Standard of care provided at an emergency department (11HDC01077, 31 March 2014)

Emergency department ~ Hospital ~ District health board ~ Fall ~ Chest and shoulder injuries ~ Competence ~ Assessment ~ Documentation ~ Discharge ~ Rights 4(1), 4(2), 4(5)

A woman complained about the standard of care provided to her husband at the emergency department of a hospital.

At approximately 10.30pm one evening the man had fallen about two metres onto concrete and had injured his left chest and shoulder. The man was taken by ambulance to the emergency department, where he was reviewed by a medical officer of a special scale (MOSS). The MOSS noted that the man was alert but in pain, his abdomen was tender on examination, and his lungs were clear. Results from laboratory tests and an abdominal X-ray were unremarkable, and a chest X-ray was interpreted as not showing any rib fractures or pneumothorax, although the result was noted to be suboptimal. The MOSS diagnosed the man with a left chest and abdominal wall contusion and, having prescribed him pain relief medication, cleared him for discharge at 1.50am. As the man was unable to arrange transport at that time, he remained in the emergency department, where nursing staff continued to monitor him.

At 6.30am nursing staff contacted the MOSS after it was noted that the man was hypotensive and had an obvious step-off in his left acromioclavicular joint. The MOSS charted further pain relief medication and IV fluids, and advised the man that he should follow up with his GP for his shoulder injury. At 8am a shift change took place. At the request of the nursing staff, the oncoming senior medical officer (SMO) prescribed the man with further pain relief medication and IV fluids, on the understanding that the man would again be reviewed by the MOSS. At handover, the MOSS advised the SMO that the man was for discharge, which occurred at 9.50am.

Eight days later the man was diagnosed with left-sided rib fractures with possible effusion at the left lung base, and possible underlying lung consolidation.

It was held that the MOSS's clinical reviews of the man at 12.45am and 7am were poor, and did not fully take account of his history and clinical presentation. In addition, the MOSS's handover to the SMO was inadequate. The MOSS failed to provide services to the man with reasonable care and skill, in breach of Right 4(1). The MOSS's clinical documentation was also inadequate, in breach of Right 4(2).

The SMO was not found in breach of the Code. However, it was recommended that, when the SMO provides treatment to a patient under another clinician's care, they should communicate that treatment to the responsible clinician. It was also recommended that the SMO reflect on the importance of ensuring the provision of relevant patient information at handover.

The DHB is responsible for ensuring that patients receive care that complies with the Code. The DHB failed to take adequate steps to ensure that the MOSS was competent to perform the services for which they were employed. Therefore, the DHB failed to ensure that the man was provided with services with reasonable care and skill and, accordingly, breached Right 4(1). In addition, the pattern of suboptimal clinical documentation by multiple staff members compromised the continuity of care provided to the man, in breach of Right 4(5).