and exam that week, I thought the least I could do to help myself was to get a medical certificate, it was not the sole purpose I came." Ms A told HDC that she does not think that the nurse to whom she spoke would have arranged for a medical certificate if she had not been pushed for it. Ms A said:

> "[I was sent home] with nothing to consider for further examination, even though my face and mouth was numb and I could not feel it in parts. I also had blood coming out of my nose."[16]

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[15] Category 5 is for "less urgent [cases], or dealing with administrative issues only", with a triage time of no more than 120 minutes.

[16] See footnote 13 above.

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Follow-up treatment

48. The following morning, Ms A presented to the university medical centre and was seen by a nurse. Ms A was unable to see a doctor that afternoon as she was going home. Ms H told HDC that Ms A had to return home as she could not be cared for in the hall of residence.

49. On 15 September 2015, after returning home, Ms A consulted her general practitioner, Dr E. Dr E referred Ms A to a radiology service in her home town for an X-ray of her face. The X-ray revealed a slightly displaced fracture of the left zygomatic arch.[17]

50. The following day Ms A was referred to the public hospital in her home town for a CT scan, which showed numerous facial fractures.

51. On 17 September 2015, Ms A attended an appointment at the otolaryngology clinic to be reviewed for a possible nose fracture. An otolaryngologist reviewed Ms A and concluded that no intervention was necessary. In his reporting letter to Dr E, he noted: "While she was in clinic with me, it is clear that she was struggling. She has been vomiting. She is obviously dehydrated. I have discussed her with the Medical Registrar to be admitted for supportive treatment over the next day or two." Ms A was admitted to hospital overnight and given fluids and antibiotics.

52. On 22 September 2015, Ms A's facial fractures were corrected surgically by maxillofacial surgeon.

Further information

Dr C

53. Dr C told HDC: "I understand that the delay in diagnosis of a facial fracture caused [Ms A] significant emotional distress and for this I apologise." Dr C said that he has thought about his consultation with Ms A on countless occasions, and that Ms A did not mention facial numbness as a complaint during the consultation, which would "normally trigger alarm bells for me of facial injury". Dr C does not recall Ms A having any obvious visual signs of facial facture, and said that it would have been more difficult to diagnose because the knowledge he had was of a hit to the head rather than the face. He said that he recalls assessing the temporal region of the head because he was under the impression that that was the area involved in the collision with the brick wall. Dr C stated: "In retrospect, I should have had a higher index of suspicion given the mechanism, in assessing [Ms A] for a facial fracture."

54. Dr C told HDC that he has undergone a teaching session regarding facial fractures with his consultant from ED, and has improved his practice by including facial examination in all head injury cases. He said that he also recognised the importance of reading the triage and ambulance notes more thoroughly to get a better overall picture as to the presentation.

[17] Cheekbone.

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ADHB

55. ADHB acknowledged that there was a failure to identify a facial fracture at Ms A's initial presentation, and that there had been a departure from the expected standard of care provided to Ms A. ADHB said that the fracture should have been identified, based on the history and examination findings, and that an appropriate investigation for facial injuries is a CT scan of the face. However, clinically Dr C did not suspect a facial facture. ADHB stated:

> "[Dr C] did discuss a head CT with [Ms A] and given her clinical picture opted not to scan her head given the risk/benefit of radiation. Regrettably this decision was wrong and a CT should have been done."

56. Since this event, ADHB has taken the following action:

a) On 13 October 2015, a consultant undertook an education session on facial fractures, for the resident medical officers.

b) From 14 December 2015, ED has had an SMO on nightshift at weekends, to improve clinical safety.

c) In February 2016, Ms A's care was reviewed formally at the Morbidity and Mortality meeting, to share learnings and prevent errors in the future.

d) In December 2016, a new mentoring programme was introduced to assist junior staff to adjust to work in ED better.

57. In response to the provisional opinion, ADHB provided an update on its review of the systems and processes in triage. It advised that the importance of triaging all patients was discussed at an ED charge nurses workshop on 22 June 2016. In addition, ADHB advised of the following further changes:

a) All patients presenting to ED must be triaged and documentation completed.

b) Regular teaching sessions take place on this topic.

c) The importance of triage documentation and documentation in general is highlighted in the daily ED departmental meetings.

d) The triage guidelines have been updated. All patients must have mandatory triage before any advice is given.

e) A 3–12 month IT development plan is in place to make a number of enhancements to its existing IT system to improve the capture of information electronically if the triage process has been started.

Ms A

58. Ms A told HDC that the delayed diagnosis of her facial fracture cost her and her family financially, and it also affected her university education. She stated:

> "I would hope that through this process improvements can be made and that other young people, or particularly a first year university student like myself, living in student accommodation — away from home and possibly not familiar with the

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hospital process/emergency after hours care in a large city. I was feeling so unwell that I couldn't advocate for myself … I feel that it is really important to be able to learn from this situation and look at ways to improve the services that [ADHB] provide in the future. I can appreciate that working in this environment is both demanding and stressful, however some standards should be maintained and even though I am not a medical person, after sustaining an injury such as I did, I would have thought that X-rays and facial examination would be standard practice."

Responses to provisional opinion

Ms A

59. Ms A was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. Where relevant, Ms A's response has been incorporated into the "information gathered" section above.

ADHB

60. ADHB provided a response to the provisional opinion. Where relevant, aspects of the response have been incorporated into the "information gathered" section above or set out below.

Dr C

61. ADHB advised that Dr C had an opportunity to review the provisional opinion and advised that he agrees with it.

Dr D

62. Dr D provided a response to the provisional opinion. Dr D detailed the changes she has made to her practice and what she has learnt from this complaint. She stated:

> "… Following the outcome of the case and the findings of the Commissioners report I would like to state I have significantly altered my practise in the area of providing medical certificates and documentation …"

Opinion: Introduction

63. Ms A had the right to services of an appropriate standard when she presented to the ED on 13 September 2015. The following sections outline my opinion on the standard of the care provided to Ms A.

Opinion: Dr C — adverse comment

64. On 13 September 2015, Dr C reviewed Ms A in ED. I have concerns about four aspects of the care provided by Dr C to Ms A.

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Incomplete examination

65. Dr C examined Ms A's cardiovascular, respiratory, abdominal, and neurological systems, which revealed no significant abnormalities except for dehydration. An ECG was done, and assessed and signed by Dr C. A urine test was ordered but a urine pregnancy test was not. My expert, emergency physician Dr Tom Jerram, advised that Dr C's examination of Ms A was appropriate except that he did not comment on the ECG in the clinical notes, and did not order a urine pregnancy test. Dr Jerram advised:

> "The ECG is a crucial test in the investigation of all syncope patients. In a small percentage, there are changes which may suggest an underlying arrhythmia as the cause of the collapse … I note an ECG was performed, and appears to have been signed. It is therefore possible that he did consider this, but it is not apparent in the clinical note. If this was the case there is no significant departure from the standard of care … Similarly, it would be standard to perform a pregnancy test in all women of childbearing age who present with syncope and/or lower abdominal pain. In a small number of cases, this can be the presenting sign of ruptured ectopic pregnancy, which is life threatening. However in this clinical context, this was unlikely. I would therefore consider this only a minor departure from the standard of care."

66. Dr C acknowledges that a urine pregnancy test should have been done when the urine sample was tested but, as Ms A had a lack of abdominal or gynaecological symptoms, he felt that it was an unlikely cause of her presentation. I accept Dr Jerram's advice in respect of the ECG and the indication for a urine pregnancy test, and I am critical that Dr C did not comment on the ECG in Ms A's clinical notes, and did not order a pregnancy test.

Missed opportunities to identify facial injury

67. The ambulance records and triage documentation clearly note that Ms A was complaining of pain to the left side of her face, and the ambulance records note a contusion on Ms A's cheek. Dr C told HDC that he read the ambulance and triage documentation "too quickly" or, from the history Ms A gave him, was too focused on the fact that she might have a head injury, and he did not pick up that there could be a possible facial injury.

68. I am critical that Dr C missed a number of opportunities to elicit that Ms A had suffered a facial injury, including through review of the ambulance and triage documentation, discussion with Ms A, and examination of Ms A. This information was crucial to ensuring that Dr C was able to provide Ms A with appropriate care. Dr C has accepted that he made an error in his assessment.

No thumb injury follow-up

69. Ms A injured her thumb when she fell. Dr C assessed Ms A's thumb as having a full range of movement and no swelling. Dr Jerram advised that these observations made a fracture unlikely. However, he advised that it would have been helpful if Dr C had commented on the presence or absence of any focal tenderness.

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70. Ms A's discharge summary advised her to seek medical attention if she was not improving over the next few days. Although this was appropriate advice, the discharge summary did not suggest a review of Ms A's thumb injury. Dr Jerram advised that Dr C's failure to suggest follow-up or consider splinting for Ms A's thumb injury for a short time was a minor departure from the standard of care.

71. I accept Dr Jerram's advice. I am critical that Dr C did not cover focal tenderness, and that he did not suggest follow-up or consider splinting for Ms A's thumb injury.

Lack of consultation with an SMO

72. ADHB told HDC that all patients seen by a house officer must be discussed with an SMO before being discharged. This is detailed in the electronic ED orientation handbook, and explained at the compulsory orientation session at the start of each house officer's three-month run. Dr C acknowledges that he should have discussed Ms A's case with an SMO prior to discharging her.

73. I am concerned that Dr C did not discuss Ms A's presentation with an SMO before discharging her. This requirement is an important safeguard for patients who are being reviewed by junior doctors. By bypassing this requirement, Dr C did not ensure that Ms A received input from a senior doctor about her care and treatment. Dr C said that he now ensures that he discusses a patient's case with the on-call consultant/senior staff member if the patient is to be discharged.

Opinion: Auckland District Health Board

First presentation to ED on 13 September 2015 — other comment

74. On 13 September 2015, Ms A presented to the ED. Ms A was triaged by a triage nurse and was examined by Dr C.

75. As noted above, there were deficiencies in the care provided to Ms A by Dr C, who then discharged her without discussing her presentation with an SMO. The requirement to do this is detailed in the electronic ED orientation handbook, and explained at the compulsory orientation session at the start of each house officer's three-month run. Dr C acknowledges that he should have discussed Ms A's case with an SMO prior to discharging her.

76. In my view, the deficiencies in Dr C's care were individual clinical errors in decision-making. ADHB had a process in place to ensure that patients who are reviewed by house officers have senior doctor input prior to being discharged. This process acts as an important safety net for patients and junior doctors. Dr C did not follow this. I am not critical of ADHB in this regard.

77. Since this event, ADHB has taken the following action:

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a) On 13 October 2015, a consultant undertook an education session on facial fractures, for the resident medical officers.

b) From 14 December 2015, ED has had an SMO on nightshift at weekends, to improve clinical safety.

c) In February 2016, Ms A's care was reviewed formally at the Morbidity and Mortality meeting, to share learnings and prevent errors in the future.

d) In December 2016, a new mentoring programme was introduced to assist junior staff to adjust to work in ED better.

e) ADHB is reviewing its triage process to ensure that it is not bypassed under any circumstances. Teaching sessions will take place for all triage and clerical staff.

78. I consider the changes made by ADHB to be appropriate.

Failure to triage Ms A on 13 September 2015 — breach

79. On the evening of 13 September 2015, Ms A re-presented to the ED.

80. Ms A told HDC that she had remained unwell following her discharge earlier that day. Ms A had a video call with her mother after returning home. Mrs F told HDC that Ms A looked really unwell, and that she told her to go back to hospital to be reviewed.

81. At 5.54pm, Ms A wrote a Facebook Messenger message to Ms H, saying, "Could someone please come see me I need help. Ive gone backward[.]" Ms H said that she went to see Ms A and that Ms A looked terrible, and was pale, clammy, and "coherent but not by much". Ms H told HDC that she took Ms A back to ED, as Ms A was getting worse.

82. Ms G told HDC that she went with Ms A to ED as Ms A had been complaining of being in a lot of pain.

83. There was some uncertainty raised by ADHB as to the reason for Ms A's re-presentation to ED. ADHB suggested that Ms A re-presented solely for the purpose of obtaining a medical certificate, but stated that, even had that been the reason for Ms A's re-presentation, she should have been triaged.

84. Ms A told HDC that she returned to ED in the evening because she wanted to be "looked at again". Ms A said that she explained to someone at the front desk in ED that she had no feeling in her face, and blood coming from her nose, and requested an X-ray of her face. Ms A said she was advised that ED was very busy, that she should take paracetamol and not come back unless she started vomiting multiple times, and that all they could do for her was give her IV fluids. Ms A then asked for a medical certificate. Due to a lack of documentation by ADHB staff, there is no other evidence of the conversation between Ms A and the ADHB staff member.

85. There are no notes in Ms A's clinical record about her re-presentation, other than that a medical certificate was issued by Dr D. Dr D did not review Ms A, and told HDC

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that she was approached by a triage nurse, who asked if she would provide a medical certificate for a patient who had been discharged earlier in the day.

86. On balance I am satisfied that Ms A was unwell and that, given her evidence and the evidence of Mrs F, Ms G, and Ms H, Ms A presented as such. On the basis of the information available, I am unable to make a finding as to whether Ms A specifically asked for a review, but I am satisfied that Ms A did not re-present solely for the purpose of obtaining a medical certificate.

87. I note ADHB's suggestion in response to the provisional opinion that the information from Ms A and her friends contained in this report "suggests that the triage nurse started the triage process", but that this was "not completed/captured by the IT system". However, while I am satisfied that there was a conversation between Ms A and an ADHB staff member, including about Ms A's ongoing concerns and how busy ED was, I remain of the view that triage was not completed during this presentation.

88. Dr Jerram advised that, in general, he would expect any presentation to an ED to go through a formal triage process and generate appropriate documentation, even if only seeking a medical certificate. Dr Jerram advised further that if Ms A appeared to be in pain or was distressed, and was not offered a medical review, he would consider this to be a moderate departure from the accepted standard of care. Dr Jerram also said that he would consider it a significant departure if Ms A asked for a medical review and was not triaged formally.

89. In my view, regardless of whether or not Ms A told the ADHB staff member that she wanted an X-ray, medical review, or medical certificate, it is clear that she should have been triaged.

90. Ms A re-presented within 24 hours at a time when she was unwell. Despite the involvement of a triage nurse in Ms A's re-presentation (as evidenced by Dr D's statement), no notes were made and no triage was completed. I find it unacceptable that Ms A was not triaged when she re-presented to ED on 13 September 2015. Accordingly, in my view, ADHB did not provide Ms A with services with reasonable care and skill, and breached Right 4(1) of the Code.

91. I am also critical that there is no record of Ms A's visit except for the medical certificate that was issued, and that ADHB is not able to identify the ADHB staff member who spoke with Ms A.

Medical certificate — other comment

92. On 13 September 2015, Dr D issued a medical certificate for Ms A. Dr D did not review Ms A, and provided the certificate on the basis of the clinical notes from Ms A's presentation earlier in the day. ADHB told HDC that Dr D should have had some face-to-face contact with Ms A before issuing the medical certificate, and should have documented this contact in Ms A's clinical notes.

93. Although not specifically stated as a requirement in the Medical Council of New Zealand's statement on medical certification dated 13 September 2013, in my view,

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and as noted by ADHB, it is important that, prior to a medical certificate being issued, there is some form of direct contact with the patient (where possible), and that this is documented in the patient's clinical notes.

Recommendations

94. I recommend that Dr C provide a written apology to Ms A. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

95. I recommend that Auckland District Health Board:

a) Provide an update to HDC on the implementation of its mentoring programme for junior staff, introduced in December 2016. The update should be sent to HDC within three weeks of the date of this report.

b) Report to HDC on its review of the Emergency Department triage process, within three weeks of the date of this report.

c) Provide evidence to HDC of the triage process training sessions provided to triage and clerical staff. The update should be sent to HDC within three weeks of the date of this report.

d) Provide a written apology to Ms A. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

Follow-up actions

96. A copy of this report with details identifying the parties removed, except Auckland District Health Board and the expert who advised on this case, will be sent to the Royal New Zealand College of Urgent Care, the Australasian College for Emergency Medicine, and TAS, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from emergency medicine specialist Dr Tom Jerram:

"I have been asked to give an opinion on the care provided, including the following issues:

1. Please comment on [Dr C's] assessment and treatment of [Ms A's] presentation, and whether due consideration of the facial injuries were undertaken. Specifically do you believe an X-ray/CT of the facial injuries were warranted?
2. Please comment on the adequacy of supervision of House Officer [Dr C]. Please comment on whether [Ms A] should have been reviewed by a more senior doctor before being discharged?
3. Please comment on the quality of the documentation of [Ms A's] presentation?
4. When [Ms A] presented to [the hospital] for a second time, do you believe a formal assessment should have occurred, and whether a review by a more senior clinician should have taken place?
5. Do you have any other comments on the overall management of [Ms A] by [the hospital]?

Case summary

[Ms A] presented to [the] ED at 0350 on 13 September 2015. She had been suffering from an influenza like illness for 4 days, and had a syncopal (fainting) episode at her university hall of residence, where she fell and hit her head. An ambulance was subsequently called. The ambulance documentation notes that she had 2 unwitnessed syncopal events, hitting her left cheekbone on the corner of a desk. She complained of feeling unwell and pain in the face. They also noted a contusion to her left cheek bone. She was noted to be febrile, tachycardic (fast heart rate), and mildly tachypnoeic (fast breathing rate), with a normal blood pressure. She was transported to [the] Emergency Department. She was triaged to ATS category 3, and moved to an acute area in the department. The initial nursing note was timed 0405, and makes note of the 2 syncopal events and fever. Note was also made of left sided facial pain and right sided thumb pain, with a plan for X ray. At that point she was still febrile and tachycardic, but had a normal respiratory rate and blood pressure.

She was seen by [Dr C] (an ED Senior House Officer), with his note timed 0443.

He makes note of a 4 day history of fevers and productive cough for 4 days. He then describes the 2 syncopal events, noting that she hit the left side of her head on a brick wall during the second event. He describes a mild headache on the left side, but makes no note of facial pain or bruising/tenderness.

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His examination describes a fever, but otherwise normal vital signs. There is no documentation of any examination of the head and face other than the comment that there is no haemotympanum (blood behind the eardrum, which may be associated with a skull fracture). He also notes that the right thumb has no swelling with a full range of movement.

His impression was of a viral illness, dehydration, and syncope secondary to this. The plan was further intravenous fluids, with likely discharge if feeling better. Some blood tests were done and commented on (they were essentially normal other than a mild raise in the neutrophils, which is non specific), and an ECG was also done, but not commented on in the clinical notes (it is essentially normal other than a slightly fast heart rate).

[Dr C] documents a review following 2 bags of intravenous fluid. At this point her observations were normal, with her fever having normalised. She was apparently feeling much better, and he makes note of an RA at her hostel who can pick her up and look after her.

He makes a plan to discharge with paracetamol/ibuprofen, with clear return precautions documented for her febrile illness. There is no follow up plan or return criteria documented for the facial and thumb injuries. According to [Ms A's] complaint letter, she complained of facial numbness, and repeatedly asked for an x ray of her face and thumb. She was discharged at 0803 am.

[Ms A] subsequently returned to [the] ED at 1700 on the same day. According to her complaint letter, she was complaining of facial pain and bleeding from her nose. She appears to have been discharged with a medical certificate. There is no documentation of triage or any assessment for this visit. According to the reply from ADHB, the medical officer who issued the certificate, Dr D, was under the impression that [Ms A] had re-presented to the department with the sole purpose of obtaining a medical certificate, and not seeking medical review. The medical certificate was completed on the basis of the earlier clinical notes.

In answer to your specific questions

1. Please comment on [Dr C's] assessment and treatment of [Ms A's] presentation, and whether due consideration of the facial injuries were undertaken. Specifically do you believe an X-ray/CT of the facial injuries were warranted?

I will divide my advice on this question into 2 parts.

a) [Dr C] appears to have displayed reasonable care and diligence in assessing and managing the primary presenting complaint of syncope and Influenza-like illness. He documents a good history of the presenting complaint, with relevant negative findings. The examination also appears appropriate. He ordered relevant blood tests. All of which would be standard in a New Zealand Emergency Department. He comes to a reasonable conclusion of 'viral illness,

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dehydration, and syncope secondary to above'. Of note however, he does not appear to consider other significant causes of syncope in this differential. In particular, there is no comment on the ECG (heart tracing), and no urine pregnancy test. The ECG is a crucial test in the investigation of all syncope patients. In a small percentage, there are changes which may suggest an underlying arrhythmia as the cause of the collapse. I note an ECG was performed, and appears to have been signed. It is therefore possible that he did consider this, but it is not apparent in the clinical note. If this was the case there is no significant departure from the standard of care. If the ECG was not considered, it would be a moderate departure. Similarly, it would be standard to perform a pregnancy test in all women of childbearing age who present with syncope and/or lower abdominal pain. In a small number of cases, this can be the presenting sign of ruptured ectopic pregnancy, which is life threatening. However in this clinical context, this was unlikely. I would therefore consider this only a minor departure from the standard of care. [Dr C] prescribed 2 litres of intravenous fluids, and made a plan to review [Ms A] after this. He documented a clinical review in which she had improved significantly following the fluids. At this stage her vital signs were normal. He also noted that she had a safe place of discharge. He documented clear action specific follow up instructions, and prescribed appropriate antipyretics/analgesics. All of this is evidence of good clinical care.

b) On the specific issue of [Ms A's] facial and thumb injuries, [Dr C] appears to have fallen below the standard of care. Both the ambulance note and nursing triage note comment on the facial trauma, with bruising noted. [Dr C] makes no comment on this in his notes. The nursing note also mentions the thumb injury, and suggests that an X-ray is indicated. The only mention of the thumb by [Dr C] is that it is not swollen and has a full range of movement. He makes no note of the facial injury. [Ms A] makes note in her complaint letter that she asked for facial X rays on several occasions. She notes that she was experiencing facial numbness, which would be a strong indicator of a fracture in the setting of facial trauma. She mentions that the doctor said that 'we don't want to expose you to unnecessary radiation'. This is in general a reasonable position, with increasing evidence of the potential lifetime harm associated with excessive medical imaging. However in this context it seems like a CT of the facial bones was likely to have been indicated, especially if there was numbness of the area below the eye down to the mouth (this strongly suggests an infraorbital nerve injury, which has a high association with a fracture of the eye socket). If [Dr C] had appropriately examined [Ms A], and made note of the presence or absence of any eye signs, facial numbness, or other features suggestive of a facial fracture, it may have been appropriate not to order a CT, but to discharge her with careful time and action specific follow up instructions. This is especially relevant as it is unusual to undergo immediate surgery for minimally displaced facial fractures, with delays of over a week within the standard of care. In this context a delay to CT scanning could be reasonable. As it stands however, with no documented consideration of her facial injuries, I would consider this a departure from the standard of care. Of

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note also, the fractured nose would not generally require imaging in a New Zealand Emergency Department — this is a clinical diagnosis. It does however generally require follow up with a GP or ENT surgeon (which was not organised by [Dr C]). ADHB's reply makes note of the fact that a CT was indicated, and that [Dr C] understands that he made an error in his assessment.

Despite the breach in the standard of care, it is very unlikely that the delay to diagnosis of [Ms A's] facial fractures made any significant difference to her outcome. As stated previously, a delay of a week or more before surgery is standard in New Zealand for these sorts of injuries. [Ms A] appears to have got her surgery 9 days following her injury, which is in line with this standard.

In terms of the thumb, it is unclear whether an X ray was indicated, although it is possible that it was. [Dr C] made note of a full range of movement and no swelling, which makes a fracture unlikely. Unfortunately, he does not comment on the presence or absence of any focal tenderness, which would have been helpful. There is no evidence in the documentation available to me that [Ms A] has subsequently had an X ray, and the most likely diagnosis is of a ligamentous injury of her thumb. These injuries can however be significantly disabling in the short to medium term, and follow up for this plus or minus splinting would have been appropriate. I would consider this a minor departure from the standard of care.

2. Please comment on the adequacy of supervision of House Officer [Dr C]. Please comment on whether [Ms A] should have been reviewed by a more senior doctor before being discharged?

Ideally this would be the case with all Emergency Department patients, although it is not the standard of care in New Zealand. There is a significant resource requirement involved in getting a senior Doctor to physically review all patients before discharge, and this is not feasible in most New Zealand EDs. In particular, it would not be standard to have an SMO available to review patients from midnight to 0800 in a New Zealand ED. I note ADHB have subsequently made a move to having a SMO physically in the department for this overnight shift. Even in this context, it would be unlikely that they are well enough resourced that this SMO could physically review each patient, as this would require them to take on a minimal or no patient load of their own. I note that [Dr C] had apparently discussed all of his patients with the senior doctor on that night, which is appropriate. This verbal discussion will often miss significant findings (such as [Ms A's] facial fracture) however, as the onus is on the junior doctor to mention the relevant issues. Emergency Medicine is a high risk specialty, and under current financial and resource constraints in New Zealand, errors of this type are not uncommon and highly likely to continue.

3. Please comment on the quality of the documentation of [Ms A's] presentation?

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As commented on above, the documentation is in general of a reasonable standard. The exception is the absence of any documentation pertaining to her facial injury

4. When [Ms A] presented to [the hospital] for a second time, do you believe a formal assessment should have occurred, and whether a review by a more senior clinician should have taken place?

The circumstances around this second presentation are a little unclear. In [Ms A's] complaint letter, she seems to have been under the impression that she had presented for a full review of her ongoing symptoms. According to the ADHB however, the clinicians involved understood that she had presented with the sole purpose of obtaining a medical certificate (which they provided). Unfortunately there is no triage note or other documentation available to clarify this. In general, any presentation to an Emergency Department should result in a triage process, even if it is purportedly for a sick note or medication prescription. It is impossible for me to comment on the specific circumstances around this presentation without further information from the individuals involved, however it is likely that a formal triage should have taken place. This may have given the opportunity to pick up the previously missed fracture.

5. Do you have any other comments on the overall management of [Ms A] by [the hospital]?

As stated, the management of [Ms A] by [the hospital] was generally reasonable, with the specific exception of her facial injuries, and the possible missed opportunity to review her at her second presentation. She was provided with timely fluid management and analgesia, was reviewed prior to discharge, and was discharged to a place of safety with return instructions. It is unfortunate that her facial injuries were missed at her initial presentation, and I appreciate that this caused her significant distress. However I feel it is very unlikely that it had any significant impact on her final outcome. Emergency Medicine is a specialty that is inherently risky, and it would be very difficult to eliminate all errors such as those in [Ms A's] case. The workforce in New Zealand Emergency Departments is reliant on junior doctors such as [Dr C], and physical review of all patients by a senior doctor is seldom feasible (although it is desirable). It appears that [Dr C] has learned from his error, and ADHB appears to have made a number of laudable process changes to minimise the possibility of a similar error in the future."

Further advice

The following further advice was obtained from Dr Jerram:

"You have asked me for further clarification of my opinion on 2 points as follows:

1- 'In point one (b) you state in regards to [Ms A's] facial injury:

In this context it seems like a CT of the facial bones was likely to have been indicated. If [Dr C] had appropriately examined [Ms A], and made note of the presence or absence of any eye signs, facial numbness, or other features

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> *suggestive of a facial fracture, it may have been appropriate not to order a CT ... as it stands however, with no documented consideration of her facial injuries, I would consider this a departure from the standard of care.*

You then state in regards to [Ms A's] hand injury

> *in terms of the thumb, it is unclear whether an X-ray was indicated, although it is possible that it was. [Dr C] made note of a full range of movement and no swelling, which makes a fracture unlikely. There is no evidence in the documentation available to me that [Ms A] has subsequently had an X-ray, and the most likely diagnosis is ligamentous injury of her thumb. These injuries can however be significantly disabling in the short to medium term, and follow up plus or minus splinting would have been appropriate. I would consider this a minor departure from the standard of care.*

Please could you clarify if the minor departure is referring to the hand injury only or both the hand and facial injuries?

If the minor departure is related to the hand injury only please could you clarify the level of departure which you have referred to relating to the facial injury.'

2- 'Finally in point four, you conclude by saying that [Ms A's] second presentation to the Emergency Department '*may have missed the opportunity to pick up the previously missed fracture*'.

Please could you comment on whether you consider this a departure from the standard of care and if so, how significant a departure do you consider it is?'

Response

1- The minor departure from the standard of care relates to the thumb injury. I would consider the failure to properly examine and document the facial injuries, and at least consider imaging, to be a moderate departure from the standard of care.

2- It is very difficult to comment on this presentation due to the lack of documentation available. In general, I would expect any presentation to an Emergency Department to go through a formal triage process and generate appropriate documentation, even if only seeking a medical certificate. It would be helpful to hear from [Ms A] as to exactly what her expectations were of this visit, and how clear she made these to the triage staff. If she simply asked for a medical certificate and made it clear that she did not want a medical review, I would consider it at most a minor departure from the standard of care. If she did not specifically ask for medical review, but did not have review offered (especially if she appeared in pain or was distressed), I would consider it a moderate departure. If she did ask for a medical review and did not get triaged formally then I would consider it a significant departure."

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