Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Complaint

The Health and Disability Commissioner received a complaint from the complainant (child's mother) concerning the care and treatment provided to her son from a Hospital and Health service in September 1998. The complaint is that:

- *At the end of September 1998 at a Hospital Accident and Emergency Department, the* [house surgeon] *incorrectly diagnosed the* [the child's] *fractured shoulder as a pulled muscle.*
- *At the end of September 1998 the* [casualty officer] *advised an Emergency Department staff nurse that he would not examine* [the child] *when he presented at the Emergency Department with his mother, suffering from a sore arm and shoulder.*
- *At the end of September 1998 when the* [complainant] *and her son returned to the Accident and Emergency Department seeking a review of the diagnosis,* [the staff nurse] *advised them that* [the son] *did not need to be seen again. In addition,* [the staff nurse] *advised* [the complainant] *that* her [son's] *notes had not been reviewed and that they were to let the injury settle for a week.*

Investigation Process

The complaint was received by telephone at the end of September 1998 and an investigation was undertaken in early November 1998. Information was obtained from:

Complainant
House Surgeon / Provider
Staff Nurse / Provider
Casualty Officer / Provider
Quality Manager, Hospital and Health Services

Relevant medical and clinical records and documents were obtained from the Hospital and Health Services. Advice was obtained from an independent emergency medicine specialist.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

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Information Gathered During Investigation

The consumer was born in early August 1992 and was six years old at the time of the incident. The consumer is partially deaf and not able to communicate clearly. According to his mother, the consumer has a high tolerance to pain. On Monday towards the end of September 1998 the consumer fell on his right side while playing at his grandmother's home. Following this, the consumer was holding his right forearm up and not using it much.

Late of September 1998: Monday

General practitioner consultation

At about 11am in late September 1998, the consumer's father took him to the emergency doctor, at the town's Medical Centre. The emergency doctor referred his son to the Accident and Emergency Department at a Hospital for an x-ray of his shoulder. The referral letter dated late September 1998 stated:

> "*Thanks for seeing this lad for XR* [x-ray] *R* [right] *humerus following a fall at grandmother's last night.*"

Accident and Emergency Department consultation

The consumer's father took his son to the Accident and Emergency Department at a Hospital. A second year house surgeon, took a history and examined him. The house surgeon documented in the medical notes that the child had been playing with his brother at his grandmother's place and had fallen on his right side. The house surgeon noted that on palpation, the child had no tenderness on his hand, forearm, elbow, humerus or shoulder.

The house surgeon advised:

> "*During the consultation* [the child] *sat quietly on the bed and held his whole right upper limb still. He reported (by indicating with his left hand) pain from around the shoulder, down his arm, forearm, wrist and hand. … He had minimal tenderness on passive movement but reported vague tenderness across his shoulder, humerus and elbow on active movement. There was no neurological or vascular impairment ….*

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Information Gathered During Investigation *continued*

> *My impression was that* [the child] *had suffered a sprained muscle, which I discussed with his father. I explained that given the non specificity of the pain a sprain was likely as in the case of fractures pain was normally specific and localised. I also explained that to investigate further, would require x-rays from the neck to the hand because there was no specific site of injury. I also informed him that he should either bring* [the child] *back to the department or go to his GP if the pain did not settle.* [The child's] *father was happy with this.*"

The child was given Paracetamol for pain relief then discharged home. The house surgeon documented the discharge plan in the clinical notes for the consumer, stating: "*Plan – discharge. If doesn't settle by weekend come back or* [see] *GP*." The house surgeon had no further involvement in the child's care following the consultation at the end of September 1998.

Late September 1998: Tuesday

Accident and Emergency Department Consultation

The complainant took her son back to the Accident and Emergency Department at a Hospital towards the end of September 1998, where she asked to see a doctor. The child's pain had increased overnight, and although he had been seen playing happily, he appeared to be unable to use his right arm. The complainant and her son were directed into the treatment room. The complainant was then seen by the staff nurse and triage nurse, and asked to wait in cubicle five in the treatment room.

Discussion between Nurse and Casualty Officer

The staff nurse advised that she then spoke with the casualty officer concerning the consumer and gave him the child's notes from the previous day. The staff nurse advised that the casualty officer declined to see the consumer. She stated that the Emergency Department was not busy at that time.

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Opinion - Case 98HDC18186

Information Gathered During Investigation *continued*

The casualty officer confirmed that at the end of September 1998 he was presented with the child's notes and asked by the staff nurse if the the child should be seen. The casualty officer noted that the child had been examined by two doctors on the previous day and advised:

> "*Neither* [doctor] *deemed necessary to ask for an x-ray. It was documented that he had tenderness and bruising about the upper arm and shoulder. I advised the staff nurse that he should be seen by his own GP (who worked quite close to the hospital). …*
>
> *The child was subsequently seen by his GP, sent back to the hospital the following day for an x-ray that revealed a minor fracture which was treated appropriately by myself.*"

No notes of this discussion were documented by the casualty officer. In his response to the provisional opinion, the casualty officer stated:

> *"I was informed by the triage nurse; the staff nurse that this child had presented for review and that he seemed to be in no particular distress. I looked at the notes and felt that the child should be reviewed at the G.Ps' (ie someone known to the family). This was done, the x-ray was ordered and the diagnosis established."*

Further he explained:

> *"What I was not told by the triage nurse was that* [the child's mother] *was very upset to the point of being distraught and angry on her presentations at the end of the month (prior to being told that she should attend her G.P). I feel confident that if I had known of her level of distress that I would have seen* [the consumer]*."*

Discussion between the [staff nurse], [the complainant] *and* [the child]
The staff nurse told the [complainant] that the casualty officer advised that the child did not need to be seen again, and after a week his shoulder should settle.

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Information Gathered During Investigation

The staff nurse documented:

> "[The casualty officer] *read notes and declined to see pt. … if still concerned in a couple of days to see GP.*"

The staff nurse tried to reinforce to the complainant what the house surgeon had said to the child's father the previous day; that if she was worried to see the complainant's general practitioner. However, the complainant insisted that her son needed a doctor and told the staff nurse that "*… she would feel dreadful if something was diagnosed in several days time*".

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Independent Advice to Commissioner

Late September 1998: Wednesday

Accident and Emergency Department consultation

At the end of September 1998 the complainant took her son her general practitioner, on the advice of the staff nurse. The general practitioner arranged for x-rays to be taken at a private radiology service in the town. These x-rays confirmed that the child had a fracture of the humeral neck (largest bone of the upper arm) with minor angulation (an angular shape or formation) at the fracture site of the right shoulder. The complainant was then advised to return with the child to the town's Hospital Accident and Emergency Department to have his shoulder strapped.

During the return visit to the town's Hospital, the complainant complained to the doctor who saw them that the casualty officer would not see her on Tuesday. The doctor went and spoke with the casualty officer. The complainant said she overheard the doctor asking the casualty officer to explain what sort of assessment he had performed on the child the previous day. The complainant advised that the new doctor then returned, and apologised for what had happened on that day.

The casualty officer advised in his response to the provisional opinion that:

> *"I subsequently dealt with the child at the Emergency Department, apologised to the* [mother] *for the delay in diagnosis (there was no other doctor involved on that day as contended by* [the mother]*)."*

Advice from Quality Manager

The Quality Manager at a Hospital and Health Service, advised that if a child came into the Accident and Emergency Department a house surgeon would usually speak with the consultant on call about the case. The Quality Manager advised that the house surgeon would generally order an x-ray of the child and speak with the consultant following this. She stated that this was something everyone knew to do, although this was not written down in any policy or protocol.

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Independent Advice to Commissioner ***continued***

I received the following advice from an independent emergency medicine specialist as follows:

"***Emergency Department Medical Assessment of children with arm injuries***

Orthopaedic trauma is a common cause of presentation to the Emergency Department and, as a consequence, can be the source of many problems with management. Many of these problems can be avoided if the following 10 general principles are kept in mind:

1. *Most orthopaedic injuries can be predicted by knowing the chief complaint, the age of the patient, the mechanism of injury, and an estimate of the amount of energy delivered.*
2. *A careful history and physical examination will predict x-ray findings with a high degree of accuracy.*
3. *If a fracture is suspected clinically but x-ray films appear negative, the patient should initially be treated for a fracture.*
4. *Well-defined criteria for adequate radiographic studies exist, and inadequate studies should not be accepted.*
5. *The x-ray studies should be performed before reductions, unless a delay is potentially harmful to the patient.*
6. *Neurovascular competence should be checked and recorded before and after all reductions.*
7. *Patients must be checked for the ability to ambulate safely before discharge from the ED and should not be discharged unless this can be established.*
8. *Patients should receive explicit after-care instructions before leaving the department covering such areas as monitoring for signs of neurovascular compromise, cast care, and timing and need for follow-up.*
9. *In the multiple trauma patient, non-critical orthopaedic injuries should be diagnosed and treated after other more threatening injuries have been addressed.*
10. *All orthopaedic injuries should be described precisely and according to established conventions.*

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Independent Advice to Commissioner *continued*

Medical Evaluation of a patient presenting with an injured limb or joint:
Evaluation should include a careful history of the exact sequence of events at the time of the injury, as well as ascertaining the position of the extremity and the forces applied to it at that moment; a history of any audible sounds at the time of injury should also be sought.
The clinical presentation of a patient with a sprain of the extremity may be indistinguishable from that of the patient with a fracture. The injury often occurs during a vigorous athletic activity wherein forces applied in opposite directions result in a joint being stressed in an abnormal or exaggerated direction.
Examination of the limbs and in particular the joints should then take place with the limbs and joints gently stressed to demonstrate abnormal motion. If radiographs are planned to rule out a fracture anyway or if exquisite pain is produced by mild attempts to apply stress, it is probably better to delay stressing until films have proven the absence of a significant fracture.

Plain radiography is indicated in some but not all cases to rule out a fracture. Avulsion fractures may occur concomitantly with sprains. In children, epiphyseal fractures will occur more commonly than ligamentous disruption because of the relative ligamentous strength compared with the ease of disrupting the epiphyses.
The initial survey should also note the presence or absence of pulses and the state of capillary filling. Similarly, note should be made of nerve function. Nerves can be injured by either blunt or penetrating trauma. Neurapraxia is the contusion of a nerve, with disruption of the ability to transmit impulses. Paralysis, if present, is transient, and sensory loss is slight. The results of these studies should always be recorded.

Advice to the Commissioner

1. *Was there enough information given to the* [child's] *parents in your opinion from* [the house surgeon] *and* [casualty officer]*?*

1.1 *The* [House Surgeon].

1.2 *The* [house surgeon] *reviewed* [the child] *at the end of September. In his letter dated at the end of November 1998,* the [house surgeon] *advises that he discussed his impression' with* [the child's] *father.*

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Independent Advice to Commissioner *continued*

1.3 *He states: 'My impression was that* [the child] *had suffered a sprained muscle which I discussed with his father. I explained that given the non-specificity of the pain a sprain was likely as in the case of fractures pain was normally very specific and localised. I also explained that to investigate further, would require x-rays from the neck to the hand because there was no specific site of injury. I also informed him that he should either bring* [the child] *back to the department or go to his GP if the pain did not settle.'*

1.4 [The house surgeon] *provided* [the child's father] *with his initial impression (diagnosis), his reasons for coming to his conclusion, his reasons for not wishing to pursue further investigations – that is the risk of extensive x-rays and a plan to return to the ED or to his GP if the pain did not settle. For the type of injury with which* [the child] *presented, this would be within the standard normally to be expected. It was implicit in the information presented, that* [the child's] *father could have requested further investigation on this date.*

1.5 [The Casualty Officer]

1.6 *At the end of September,* [the casualty officer] *did not see* [the complainant] *or provide her with any information.* [The Staff Nurse] *informs us that:*

1.7 *The ED was not busy.*

1.8 *That the doctors were in the general area.*

1.9 *That* [the complainant] *and* [her son] *were in the paediatric treatment cubicle.*

1.10 *That* [the casualty officer] *'… turned towards me with hands on either side of the patient's folder and as he firmly laid the notes on the bench, he said* [to the staff nurse]*, I will not see this patient".'*

1.11 *That she did not know how* [the casualty officer] *had become involved with the patient.*

1.12 *That* [the child] *appeared to be in no distress and was playing happily but appeared not to be using his right arm.*

1.13 *That she tried to be tactful and provided* [the complainant] *with the information that* [the house surgeon] *had given to* [the complainant] *the previous day.*

1.14 *That if '… she* [the complainant] *was worried she would have to see her GP'.*

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion – Case 98HDC18186, continued

Independent Advice to Commissioner *continued*

1.15 [The casualty officer], *in his letter of 19 March 1999, noted that he was '… presented with the patient notes for* [the child] *and was asked by the triage nurse if this patient should be seen.' He further notes '… he had been examined by two doctors on the previous day, neither of whom deemed it necessary to ask for an x-ray'. That: '… it was documented that he had tenderness and bruising about the upper arm and shoulder'. And, that he 'advised the staff nurse that he should be seen by his own GP'.*

1.16 [The casualty officer] *did not see* [the complainant] *or* [the child] *and therefore did not inform them of why he would not be seeing* [the child]. *According to both* [the casualty officer] *and* [the staff nurse], *he did not inform* [the staff nurse] *as to his reasons for declining to see* [the child]. *This is below the standard required as he should, at a minimum, have communicated his reasons for not reviewing a patient to the staff nurse responsible for communicating with* [the complainant] *and* [her son].

2. *Was there enough done to prevent the misdiagnosis?*
If not why not?

2.1 [The House Surgeon]

2.2 *According to the standard required (and set out in the section entitled 'Emergency Department assessment of children with injuries')* [The house surgeon] *undertook and recorded all of the necessary components of an examination including an informed history of the nature of the injury and examining the limb for pain with both passive and active motion and documenting a lack of vascular or neurological compromise.*

2.3 [The house surgeon] *at the time of reviewing* [the child], *was in the latter third of his internship year. As such, it is my opinion that* [the house surgeon] *failed to understand, due to his junior clinical status, the particular nature of injuries in children of this age group and the difficulty in distinguishing sprain injury from fracture injury without the benefit of an x-ray.* [The house surgeon], *to be prudent, should have requested the opinion of a more experienced doctor – particularly in the fact that* [the child] *was not spontaneously moving his right arm and was noted to be holding it. Guidelines should be available for very junior doctors in provincial hospitals to ensure that they consult more experienced doctors in these types of cases.*

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC/18186

Independent Advice to Commissioner *continued*

One of the performance measures for house surgeons is that they are aware of their own limitations and act accordingly. [The house surgeon]*, however, did properly and prudently advise* [the child's father] *that if the pain should persist, he should return* [the child] *to the ED or seek his GP's advice.*

2.4 [Casualty Officer].

2.5 [The casualty officer] *read* [the child's] *notes and indicated that two doctors who did not 'deem it necessary to ask for an x-ray' had seen* [the child]. *According to the information provided,* [the child's] *GP, had referred him to the ED for an x-ray of the right humerus following a fall at his grandmother's.* [The casualty officer] *chose to accept the opinion of a very junior doctor without examining* [the child] *himself or meeting with* [the complainant] *to hear her reasons for concern.*

2.6 *In my opinion* [the casualty officer] *did not provide the standard of communication with* [the complainant] *to properly diagnose* [the child's] *condition, instead deciding that he would not see* [the child].

3. *Was* [the house surgeon's] *choice of diagnosis, intervention and actions for* [the child's] *shoulder appropriate?*

3.1 [The house surgeon's] *choice of diagnosis was not correct in that he assumed that the problem was one of a sprain rather than a fracture. According to the information I have provided to the Commissioner in this report, the differentiation of a sprain injury from a fracture in a child is extremely difficult and where there may be doubt it is prudent to seek another medical opinion and to obtain an x-ray of the area involved. As such, there were not specific interventions provided to* [the child] *for management of his minimally angulated proximal metaphyseal fracture.* [The child] *was provided with paracetamol for pain, which was appropriate. The particular intervention required for* [the child's] *fracture if it had been diagnosed would have been the use of a sling and swathe applied in the ED followed by an outpatient fracture clinic review in 2 to 3 weeks. Similarly, given the fact that sprains and fractures are difficult to differentiate in children, it would have been prudent to provide a sling and swathe to assist with immobilising the limb.*

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Independent Advice to Commissioner *continued*

4. *Were the actions by* [the house surgeon] *or* [the casualty officer] *for* [the child's] *shoulder timely or should there have been earlier intervention? If so, what would this have been and when should this have occurred?*

4.1 [The house surgeon] *did not record the time of his assessment in the notes and it is therefore impossible to comment on the timeliness of his assessment.*

4.2 [The casualty officer] *did not see* [the child] *on the due day, but did see him in a timely manner on the next day following the diagnosis by an x-ray performed in private radiological rooms.*

4.3 *The diagnosis of* [the child's] *fractured humerus should have occurred during his first visit to* [the town's] *Hospital ED.*

5. *Were the actions by* [the house surgeon] *and* [the casualty officer] *in treating* [the child's] *shoulder appropriate to meet professional standards required?*

5.1 *This question has been predominantly answered under questions one and two.*

5.2 *It is accepted, that even very experienced doctors will miss the diagnosis of a fracture. For example, patients with fractures of the ankle who undergo an assessment under the 'Ottawa ankle rules' can still have a fracture on return to the ED or a GP within 10 days of the injury. The important issue is that a patient who returns for re-assessment, following the advice of a medical practitioner, should be given the benefit of the doubt and be x-rayed. It must be remembered, however, that fractures in children are difficult to separate from sprain injury and therefore, the injury should be assumed to be a fracture (or slipped epiphysis etc.) and either treated as such or confirmed by x-ray.*

5.3 [The house surgeon] *did not provide the standard of care required in that he made a disposition decision without taking the time to discuss the situation with* [the complainant] *or to re-assess* [the child]. *This is even more important given the knowledge from* [the staff nurse]*, that the ED was not particularly busy.*

6. *Was it appropriate for* [the casualty officer] *not to have seen and/or assessed* [the child] *on the due date?*

6.1 *As discussed, it was not appropriate for* [the casualty officer] *neither to have discussed the nature of* [the complainant's] *concerns with her directly or for* [the casualty officer] *to have re-assessed* [the child].

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion – Case 98HDC18186, continued

Independent Advice to Commissioner *continued*

7. *Any other issues that arise in the supporting information.*

7.1 *This case underlines the importance of a structured provision of care for patients within the hospital-based Emergency Department. First year house officers are in their pre-registration year and should be carefully mentored and supervised if they provide care to patients directly.*

They should be instructed to review patients with a more senior doctor, in particular patients in whom the diagnosis is uncertain or those in the pediatric and elderly age group or with complex problems.

7.2 *If patients return to the ED with the same problem because of a continuation of similar symptoms, an exacerbation of symptoms or even 'concern' that the problem is not resolving, it is essential that they be followed up. It is inappropriate for a patient who has been a patient with that particular problem in that ED, to be refused re-assessment without very good reasons for that refusal written in the notes.*

7.3 *It is very important for doctors and nurses to learn to 'listen' to patients and their family members. The most important component of diagnosis and patient –clinical interaction, is the taking of a very good history. This includes 'active listening' 'communication' and 'dialogue' with the patient and/or family member. In* [the child's] *case, at the age of 6 years, he was able to provide a good history of the nature of his injury to* [the house surgeon] *could, similarly, have provided* [the casualty officer] *with information of his subsequent problems (pain, sore arm etc.). Similarly, mothers and fathers are very much aware of when 'something' is wrong with their children. If a parent says there is something wrong, a prudent and careful clinician will listen to this and will re-assess their diagnosis.*

7.4 *Evidence informs us that in an ED environment, that only about 30% of diagnoses are absolutely accurate in the first instance. This means there is a graduation of accuracy over the latter 70%. A prudent Emergency Department doctor therefore would re-assess any patient returning to the ED with ongoing problems from a previous complaint.*

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Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Independent Advice to Commissioner *continued*

Conclusion

It is important to note that the issues involved in this complaint are twofold:

The inaccuracy of the initial diagnosis – as mentioned this occurs frequently in an acute ED setting and this requires understanding by all nursing and medical practitioners. One of the important factors is that a prudent clinician will expect the worst and provide information to the patient to return if there are any problems or might even place them under observation to better improve the accuracy of the diagnosis. Also, in many instances, the treatment provided can meet the standard of both types of conditions. In this case immobilising the limb using a sling and swathe would have been a prudent therapy for both a sprain and a fracture of the metaphysis of the humerus.

2. *The lack of communication, by* [the casualty officer]*, with* [the complainant] *– as* [the complainant] *has indicated: 'Providers should listen more to people/mothers.' She is tired of not being listened to, she knew something was wrong but this was dismissed. The duty of care clinicians owe to patients involves listening to their concerns, providing careful assessment, making sure that both parties understand the nature of the problem, the care required and the plan for further management and that this is all verbally communicated as well as written in the documentation in order to assist future providers.*"

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

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Other Relevant Standards

The town's Hospital Emergency Department protocol dated January 1996 states:

> "*Emergency department treats all accident patients who report for treatment within 24 - 48 hours of the accident happening ... Emergency department treats all medical patients sent in by their G.P. Patient usually has referral letter with them and G.P. has rung the treatment room ahead ... If any doubt at all about patients' eligibility for treatment, you must check with treatment room staff.* ***NO PATIENT IS TO BE REFUSED TREATMENT UNLESS ON INSTRUCTIONS FROM TREATMENT ROOM STAFF****.*"

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion – Case 98HDC18186, continued

Other Relevant Standards *continued*

New Zealand Medical Association 'Code of Ethics'

Responsibilities to the Patient:
Standard of Care -

"*3. Ensure that every patient receives a complete and thorough examination into their complaint or condition.*
…

4. Ensure that accurate records of fact are kept.
…

Patient's Right -
9. Recognise one's professional limitations and, when indicated, recommend to the patient that additional opinions and services be obtained."

The Medical Council of New Zealand, 'Medical Practice in New Zealand: A Guide to Doctors Entering Practice' (1995)

13. THE PATIENT'S MEDICAL RECORD

13.1 "*[A] doctor is expected as part of the quality of service provisions to maintain adequate records.*"
13.2 "*... the absence of some written, possibly computer, record or annotation invariably makes the task of establishing the truth very difficult.*"

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion – Case 98HDC18186, continued

Response to Provisional Opinion

The casualty officer provided the following response to my provisional opinion:

In response to your invite to comment on your provisional opinion, I believe that this complaint has arisen because of some difficulties in the area of triage and follow-up in the Emergency Department at [the town's] *Hospital.*

…

I accept that there is policy in the Emergency Department that everyone who presents is seen and assessed, but this does not necessarily hold for follow-ups, and a decision had been made within the department to attempt to reduce the burgeoning numbers of attendances at the Emergency Department for minor complaints, particularly follow-ups. I believe that seeing three different doctors in three days is not a particularly good way to practise medicine and that a G.P. known to the family is in a much better position to provide primary care, particularly when we are well aware of the common scenario of child abuse victims presenting to multiple doctor ie locums and Emergency Departments.

…

I believe that her handling of this triage situation was far from satisfactory and [the triage nurse] *certainly didn't make me fully aware of the situation.*

I accept that I failed to document my reasons for not seeing [the child] *on the due date, and have subsequently reviewed my practice in this area accordingly.*

The casualty officer submitted an apology to the complainants with his response to my provisional opinion.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion – Case 98HDC18186, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights apply 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.*

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Opinion: No Breach Staff Nurse

Right 4(1)

In my opinion the staff nurse did not breach Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

The town's Hospital Emergency Department protocol at the time of this incident stated that patients should not be refused treatment except on instructions from treatment room staff. The staff nurse approached the casualty officer and requested that he see the child, but he declined to do so. It may be that, as suggested by the casualty officer, the staff nurse failed to make it sufficiently clear that the child's mother was very upset and insistent that the child be seen. However, the staff nurse was not in a position to require medical assessment of the child. Accordingly, the staff nurse informed the child and the child's mother that the casualty officer considered that the child did not need to be seen and that if the child's pain persisted, they should consult the child's general practitioner. The staff nurse recorded her concerns about the decision.

In my opinion, the staff nurse acted with reasonable care and skill and did not breach Right 4(1) of the Code.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Opinion: Breach House Surgeon

Right 4(1)

In my opinion the house surgeon breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights by failing to seek another medical opinion and/or obtaining an x-ray.

The child's general practitioner had referred the child to the Accident and Emergency Department for an x-ray. The house surgeon's assessment of the injury differed from that of the general practitioner. The house surgeon took into account the presenting history of the child's injury, examined the limb for pain and for a range of motion, and found that there was no compromise of the child's shoulder. My independent advisor indicated that there is a degree of difficulty in distinguishing a sprain injury from a fracture injury without the benefit of an x-ray and that it is prudent to seek another medical opinion and to obtain an x-ray of the area involved. While I accept that experienced doctors will miss the diagnosis of a fracture in a child, I agree with my advisor that an injury in a child should be generally assumed to be a fracture and treated as such, or confirmed by x-ray. I further note that my independent advisor commented that it would have been prudent for the house surgeon to place the child's arm in a sling and swathe.

Junior doctors, such as the house surgeon, are required to be aware of their professional limitations. I am informed that protocols were in place in 1998 advising house surgeons to ask for help if they had any doubts with orthopaedic cases. Given his limited clinical experience, it would have been prudent for the house surgeon to have consulted a more experienced clinician and obtained an x-ray to this case.

In my opinion, the house surgeon failed to provide the child with services with reasonable care and skill and accordingly breached Right 4(1) of the Code.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Opinion: Breach **Right 4(1)**

The Casualty Officer

Assessing [the child]
In my opinion, the casualty officer breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights by failing to adequately assess and follow up the child when he returned to the town's Hospital Accident and Emergency Department.

If a patient returns to the Emergency Department with the same or continuation of similar problems or an exacerbation of symptoms or a concern that the problem is not resolving, it is essential that they be followed up adequately. I agree with the complainant's statement that *"providers should listen more to people/mothers"*. It is indeed very important for doctors and nurses to "listen" to patients and their families. If a parent says there is something wrong, this should be carefully heeded, not dismissed. As noted by my expert advisor:

> "*The duty of care clinicians owe to patients involves listening to their concerns, providing careful assessment, making sure that both parties understand the nature of the problem, the care required and plan for the further management and that is all verbally communicated as well as written in the documentation in order to assist future providers*."

I accept that the triage nurse, may not have made it sufficiently clear to the casualty officer that the child's mother was very upset and insistent that the child be seen. However, it is significant to note that the child returned for re-assessment following the documented advice of the house surgeon. The casualty officer read the medical notes, which included the advice "*if doesn't settle by weekend come back or* [see] *GP*". It would have been reasonable for the casualty officer to have seen the child, since the Emergency Department was not busy at that time. Despite this, the casualty officer determined not to do so and advised the staff nurse to advise the child and the child's mother of this.

In my opinion, the casualty officer's actions were below the standard expected of a casualty officer. In refusing to assess the child when he presented a second time, the casualty officer breached Right 4(1) of the Code.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Opinion: Breach The Casualty Officer *continued*

Right 4(2)

Documentation

The New Zealand Medical Association 'Code of Ethics' notes under 'Responsibilities to the Patient' that medical practitioners should keep accurate records of fact. In this case, the casualty officer, did not make any written record of his management of the child. The casualty officer, as a medical practitioner, had a duty to keep good records. As a result of his failure to do so, the task of establishing the truth is now very difficult for the casualty officer. I concur with my advisor that the casualty officer needed to document very good reasons for his refusal to see the child.

Accurately recording the doctor's assessment of a patient assists subsequent health providers. Medical records should be documented fully and accurately so that other providers are also able to ensure quality and continuity of care for a patient.

In my opinion, the casualty officer should at a minimum have recorded the reasons for not seeing the child. In failing to document any notes on the child's second presentation to the Emergency Department, the casualty officer breached Right 4(2) of the Code.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Opinion: No Breach The Public Hospital

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing which breached the Code.

The town's Hospital Emergency Department protocol dated January 1996 stated that "*no patient was to be refused treatment unless on instruction from treatment room staff*". The Hospital and Health Service cannot reasonably be expected to be responsible for the way in which individual members of their medical staff apply this directive, unless management had reason to be aware that it was not being complied with.

In my opinion, the Hospital and Health Service is not vicariously liable for the house surgeon's or casualty officer's breaches of the Code.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Actions

The House Surgeon

I recommend that the house surgeon take the following actions:

- Apologises to the child's parents for his breach of the Code. The apology is to be sent to my Office and will be forwarded to the child's parents.
- Reviews his practice in light of this report.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

Opinion - Case 98HDC18186

Actions

The Casualty Officer

I recommend that the casualty officer take the following actions:

- Reviews his practice in light of this report.

- Ensures that he clearly documents all examinations, treatment plans and follow-up details for patient consultations. In circumstances where he declines to see a patient, this should be clearly documented, with reasons.

Staff Nurse / House Surgeon / Casualty Officer / Hospital and Health Service

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Other Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand and to the Nursing Council of New Zealand.

- A copy of this opinion with identifying features removed will be sent to the Australasian College of Emergency Medicine and the Royal Australasian College of Surgeons, for educational purposes.