Triage of woman re-presenting to Emergency Department
15HDC01560, 22 May 2017

District health board ~ Senior house officer ~ Emergency department ~ Triage ~ Facial fracture ~ Assessment ~ Right 4(1)

A university student had been unwell for four days with flu-like symptoms. One night, she fainted twice. The second time she fell, she hit her face. She also hurt her right thumb.

The woman was transported to a public hospital via ambulance and triaged. Notes made by the ambulance officer and by the triage nurse record that the woman had fainted twice and had hit the left side of her face, and was complaining of pain in her face and right thumb. The ambulance notes also record that she had a contusion (bruise) on her left cheek bone.

Following triage, the woman was examined by a senior house officer. The senior house officer recorded his impression as syncope (fainting) secondary to viral illness and dehydration. The woman remained in hospital overnight for observation until the next morning, when she was discharged.

The woman re-presented to the hospital that evening, as she felt unwell and thought that something was wrong with her face. She spoke to a staff member at the front desk of the Emergency Department (ED), but no triage was completed. No documentation exists for the second presentation to ED except for a medical certificate issued by a medical officer.

Subsequently, the woman was diagnosed with facial fractures.

It was held that the DHB breached Right 4(1) of the Code for failing to triage the woman when she re-presented to ED. Criticism was also made about the absence of a record of her visit except for the medical certificate that was issued, and that the DHB was not able to identify the staff member who spoke with the woman.

Adverse comment was made about the care provided by the senior house officer, including that he did not pick up that there could be a possible facial injury, and did not discuss the woman's case with a senior medical officer prior to discharge.

It was recommended that the DHB report to HDC on the implementation of its mentoring programme for junior staff, and on its review of the ED triage process, and provide evidence to HDC of the training sessions provided to triage and clerical staff on the triage process. It was also recommended that the senior house officer and the DHB each provide written apologies.