Care of patient with a complex medical history (15HDC00111, 30 June 2016)

District health board ~ Public Hospital ~ Mental health ~ Cardiology ~ Cardiac arrhythmia ~ Test results ~ Right 4(1) ~ Right 4(5) ~ Right 4(2)

A man had a complex medical history including cardiac issues and a strong family history of myocardial infarction (heart attack). He presented to the Emergency Department (ED) at a public hospital for a mental health assessment. He was discharged with a management plan in place. The following day, the man presented to the ED again after an incident of self harm. He had a cardiac event and was diagnosed with an ST-segment elevation myocardial infarction (STEMI) and he was transferred to the intensive coronary care unit (ICCU) at another hospital.

Further investigations were undertaken and the man was considered to have Takotsubo cardiomyopathy. During the admission to ICCU, the man had routine blood tests taken, which showed a very abnormal troponin T result. The cardiologist was not aware that that test had been ordered and was not informed of the result. At the time of these events at the DHB it was necessary for patients to be declared medically fit for discharge so that they could be nursed at the mental health facility.

The following day, the cardiologist reviewed the man, declared that he was medically fit for discharge, and he was transferred to the mental health facility. The man was to be observed every 10 minutes while in the mental health facility. The next morning the man was found deceased in his room. The manager of the mental health facility confirmed that the 10-minute observations had been adhered to overnight.

The Coroner found that the direct cause of death was cardiac arrhythmia and that the antecedent cause was recent myocardial infarction.

It was held that the man's discharge from the ICCU was inappropriate in his circumstances. The severity of damage to his heart was not recognised, and troponin T levels were not used to guide his further management. Accordingly, the man was not provided with services with reasonable care and skill and the DHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). The DHB processes meant that the providers involved in the man's care did not cooperate appropriately to ensure quality and continuity of services. Accordingly, the DHB also breached Right 4(5) of the Code. The documentation in this case was also suboptimal. The DHB failed to comply with legal standards, and accordingly, breached Right 4(2) of the Code.

The Commissioner made a number of recommendations to the DHB, including that the DHB implement a system to ensure a patient's treating clinician is alerted urgently when troponin T results are abnormally high, audit the rate of cross-referencing information about overnight observations into the patient's clinical records, review policies regarding the management of at-risk patients, provide staff training, and apologise to the man's family.