Delay in transfer of patient to main centre hospital (10HDC01344, 20 June 2013)

Physician ~ Rural public hospital ~ Emergency department ~ District health board ~ Neurological services ~ Cerebral abscess ~ Transfer ~ Documentation ~ Rights 4(1), 4(2)

A 54-year-old man was admitted in the afternoon to a rural public hospital and provisionally diagnosed with a cerebral abscess. Neither the Emergency Department (ED) doctor nor the newly employed locum physician, consulted with neurosurgical services at the nearest large public hospital. The physician advised that he was unaware that it was possible to fly patients to the main centre after dark.

The man was referred to the neurosurgeons the following morning. While awaiting air retrieval, his condition deteriorated and, on arrival, after an MRI scan, it was found that he had a ruptured cerebral abscess. A cerebral abscess is a neurosurgical emergency requiring urgent consultation with a specialist neurosurgeon. It is unclear whether earlier consultation or transfer on the night of admission could have prevented the abscess from rupturing, given the risks of transfer. However, the man was denied the opportunity to have specialist neurosurgical advice and consideration of transfer.

It was held that by failing to ensure that its on-call physician was informed of patient transfer processes, the district health board did not provide services of an acceptable standard and breached Right 4(1). The district health board also breached Right 4(2) for the poor standard of clinical documentation on the man's hospital record.

This case illustrates the difficulties of rural practice and the critical importance of adequate staff orientation to the provision of appropriate clinical care.