Care provided to man in hospital
15HDC01053, 28 June 2017

District health board ~ Emergency department ~ Troponin T test results ~ Heart attack ~ Right 4(1)

A 73-year-old man was admitted to the surgical ward at a public hospital with a four-week history of diarrhoea and abdominal pain. After two days he was discharged and a plan was put in place for an urgent outpatient colonoscopy, to ensure that there was no significant bowel pathology. Surgical staff thought that his symptoms were caused by the medication he had been taking.

Under a week later, the man was accepted by a surgical registrar for review in the Emergency Department (ED), as he had remained unwell following discharge. Unfortunately, due to the unexpected busyness of the ED at the time, there was a delay of 35 minutes for triage. A Troponin T test result of 990ng/L (abnormal, indicating heart damage) was processed and automatically released by the results system, but the surgical registrar was not advised of the result via telephone. A decision was made to transfer the man to the surgical ward but this was not discussed with the surgical registrar, and due to the busyness of ED this occurred without important interventions having been undertaken (including insertion of a catheter and commencement of a fluid balance chart). Medical review and antibiotic administration were also delayed. Shortly after review by an intensive care registrar, the man advised nursing staff he was cold. A blanket was provided, and antibiotics were administered. The man continued to deteriorate, and sadly he died, despite attempts to resuscitate him.

Findings
The Commissioner considered that at the first admission, medical or cardiologist input, consideration of a source of infection, and a CT scan may have been helpful. The Commissioner concluded that there were opportunities for further enquiry at the first admission and was critical that these were missed. The Commissioner acknowledged that during the second admission, ED was busier than usual, which resulted in delays in triage, medical review, and implementation of aspects of the surgical registrar's management plan. However the Commissioner was critical that at this admission, the man's high Troponin T result was not escalated in a timely manner by telephone (the DHB had two policies with differing criteria for escalation of test results to clinical staff by telephone and in practice, neither were followed for Troponin T results), there was no on-call consultant physician readily available for assisting when delays were experienced in medical review, and the man was transferred to a lower acuity ward without discussion with the man and without required interventions having been undertaken, in order to meet a target. The Commissioner concluded that the DHB failed to provide the man with services with reasonable care and skill and breached Right 4(1).

The surgical registrar did not breach the Code.

Recommendations

The Commissioner made a number of recommendations, including that the DHB audit aspects of the effectiveness of its new triage process, review its sepsis management policy and adult sepsis pathway (and provide training for relevant staff on the new pathway), develop a clear policy for responsibility for following up test results ordered by ED registered nurses, consider implementing a system that requires the laboratory to alert the patient’s treating clinician urgently, review the ED’s standard operating procedure, develop a care escalation plan for the general medicine team, review the role of on-call consultants to ensure that adequate supervision of junior doctors is occurring, and remind all staff working in the ED that the transfer and the location the patient is transferred to must be clinically appropriate. The Commissioner also recommended that the DHB provide a written apology to the man’s family.