Medical Officer of Special Scale, Dr B

Senior Medical Officer, Dr C

Lakes District Health Board

A Report by the

Health and Disability Commissioner

(Case 11HDC01077)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

Factual background

1. At approximately 10.30pm on 24 September 2011, Mr A fell about two metres onto concrete, and injured his left chest and shoulder. Mr A was taken by ambulance to the Emergency Department at a public hospital (Hospital 1), where he was reviewed by a medical officer of special scale (MOSS), Dr B, at 12.45am on 25 September.

2. Dr B noted that Mr A was alert, but in pain, his abdomen was tender on examination, and his lungs were clear. Dr B ordered abdominal and chest X-rays, blood and urine tests, and an ECG. The laboratory results and the abdominal X-ray were unremarkable, and the chest X-ray was interpreted as not showing any rib fractures or pneumothorax, although the result was noted to be suboptimal. Dr B diagnosed Mr A with a left chest and abdominal wall contusion.[1] She prescribed him pain relief medication and cleared him for discharge at 1.50am.

3. Mr A was unable to arrange transport home at that time, and remained in the Emergency Department, where he continued to be monitored by nursing staff. Nursing staff contacted Dr B at 6.30am after it was noted that Mr A was hypotensive,[2] and had an obvious step-off in his left acromioclavicular (AC) joint. Dr B advised HDC that she reviewed Mr A at 7am. She charted further pain-relief medication and IV fluids for Mr A's low blood pressure, and advised that he should follow up with his GP for his shoulder injury. A medical team shift change took place at 8am. At the request of the nursing staff, the oncoming doctor, senior medical officer (SMO) Dr C, prescribed pain relief medication and IV fluids for Mr A, on the understanding that Mr A was shortly to be reviewed by Dr B.

4. At handover, Dr B advised Dr C that Mr A was for discharge. Mr A was discharged at 9.50am. On 3 October 2011, Mr A was diagnosed with left-sided rib fractures with possible effusion at the left lung base,[3] and possible underlying lung consolidation.[4]

Findings

5. It was held that Dr B's care of Mr A was suboptimal. Both of her clinical reviews of Mr A at 12.45am and 7am were poor, and did not fully take account of his history and clinical presentation. In addition, Dr B's handover to Dr C was inadequate. In these respects, Dr B failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1)[5] of the Code of Health and Disability Services Consumers' Rights (the Code). Dr B's clinical documentation was also below the expected

[1] A bruise, or contusion, is caused when blood vessels are damaged or broken as the result of a blow to the skin.
[2] Low blood pressure.
[3] A collection of fluid in the space between the two linings (pleura) of the lung.
[4] Where the lung tissues solidify because of the accumulation of solid and liquid material in the air spaces.
[5] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

standard of a registered medical practitioner and, accordingly, Dr B breached Right 4(2)[6] of the Code.

6. Dr C was not found in breach of the Code. However, it was recommended that, when he provides treatment to a patient who is not under his care, he should communicate the provision of such treatment to the responsible clinician. It was also recommended that he reflect on the importance of ensuring he is provided with relevant patient information at handover.

7. Lakes District Health Board (Lakes DHB) is responsible for ensuring that patients receive care that complies with the Code. Lakes DHB failed to take adequate steps to ensure that Dr B was competent to perform the services for which she was employed. Therefore, Lakes DHB failed to ensure that Mr A was provided with services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code. In addition, the pattern of suboptimal clinical documentation by multiple staff members compromised the continuity of care provided to Mr A, and thereby Lakes DHB breached Right 4(5)[7] of the Code.

Complaint and investigation

8. The Commissioner received a complaint from Mrs A about the services provided to her husband, Mr A, at Lakes DHB. The following issues were identified for investigation:

- *The adequacy of the care provided to Mr A by Dr B on 25 September 2011, including the adequacy of documentation.*
- *The adequacy of the care provided to Mr A by Dr C on 25 September 2011, including the adequacy of documentation.*
- *The adequacy of the care provided to Mr A by Lakes DHB on 25 September 2011.*

9. An investigation was commenced on 20 November 2012. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Complainant (consumer's wife)
Dr B[8]	Medical officer of special scale (MOSS)
Dr C	Senior medical officer (SMO)
Lakes DHB	Facility/provider

[6] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[7] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."
[8] Dr B has advised HDC that she now practices overseas and, when she returns to New Zealand, will work "only on a sporadic basis as a rural medicine locum".

Also mentioned in this report:

Hospital 1	A regional hospital
Hospital 2	A regional hospital
Hospital 3	A main centre hospital

10. Information was also reviewed from registered nurses Ms D and Ms E.

11. Independent expert advice was obtained from an emergency medicine specialist, Dr Vanessa Thornton (**Appendix A**).

Information gathered during investigation

Admission to hospital

12. At approximately 10.30pm on 24 September 2011, Mr A fell about two metres onto concrete, injuring his left chest and shoulder. An ambulance was called and it transported Mr A and his wife, Mrs A, to the Emergency Department at Hospital 1. At 10.40pm, ambulance staff noted that Mr A's heart rate (HR) was 84 beats per minute (bpm),[9] his blood pressure (BP) was 180/150mmHg,[10] his respiration rate (RR)[11] was 24 breaths per minute, and his oxygen saturations (saturations)[12] were 89%. The ambulance arrived at Hospital 1 at 12.33am on 25 September 2011.

13. Registered nurse (RN) Ms E triaged Mr A at 12.38am. She documented in the notes that, on arrival, Mr A was able to transfer himself but he was pale, nauseous, and complained of pain to his left shoulder, left abdomen and left chest. She also noted that Mr A had a history of hypertension, but was not on any medication, and she wrote in the clinical records that Mr A had drunk one and a half bottles of wine prior to his admission. RN E recorded Mr A's observations as HR 90, BP 140/80, RR 24, and saturations as 92%. Mr A reported pain at a level of 5/10.

14. RN E told HDC that she spoke to medical officer Dr B once she had completed her triage, and advised Dr B of her concern that Mr A's respiration rate and saturations were possible indicators of a rib or lung injury.

First review by Dr B

15. Dr B assessed Mr A at 12.45am. She documented in the notes that Mr A was alert but in pain, and that he was specifically complaining of pain with inspiration and

[9] The normal human heart rate ranges from 60–100 bpm.
[10] In a study of 100 human subjects with no known history of hypertension, an average blood pressure of 120/80mmHg was found, which is currently classified as a "normal" value.
[11] The average respiratory rate reported in a healthy adult at rest is usually given as 12–18 breaths per minute. When checking respiration, it is important also to note whether a person has any difficulty breathing.
[12] Oxygen saturation is the measure of the fraction of the haemoglobin molecules in a blood sample that are saturated with oxygen at a given partial pressure of oxygen. Normal saturation is 95–100%.

movement. She noted that his abdomen was tender on examination, and that his lungs were clear. Dr B ordered abdominal and chest X-rays, an ECG, and blood and urine tests. Mrs A told HDC that Mr A was in a lot of pain at that time.

16. Dr B documented Mr A's laboratory results as unremarkable. The chest X-ray was interpreted as not showing any rib fractures or pneumothorax, and the abdominal X-ray was also noted to be unremarkable. The chest X-ray was suboptimal, as Mr A was unable to take a full inspiration because he was in too much pain.

17. At 1.00am Dr B charted pain relief for Mr A.

18. At 1.08am Mr A was given intravenous (IV) morphine and the anti-nausea agent Zofran. At that time, RN E recorded that Mr A was complaining of pain on breathing. Mr A's observations were taken at 1.08am and showed HR 88, BP 110/60, RR 23, and saturations of 93%.

19. RN E stated that, after assessing Mr A's vital signs at 1.35am, she remained concerned about his oxygen saturation. Mr A reported a pain score of 4/10 at that time. RN E recalls that she discussed Mr A's vital signs and pain levels with Dr B, and was advised by Dr B that the X-ray showed no fracture and Mr A had muscular pain. RN E said that she suggested a blood gas test,[13] but Dr B instead wrote an order for IV Dynastat[14] and told her that Mr A could be discharged.

20. No conversation between RN E and Dr B is documented as occurring at that time. However, at 1.50am Mr A was given IV Dynastat, and the progress notes record that Dr B was happy for Mr A to go home. Dr B recorded in the notes that she gave the following instructions to Mr A for his care once discharged:

- rest;
- apply a pillow splint to his ribs;
- take prescribed ibuprofen and codeine;
- follow up with his GP; and
- return to ED if his condition worsened or he experienced additional symptoms.

21. Dr B documented that repeat X-rays might need to be considered because of the poor quality of the films taken. The final diagnosis was recorded as a left chest and abdominal wall contusion.

22. Mrs A told HDC that, at this time, Mr A could not sit up, walk, or get into a car. RN E said that Mr A could not tolerate sitting up beyond a 60 degree angle.

23. As Mr A and Mrs A did not have any transport, they remained in the ED until later that morning.

[13] An arterial blood gas (ABG) test measures the levels of oxygen and carbon dioxide in the blood to determine how well the lungs are working.
[14] This medicine belongs to a group of medicines called Coxibs. These medicines work by relieving pain and inflammation (see: http://www.medsafe.govt.nz/consumers/cmi/d/dynastat.pdf).

24. RN E advised that she continued to monitor Mr A. At 4.20am she recorded that Mr A's RR was 18, his saturations were 99%, and he was not complaining of pain. Mr A is recorded as sleeping between 3.20am and 6.20am.

Second review by Dr B

25. At 6.35am Mr A tried to get up but felt dizzy. RN E checked Mr A's vital signs, and recorded his BP as 70/40, HR 100, and RR 22. Mr A complained of left shoulder pain, and RN E noted what she described as an obvious step-off[15] in his left acromioclavicular (AC) joint.[16] She also recorded that he was pale.

RN E's recollection of request for second review

26. RN E advised HDC that she "immediately" phoned Dr B and requested that she review Mr A. RN E recalls that Dr B said that there was nothing wrong with Mr A's shoulder, and that the blood results did not indicate any bleeding, but that she would review Mr A. RN E did not document her conversation with Dr B. Dr B recalls talking to RN E, but cannot recall the details of the conversation. Dr B advised HDC that, if she did say to RN E that there was nothing wrong with Mr A's shoulder, she would have been basing that observation on the chest X-ray.

27. RN E checked Mr A's observations at 6.40am and 6.50am. Mr A's BP was recorded as 90/50 and 85/60 at those times, with saturations of 94% and 95% and an HR of 100.

Dr B's recollection of second review

28. Dr B advised HDC that she reviewed Mr A at around 7am, in direct response to RN E's call at around 6.30am. No clinical review is documented at 7am, but the clinical notes record an "addendum", not dated or timed, in which Dr B documented that Mr A had tenderness and a step-off in his left AC joint, and that Mr A should follow up this with his GP if the shoulder injury persisted, as it might require referral to an orthopaedic surgeon and/or additional diagnostic studies.

29. At 7am Dr B charted further pain-relief medication and one litre of IV fluids (normal saline), as Mr A's blood pressure remained low.

Nursing shift handover — RN D

30. Also at 7am (and while RN E said she was waiting for Dr B's arrival), the nursing shift changed, and RN D came on duty. At handover, RNs E and D discussed that Mr A was not currently in a state to be discharged. RN E advised HDC that, during that discussion, she informed RN D that she had asked Dr B to review Mr A; however, RN D cannot recall being informed of this then. RN D advised HDC that she does not recall seeing Dr B review Mr A at that time, but accepts that this may have occurred while she was attending to another patient.

[15] "Step-off" usually means the bones are not lined up properly, and may be bent or deformed, potentially forming a "step" at the junction of the broken bone.
[16] The acromioclavicular joint, or AC joint, is a joint at the top of the shoulder.

31. RN D advised that, after she received handover from RN E, she assessed Mr A. Nursing documentation records that, at 7.15am, Mr A's observations were BP 80/50, HR 100 and saturations of 91%.

RN D's recollection of request for second review

32. RN D recalls that around that time she notified Dr B that Mr A looked unwell, and still had nausea, ongoing shoulder pain, and low blood pressure and oxygen saturations, and required a review and possibly further X-rays. No request for medical review at that time is documented in the clinical records. RN D recalls that that conversation took place face-to-face, in the ED Office. RN D stated that she cannot recall Dr B reviewing Mr A at that time.

33. Dr B does not recall discussing Mr A with RN D; she recalls discussing Mr A only with RN E.

Phone call between RNs E and D

34. At around 7.45am, RN E called RN D and asked her to document her earlier call with Dr B (RN D advised HDC that she subsequently forgot to do this). It was during that conversation that RN D recalls becoming aware that RN E had also asked Dr B to review Mr A again (which, as mentioned above, she had not seen occur).

35. RN D advised HDC that, during the above phone conversation, RN E may have told her that Dr B had refused to see Mr A. However, RN E denies saying that, and Dr B advised HDC:

> "I have never refused to see a patient when asked to do so by a member of the nursing staff at any point in my entire professional career, and [Mr A's] case is no exception."

36. By 7.50am, Mr A's BP had improved to 120/80, and his saturations to 95%. He was noted to be less pale, and his nausea had settled.

Other comment regarding whether a second review occurred

37. Mrs A and Mr A advised HDC that Dr B did not undertake a second review of Mr A that morning. Lakes DHB advised HDC that "we can confirm that this patient was not assessed by [Dr B] when requested by nursing staff at 06.00 hours. The night nurse … contacted [Dr B] to return to ED and review this patient but [Dr B] declined."

38. Overall, Mrs A complained that she found Dr B to be "rude and unapproachable".

Care provided after 8am

39. At 8am the doctors' shift changed and senior medical officer Dr C arrived in the ED.

RN D

40. At 8.10am RN D recorded in Mr A's notes that he had attempted to get up, but "on sitting felt dizzy, nauseous, became pale". RN D also documented "shoulder pain less severe but has ongoing central chest/epigastric pain".

41. At 8.35am RN D recorded in Mr A's notes that he was pale and sweaty when trying to get up to use the bathroom. At that time, Mr A's saturations were recorded as 88% improving to 93% with deep breathing. RN D told HDC that she asked Dr C to review Mr A at this time.

Dr C

42. Dr C advised HDC that he recalls a nurse asking him to chart analgesics and IV fluids for Mr A, but said that he had yet to receive a handover from Dr B, and was told that Dr B had been asked to review Mr A (Dr C was therefore of the impression that Dr B's review was imminent). Dr C advised HDC that the nurse did not give him an overview of Mr A's condition at that time.

43. Dr C said that he thought it was reasonable to chart pain relief and IV fluids for Mr A while waiting for Dr B to either review Mr A or hand over his care. Dr C stated that he looked at Mr A's notes and charted a litre of normal saline and tramadol. The time at which Dr C charted the medication is not documented, but the saline was given at 8.40am and the tramadol at 8.50am. Dr C advised HDC:

> "It would be unusual to chart further IV fluids and analgesia if the patient had not yet been seen by another doctor. However in this case the patient had been in the ED all night and assessed by [Dr B] so that [sic] it was reasonable to chart or continue fluids and pain relief."

Dr C's recollection of handover

44. Dr C initially advised HDC that, "shortly after 0800 hours", Dr B came to the ED ward and advised him, "[D]o not worry about [Mr A] he is all sorted and going home." On that basis, Dr C advised HDC that he did not review Mr A. Dr C said that he would have had "… no hesitation to review [Mr A] if [he] had been handed over [Mr A] by [Dr B] to review".

45. However, Dr C later advised HDC that, at around 8.30am or 8.45am (ie, soon after he charted the analgesia and IV fluids for Mr A, referred to above), Dr B arrived in the ED and handed over her patients, including Mr A. Dr C recalls that Dr B said that Mr A was to be discharged. Dr C advised HDC of his understanding that, at that point, "[Dr B] had recently reviewed [Mr A] but we did not discuss when that occurred". During the handover, Dr C advised that Dr B did not ask him for a second opinion or to review Mr A. Rather, Dr C said that Dr B "asked [him] why [he] was getting involved with [Mr A] as he was to be discharged". Dr C advised that Dr B then "went away".

Dr B's recollection of handover

46. Dr B advised HDC that, when she handed over Mr A to Dr C, who was more senior than her, Mr A's condition had improved. Dr B advised that she therefore told Dr C that Mr A was ready for discharge, and that his transport had arrived to pick him up. Despite that, and without specifying what her "concerns" were at that stage, Dr B advised HDC:

> "… I could have voiced my concerns more clearly to the oncoming physician thereby increasing their level of clinical suspicion and lowering their threshold for ordering repeat testing and/or initiating transfer to a higher level of care for surgical assessment."

47. Dr B later advised HDC that Dr C was a "big boy" and was ultimately responsible for Mr A once she had finished her shift. She also advised HDC:

> "Despite my own actions — and in my initial response I acknowledged that a fuller explanation of [Mr A's] condition would've been helpful to the oncoming physician — the oncoming doctor was responsible for performing his own review of both the patient and the chart and was free to respond in whatever fashion he deemed appropriate. Formal handover rarely occurred in [Hospital 1] ED due to single physician coverage in high volume situations, as was true in this instance."

Discharge

48. By 9.25am Mr A was feeling much better and could walk unassisted. At that time, Mr A's observations were recorded as BP 125/80, HR 95 and saturations of 97%. RN D said that Mr A's observations and his response to the treatment were reported to Dr C, who advised that Mr A could be discharged. Mr A was given an arm sling and discharged at 9.50am.

Further treatment and readmission to hospital

49. A few days after arriving home, Mr A attended a medical centre. The medical centre treated him conservatively with painkillers and took no further images. He visited the medical centre again on 3 October 2011 with progressive shortness of breath and ongoing pain. The medical centre then took X-rays, which showed left-sided rib fractures with possible effusion at the left lung base and possible underlying lung consolidation. The left lung basal changes had progressed since the X-ray taken in Hospital 1, and a CT scan was recommended.

50. The medical centre arranged for Mr A's admission to Hospital 3, where a CT scan was undertaken. This confirmed mildly displaced posterolateral rib fractures involving the left 11th, 10th and 9th ribs, and showed subtle, non-displaced fractures of the lateral aspect of the left 6th, 7th and 8th ribs. There were "extensive contusions and lacerations involving the spleen … and there [was] a large adjacent haematoma as well as a small to moderate amount of haemorrhage layering within the pelvis".

51. Mr A remained stable and was managed conservatively with observation, analgesia and antibiotics. There was some progression of his pleural effusion, but he was discharged on 9 October 2011. The discharging doctor recommended a follow-up chest X-ray in the community and consideration of drainage of the effusion if it progressed further.

52. The medical centre reviewed Mr A on 13 October 2011. A follow-up chest X-ray showed that there had been no resolution of the effusion, and Mr A remained in pain and short of breath. The medical centre sent Mr A back to Hospital 3, and the effusion was drained. Mr A was discharged on 16 October 2011 for outpatient follow-up.

Additional information

Dr B

53. Dr B advised HDC that the "somewhat hectic nature of that evening" affected her documentation of Mr A's care. She stated that she performed examinations of his chest and abdomen throughout his time in the Emergency Department. She also stated:

> "There were several significant external factors impacting my encounter with [Mr A]. The most significant being a very busy Emergency Department covered by only one doctor and one nurse. Staffing issues were not an infrequent occurrence in [Hospital 1] mostly due to a high volume of patient transfers to [Hospital 2] and occasional calls for assistance from the inpatient ward. I disagree with the assertion that I may have placed too much emphasis on [Mr A's] alcohol ingestion. I didn't test for blood alcohol levels and only mentioned it as a possible mechanism for his fall …"

54. In response to my provisional opinion, Dr B acknowledged that there were "errors in [her] clinical judgement and management of [Mr A's] case", following his presentation at Hospital 1 Emergency Department, and set out the various courses she has since taken to improve her clinical practice and communication skills (summarised later in my report). Dr B went on to advise that "[t]he positive learning I am able to glean from this experience pertains to patient safety, collegial support, and physician workload…".

55. Dr B did advise that, without attempting to "exonerate" or "downplay" her mistakes, at the time of Mr A's presentation she was having to work extra shifts and was consequently suffering from fatigue. Dr B advised that she reported feeling "overwhelmed" to the Operations Manager, however indicated that these concerns were not taken seriously.

Lakes DHB

56. Lakes DHB advised that the workload in the Hospital 1 Emergency Department was no busier than usual at the time of Mr A's presentation on 25 September 2011, and there are guidelines for staff to obtain support from Hospital 2 when required, which also includes diagnostic advice.

57. Lakes DHB advised that the only way the full extent of Mr A's injuries would have been established was with a CT scan, which is not available at Hospital 1. Had it been suspected that Mr A required further investigation, he would have been transferred to Hospital 2. Lakes DHB's "Referral Guidelines for Transfer of Adult Patients Between [Hospital 2] and [Hospital 1]" state that the Hospital 1 senior medical officer may, of right, transfer inpatient or Emergency Department patients to Hospital 2 when clinically indicated. In addition, Lakes DHB's document "SMO Expections [Hospital 1] — Emergency Department" (sic) states that [Hospital 1's] Emergency Department senior medical officer "… should keep a low threshold to phone for advice from [Hospital 2] ED" and "… should not hesitate to transfer [patients] to [Hospital 2] ED for further assessment as needed". Lakes DHB advised that Dr B had had input into the drafting of that document.

58. In terms of handover requirements, the "[Hospital 1] [Medical Officer] Introduction" document provides: "Transfer and handover of responsibility must be such that it ensures the patient's clinical safety, continuity of care and requires a verbal and written handover." Lakes DHB rejected Dr B's claim that "[f]ormal handover rarely occurred in [Hospital 1] ED …" and, in doing so, referred to the "SMO Expections [Hospital 1] — Emergency Department" (sic) document, which states that "[t]he rostered and relieving ED SMOs must clearly communicate patient care duties and responsibilities at shift handover". Lakes DHB advised that doctors always hand over patients between shifts when there are patients in the department.

59. Lakes DHB also provided information disclosing that, prior to Mr A's presentation, a number of serious concerns had been identified regarding Dr B's clinical practice and communication skills. In particular, Lakes DHB provided the following information:

- In September 2010 a consumer complained to Lakes DHB about the standard of care the consumer had received from Dr B. Dr B had stitched the consumer's hand laceration and discharged the consumer, without having identified the presence of three torn tendons (which required surgery). Lakes DHB apologised to the consumer for the standard of care Dr B provided (the letter also included a personal apology from Dr B), and advised that the complaint would be included in a clinical audit.

- In November 2010 Lakes DHB was advised of three further incidents regarding the standard of care provided to patients by Dr B, summarised as follows:

    - Dr B had discharged a child who was subsequently found to have a broken femur.
    - Dr B had assessed a patient as having a conversion disorder,[17] but the patient was subsequently diagnosed with an established CVA.[18]
    - Dr B had considered a patient fit for discharge, when the patient subsequently required an appendicectomy.[19]

60. Lakes DHB undertook an internal investigation into the above incidents, which included formal meetings with Dr B on 22 December 2010, 6 January 2011 and 17 January 2011. Lakes DHB found that Dr B's clinical performance was below that expected of a doctor. In addition, Dr B's behaviour and interactions with other staff were considered to be "unacceptable". On 17 January 2011, Dr B was issued with a formal written warning and told that she was expected to improve her clinical performance and manner. In terms of steps to assist Dr B to achieve this, she was advised that she would be required to participate in 360 degree feedback in her annual performance review, and attend monthly review meetings to monitor her ongoing

[17] Conversion disorder is a mental health condition in which a person has blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation.
[18] A stroke, sometimes referred to as a cerebrovascular accident (CVA), is the rapid loss of brain function due to disturbance in the blood supply to the brain.
[19] Removal of a suppurative appendix.

performance. Lakes DHB advised HDC that, for logistical reasons, no monthly review meetings took place, and nor did a formal performance review.

61. The Clinical Director of ED found it difficult to coincide his weekly visits to Hospital 1 with Dr B's shifts. Accordingly, it was arranged that Dr B's review meetings would take place by email, on the understanding that Dr B would self-identify significant cases and email the details of those cases to the Clinical Director of ED, who would review the clinical notes and provide feedback. In accordance with that arrangement, Dr B sent two emails to the Clinical Director of ED, one on 8 March 2011, and one on 13 October 2011.

62. In March 2011 Lakes DHB received a further complaint from a consumer, this time regarding Dr B's manner. Lakes DHB met with Dr B to discuss the complaint, and were satisfied with her apology to the consumer. Dr B agreed to attend a communications workshop, but Lakes DHB advised HDC that it is "… not aware that [Dr B] attended a communication workshop".

63. Overall, Lakes DHB advised that Dr B did not receive any additional oversight, and was not required to undertake any additional training. Lakes DHB advised HDC that no further significant concerns were raised with it about Dr B's practice between March and September 2011, and that "there was some anecdotal improvement in [Dr B's] clinical assessment and manner with patients and staff".

64. In response to my provisional opinion, Dr B made the following comments regarding Lakes DHB's concerns regarding her clinical practice and communication skills:

> "…I failed to understand that my former employer, Lakes DHB, harboured concerns about my competency during my tenure. I distinctly recall the meetings and discussions surrounding the facts of each case, after which no further learning, explanations or actions were ever recommended. To my knowledge, I never underwent any type of audit or review…"

Changes made following the complaint

Dr B

65. Dr B advised HDC that this case has "… led to profound reflection in regards to [her] clinical decision making involving trauma". Dr B advised that she was "horrified to learn that [she] had failed to recognise such significant injury", and has apologised to Mr A for the care she provided.

66. Dr B accepted that her documentation in the clinical notes was "not at all clear", and advised that she planned to rectify this in her practice. In response to my provisional opinion, Dr B confirmed that she has undertaken the following further training:

- Refresher courses in emergency management in severe trauma (Dr B also provided a summary of her learning in this regard).[20]

[20] Dr B provided proof of attendance at two Comprehensive Advanced Life Support courses, an Emergency Life Support course, and an Advanced Trauma Life Support course (all run overseas).

- Three workshops on communication, entitled "Mastering Professional Interactions", "Mastering Your Risk" and "Mastering Shared Decision Making".[21]
- A postgraduate certificate in Clinician Performed Ultrasound.[22]

Dr C

67. Dr C advised HDC that he is "sorry that [Mr A] had this experience at [Hospital 1]", and advised that he has made the following changes to his practice:

- He now asks all his co-workers to "ensure that there is a very clear hand over in person about each patient in ED".
- He now "routinely see[s] all the patients in the ED, and makes[s] an independent opinion about them, irrespective of the notes of my co-workers".

Lakes DHB

68. At the time of Mr A's admission, Lakes DHB was undertaking an organisational handover project report, which was aimed at "… attempt[ing] to achieve a more structured handover of clinical information in circumstances where handover already took place" (rather than addressing any systemic issue of non-compliance with the existing handover policies). As a result of that project, Lakes DHB implemented the "SBARR"[23] tool, as a means of achieving structured referral or handover of care. Lakes DHB advised HDC that this project was one that was identified "as having an opportunity to have improved the care provided to Mr A from an organisational perspective".

Response to provisional opinion

69. In the course of my investigation, the parties were provided with relevant sections of my provisional opinion for comment. Those comments have been incorporated into this report, where appropriate.

Opinion: Breach — Dr B

Initial assessment and decision to discharge

70. Dr B reviewed Mr A in the Hospital 1 Emergency Department at 12.45am on 25 September 2011. Mr A's history and mechanism of injury were clearly documented in the clinical records, as were his low oxygen saturations as identified at the scene by the ambulance officers and by RN E in the Emergency Department.

[21] Dr B provided proof of attendance at these courses (run by the Medical Protection Society).
[22] Dr B provided a copy of her certificate (issued by the University of Otago).
[23] SBARR is an acronym for "situation, background, assessment, recommendation, response", and is a recognised tool used to assist health professionals to communicate about patients.

71. Dr B examined Mr A and noted that he was in pain but alert, that his abdomen was tender on examination, and that his lungs were clear. Dr B ordered blood and urine tests, an ECG, and abdominal and chest X-rays. My independent expert advisor, emergency medicine specialist Dr Vanessa Thornton, advised me that Dr B ordered appropriate investigations for Mr A at that time, and I accept her advice.

72. The blood test results and abdominal X-ray were documented as being unremarkable. While the chest X-ray was interpreted as not showing any rib fractures or pneumothorax, it was suboptimal as Mr A had been unable to take a full inspiration because of his pain. Dr B diagnosed Mr A with a left chest and abdominal wall contusion. She prescribed pain relief and advised that Mr A could be discharged. Dr B advised Mr A to rest, apply a pillow splint to his ribs, take ibuprofen and codeine, and to follow up with his GP or return to ED if his condition worsened or he experienced additional symptoms.

73. Dr Thornton advised me that plain abdominal X-rays do not provide information in blunt trauma of the abdominal organs, routine chest radiography of stable blunt trauma patients may be of low clinical value, and fractures on X-ray are "notoriously difficult" to pick up. Dr Thornton further advised that contusions of the lung are also often not seen on initial X-ray. Accordingly, in such cases it is important that a good and careful physical examination and history are undertaken to actively identify at-risk patients and, following trauma, subsequent examination and observation are required. If there are any ongoing signs of abdominal pain or respiratory distress noted on subsequent examination, then further imaging in the form of a CT scan or ultrasound scan is required.

74. Despite the lack of findings on X-ray, Mr A had abnormal observations and ongoing signs of abdominal pain and respiratory distress, which should have prompted Dr B to examine Mr A further, and to consider other underlying pathology. In my view, Dr B's review and assessment of Mr A were inadequate, and her decision that Mr A was fit to be discharged was poorly judged.

Subsequent assessment and decision to discharge

75. Despite Dr B's earlier advice that Mr A was fit to be discharged, Mr A remained in the Emergency Department because he did not have transport home at around 1.40am. Nursing staff continued to monitor Mr A.

76. At 6.35am, RN E noted that Mr A's BP was 70/40, and she was concerned that there was a step-off in his left AC joint. RN E phoned Dr B and requested a review of Mr A. RN E further recorded Mr A's BP at 6.40am as 90/50, and at 6.50am as 85/60, with saturations of 94% and 95% and a heart rate of 100. Dr B advised that she reviewed Mr A at 7am, although there is no documentation of a clinical review at that time, other than an undated and un-timed "addendum" to her clinical notes. The "addendum" documented that Mr A was tender and had a step-off in his left AC joint, and that Dr B had advised Mr A to follow that up with his general practitioner. Also at 7am, Dr B charted further pain relief and fluids for Mr A.

77. Dr Thornton advised me that, in the context of trauma, a drop in BP such as that which Mr A experienced around 6.40am has significant implications for patient management. Mr A's prolonged hypotension,[24] elevated respiratory rate, and low oxygen saturations were clearly documented in the clinical records. Mr A was also symptomatic on standing, and complained of pain in his chest and abdomen. This information was available to Dr B at the time she says she reviewed Mr A at 7am and, as noted by Dr Thornton, is information that is consistent with hypovolaemia,[25] blood loss, and fractured ribs.

78. Dr B advised HDC that she had considered that Mr A's significant hypotension might be related to analgesia and alcohol. As noted by my advisor, by the time Dr B said she reviewed Mr A, he had not received morphine since 1.35am and, while morphine does cause hypotension, its half-life is three hours. In addition, it was at least eight hours since Mr A's last drink of alcohol. Accordingly, I consider that analgesia and alcohol were not a sufficient explanation for Mr A's hypotension, and Dr B erred in her judgement by considering those factors as a cause for Mr A's ongoing condition.

79. On the basis that Dr B did review Mr A at 7am, she failed to recognise the significance of his condition at that time, in particular his hypotension coupled with his low oxygen saturations, elevated respiratory rate, and ongoing chest and abdominal pain. Dr B's failure to do so was a departure from an appropriate standard of care.

Handover

80. At 8am on 25 September 2011, the doctors' shift changed, and senior medical officer Dr C came on duty. It is unclear what time handover between Drs B and C occurred, and there is no written record of the handover in relation to Mr A.

81. Dr B advised HDC that she handed over Mr A's care to Dr C and, at that time, Mr A's condition had improved. She stated that as Mr A was about to be discharged, there was nothing much more for Dr C to do. Dr C advised HDC that, at handover, Dr B advised him that Mr A was to be discharged.

82. In my view, Dr B's handover of Mr A's care to Dr C was inadequate. Dr C, as the oncoming duty doctor, was responsible for Mr A's care and treatment from that time, including his discharge. Therefore, it was not sufficient for Dr B to tell Dr C only that Mr A was for discharge. Dr B should have ensured that Dr C was provided with a full handover, which would have included all the details he required to meet his ongoing responsibility for Mr A's care and treatment. I note that the "[Hospital 1] [Medical Officer] introduction" booklet, and the "SMO Expections [Hospital 1] — Emergency Department" (sic) document, require appropriate handover of care.

83. As noted by Dr Thornton, handover of patients is critical in emergency medicine and, if inadequate, leads to a high level of adverse patient events. Dr B's poor handover in this case was a missed opportunity to identify the serious nature of Mr A's condition.

[24] Abnormally low blood pressure.
[25] A decrease in the volume of circulating blood.

Documentation

84. Professional and legal standards for clinical documentation are very clearly established. The Medical Council of New Zealand publication "The maintenance and retention of patient records" (August 2008)[26] notes the importance of clinical records for ensuring good care for patients, and requires doctors to keep "clear and accurate patient records that report: relevant clinical findings; decisions made; information given to patients; any drugs or other treatment prescribed". A detailed and clear record of a patient's history, assessment, and management plan is one of the cornerstones of good care.

85. In this case, Dr B's documentation of her care and treatment of Mr A was poor and led to confusion. Her documentation does not support the level of clinical review that she says she undertook in relation to Mr A. In addition, there is no written record of the handover of care between Dr B and Dr C.

Conclusion

86. In my view, Dr B provided suboptimal care to Mr A. Her clinical reviews of Mr A at 12.45am and 7am were poor, and did not fully take account of his history and clinical presentation. In addition, Dr B's handover to Dr C was inadequate. In these respects, Dr B failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

87. Dr B's clinical documentation was below the expected standard of a registered medical practitioner and, accordingly, Dr B also breached Right 4(2) of the Code.

Other comment — manner

88. I note that Mrs A found Dr B "rude and unapproachable". Dr B's attitude toward her colleagues is demonstrated by her comment to HDC that Dr C was a "big boy" and responsible for Mr A after handover.

89. In my view, effective care involves appropriate communication with patients and their families. Furthermore, respectful and appropriate communication within teams is essential to ensure safe care. In my view, Dr B should continue to reflect on her manner when dealing with others.

Opinion: Adverse comment — Dr C

90. Dr C came on duty in the Emergency Department at Hospital 1 at 8am on 25 September 2011. At that time, Dr C assumed responsibility for the care and treatment of Mr A, including responsibility for Mr A's discharge.

[26] Available at: http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf.

91. Dr C did not review Mr A, although he prescribed analgesics and IV fluids for him on the understanding that Dr B would soon be reviewing him or handing over his care. Dr C advised that, when Dr B handed over the care of the patients in the Emergency Department, she advised him that Mr A was for discharge. Dr C understood, at that time, that Dr B had recently reviewed Mr A. Dr C was not asked to review Mr A.

92. I am guided by Dr Thornton's advice that, in the circumstances (including on the understanding that Dr B would soon complete a review of Mr A), it was reasonable for Dr C to prescribe analgesics and IV fluids for Mr A without conducting a thorough review. However, I agree with my advisor that Dr C should have communicated to Dr B that he had charted medication for Mr A, and that Mr A required immediate review.

93. I consider that the decision to discharge Mr A at that time was poorly judged. However, based on the information provided to Dr C about Mr A at handover, I consider that in the circumstances of this case it was reasonable for Dr C to leave the completion of Mr A's care to Dr B. I recommend that, in the future, when Dr C provides treatment to a patient who is not under his care, he should communicate the provision of such treatment to the responsible clinician. I also recommend that he reflect on the importance of ensuring he is provided with relevant patient information at handover.

Opinion: Breach — Lakes DHB

Introduction

94. A hospital should have a culture that supports safe care, promptly identifies risks to patient safety, and responds appropriately. This Office has frequently stated that District Health Boards are subject to a legal duty to provide health services with reasonable care and skill and in accordance with relevant standards. In my view, Lakes DHB failed to provide Mr A with services with reasonable care and skill and in accordance with relevant standards, for the reasons set out below.

Clinical competence - breach

95. A District Health Board has a duty to monitor the performance of its employed doctors with reasonable care and skill, and to manage poor performance appropriately. Hospitals must have in place an effective mechanism for identifying and dealing decisively with concerns about an employee. As this Office has stated previously, "A hospital has an obligation to take reasonable steps to ensure that its clinical staff are competent and fit to practise, in order to protect patients."[27] As this Office has also stated previously, "Although employees are entitled to be treated fairly, hospitals cannot allow patient safety to be jeopardised."[28]

[27] Dr Roman Hasil and Whanganui District Health Board 2005–2006 Inquiry (February 2008) at page 78. Opinion 07HDC03504 available at www.hdc.org.nz.
[28] Ibid, page 81.

96. If a hospital has, or should have in the circumstances, reason to believe a doctor may pose a risk of harm to patients, it has a duty to respond immediately and effectively to minimise the risk.

97. In this case I am concerned that Lakes DHB did not take adequate steps to respond to concerns about Dr B in order to ensure that she was competent to practise unsupervised.

98. At the time of Mr A's presentation at Hospital 1, Lakes DHB was on notice that there were serious concerns regarding Dr B's clinical competence and communication skills. While Lakes DHB investigated those concerns and issued Dr B with a formal written warning, I have not been provided with information to suggest that Lakes DHB took adequate steps to improve Dr B's clinical practice and ensure that Dr B's patients, including Mr A, received care and treatment of an appropriate standard.

99. In particular, there is no evidence that Lakes DHB, having identified the pattern in Dr B's clinical failings, particularly in respect of diagnosis and discharge, appropriately targeted her ongoing training and monitoring to those areas. In addition, I am concerned that Lakes DHB did not follow up on the requirements it placed on Dr B following its internal investigation into the complaints about her. For example, although Lakes DHB advised Dr B that she would be required to attend monthly review meetings to monitor her ongoing performance, no such meetings took place. Dr B was asked to self-identify cases to bring to the attention of the Clinical Director of ED for his review and feedback by email. I consider that this was inappropriate in light of the concerns that had been raised about her practice. More structured oversight and monitoring would have been appropriate. I note that Dr B sent only two such emails to the Clinical Director of ED, one in March 2011 (which coincides with the time at which a further complaint was made about Dr B), and one in October 2011. Having advised Dr B that she would be required to attend monthly review meetings to monitor her ongoing performance, Lakes DHB should have ensured that such meetings took place or, if that were not possible, that other mechanisms were in place to ensure that the concerns about her clinical performance and behaviour and interactions with other staff were addressed. I consider that it was unwise for Lakes DHB instead to rely on anecdotal evidence of improvements in Dr B's practice as a means of satisfying itself that no further monitoring or oversight of Dr B's performance was required. In response to my provisional opinion Lakes DHB advised that it has a monitoring, teaching and credentialing programme. However, it stated "[i]t is accepted that comments about regarding (sic) the supervision of [Dr B] should have been more robust".

100. In my view, Lakes DHB failed to take adequate steps to ensure that Dr B was competent to perform the services that she was employed to provide. Therefore, Lakes DHB failed to ensure that Mr A was provided with services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Handover – no breach

101. I have previously stated that providers have a responsibility to operate their facilities in a manner that provides patients with services of an appropriate standard. As I have commented:

> "This organisational duty of care includes providing a safe healthcare environment for its consumers and ensuring that staff comply with policies and procedures … it also includes responsibility for the actions and omissions of its staff."[29]

102. Dr B submitted that external factors had an impact on her care of Mr A, including "a very busy Emergency Department". She also submitted that formal handover "rarely occurred" in Hospital 1 ED.

103. I accept that there is no evidence that the Emergency Department was busier than usual at the time of Mr A's presentation. I also accept that Lakes DHB had an appropriate policy in place to provide for the transfer of patients to Hospital 2, and provided clear guidance to medical officers that they should have a low threshold to consult with colleagues at Hospital 2 and to transfer patients.

104. In addition, Lakes DHB's "Hospital 1 [Medical Officer] Introduction" booklet required both a written and a verbal handover, and the "SMO Expections Hospital 1 — Emergency Department" (sic) document, which Dr B had input into writing, also set out appropriate handover requirements. Lakes DHB advised that doctors always hand over patients between shifts when there are patients in the department.

105. In the absence of further information, I am not persuaded by Dr B that handover at Hospital 1 ED "rarely occurred", and consider Dr B's omission in that regard to have been an individual failing, rather than systemic.

Documentation of clinical record — breach

106. I am critical of the standard of the clinical documentation by Lakes DHB's staff in this case. It is essential to a patient's seamless continuity of care that all clinical reviews and decisions are fully documented, including requests for reviews by medical staff. The omission to do so creates potential risk, particularly in the hospital setting where multiple staff are involved in a patient's care.

107. There are several instances of poor documentation of Mr A's care and treatment at the Hospital 1 Emergency Department on 25 September 2011. In particular, although the clinical documentation provides clinical information about what was happening over the course of the night with frequent review and clinical concerns, nursing staff requests for medical review were not documented, and there is no documentation of the handover of care when nursing and medical shifts changed. In addition, as noted by my advisor, the adequacy of documentation by medical staff is less than the expected standard of care, and includes limited documentation of examination findings.

[29] Opinion 11HDC00712 available at www.hdc.org.nz.

108. While I accept that emergency departments can be busy, I do not accept that this negates the responsibility to keep clear and accurate clinical records. As noted above, a detailed and clear record of a patient's history, assessment, and management plan is one of the cornerstones of good care.

109. In response to my provisional opinion, Lakes DHB advised of its view that "the responsibility of good documentation lies with the nursing staff individually in the same way that the doctors also are personally accountable for good documentation and reporting". Lakes DHB went on to advise that:

> "The DHB does set clear expectations of standards around date, time and signatures, audits this and takes every opportunity to stress the legal obligations of all clinicians of the importance of the adequacy and accuracy of their documentation. We believe that the content of the clinical file is the professional accountability of the nurses so the DHB does not accept that that (sic) the DHB should be found in breach."

110. Irrespective of Lakes DHB's submission, the facts in this case demonstrate a pattern of suboptimal clinical documentation by multiple staff members. In my view this indicates that there was a lax attitude towards documentation at Lakes DHB, which compromised the continuity of the care provided to Mr A. Consequently, I remain of the view that Lakes DHB breached Right 4(5) of the Code.

Recommendations

111. In response to the recommendations set out in my provisional opinion, Dr B provided a written apology for forwarding to Mr A, apologising for her breaches of the Code. Dr B also provided evidence that she has completed further training in emergency management in severe trauma and advised of her learnings in this regard (set out above).

112. I recommend that, in the event Dr B again practices in New Zealand, the Medical Council of New Zealand undertake a review of Dr B's competence, and ask that it report back to me on the outcome of that review.

113. I recommend that Lakes DHB:

- Provide a written apology to Mr A. That apology should be sent to HDC, for forwarding to Mr A, within **one month** of the date of the final report.
- Provide ongoing education to staff on the importance of, and expectations for, clear, full, and accurate documentation, and provide HDC with evidence of such ongoing education, within **three months** of the date of the final report.

Follow-up actions

114. • A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Lakes DHB, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's and Dr C's names.

• A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Lakes DHB, will be sent to the Australasian College for Emergency Medicine, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from Dr Vanessa Thornton, a specialist in emergency medicine:

"I have been asked to provide an opinion to the commissioner on case number C11HDC01077, and I have read and agree to follow the commissioners Guidelines for Independent advisors.

I am the Head of Department of Middlemore Hospital Emergency Department New Zealand the largest Emergency Department in Australasia. I have been the HOD since 2008. My qualifications are FACEM (Fellow of the Australasian College of Emergency Medicine) and MBChB at Auckland University. I have been a fellow of the college for 13 years and graduated as a Doctor in 1992. I am currently completing a post grad diploma in Health Management at Auckland University.

I have reviewed the following documentation

1. Letter of complaint
2. Further information from [Mrs A] and [Mr A]
3. Responses to complaint from Lakes DHB
4. Information from [Dr B]
5. Information from [RN E]
6. Information from [RN D]
7. Information form [Dr C]
8. [Mr A] clinical notes form [Hospital 3]
9. Notification letters to Lakes DHB [Dr B] and [Dr C]
10. Lakes DHB response notifications for investigation
11. [Dr B's] response to notification of an investigation
12. File note of telephone conversation between [HDC Investigator] and [Dr B]
13. [Dr C] responses to notification of an investigation
14. Email from [HDC Investigator] to (lawyer for [Dr C]) with additional questions for [Dr C]
15. Response from [Dr C] to questions from [HDC Investigator].

I have been asked to provide expert advice about whether [Dr B], [Dr C] and Lakes DHB provided an appropriate standard of care to [Mr A].

In addition I have been asked for specific comment [on]:

1. the decision by [Dr B] to discharge [Mr A] at 0230
2. The adequacy of the review of [Mr A] by [Dr B] at 0700am
3. If [Dr C] did not review [Mr A] the decision by [Dr C] not to review [Mr A] when nursing staff had reported to him that he was dizzy and pale and sweaty at 0835

4. if [Dr C] did not review [Mr A] the decision by [Dr C] to chart medication for [Mr A] when [Dr C] had not reviewed the patient personally (but had seen the clinical notes)
5. if [Dr C] did review [Mr A] the adequacy of the review by [Dr C]
6. The adequacy of clinical documentation

Background

At 1030 pm on the 24.9.11, [Mr A] fell 2 metres landing on concrete on the L side of his chest. He called an ambulance. The ambulance report form notes that they were dispatched at 2230 to [Mr A]. On arrival they noted that his saturations were 89% and RR was 24. His HR was 84 and BP was 180/150. He was complaining of pain on inspiration and in the L abdomen. He arrived at [Hospital 1] Emergency Department at 1233am on the 25th of September 2011.

According to the Triage nurse [Mr A] arrived with L sided chest pain and shoulder pain after a fall of 2 metres. He was initially very pale and nauseated. He had a past history of hypertension but not on any medication. His recordings on arrival were a temp 37.3 BP 140/90 HR 90 RR 24 and Saturations of 92%. He was assessed as being alert and a pain score of 5/10. A Doctor was notified at 0045 and he was given a Triage Category 3.

[Dr B] reviewed the patient at 0045 noting the fall of 2 metres and the pain in the L chest. It was noted that a bottle and half of wine had been consumed. Her examination findings were that of diffuse tenderness in the Left flank and left lower ribs. [Dr B] ordered investigations including a FBC U and Es LFTs, ECG, CXR, abdo x-ray and a urine test. [Dr B] treated [Mr A] with morphine 2.5mg and zophran 4mg at 0110.

Review of nursing by documentation by [RN E] stated that at 0108 patient was complaining of pain of breathing. Observations show the HR 88 BP 110/60, RR 23 with sats of 93% and a CGS of 15/15. Patient was documented at 0135 to be lying on R side and pain score of 4 and 'sleeping on and off'. At 0150 IV parecoxcib was given and the nurse has documented that [Dr B] has said the patient could go home.

[Mrs A] states that '[Mr A] could not sit up let alone walk to the car' and thus they stayed till the morning. The [RN E] has documented the patient had no transport and thus they stayed overnight.

A further nursing note at 0420 documents that the patient was asleep with RR of 18 sats 99%. The BP and HR are not documented. At 0620 the [RN E] has documented that she suggested to [Mrs A] to find transport and it was noted that a wound was on the toe. This was cleaned and dressed. A set of observations was taken and the BP was documented at 70/40 and HR 100 the RR was 22. No saturations were recorded at this time. It was documented at 0635 that after trying to get the patient off the bed he was dizzy and unwell and complained of pain in

the shoulder. She felt there was a step off in the L shoulder and she got [Mr A] back in bed.

[RN E] documents in her statement that at 0635 when she noted a BP of 65/ she 'called [Dr B] immediately for review'. The [RN E] did two further sets of observation after the drop in BP a set at 0640 and 0650. In these the BP was 90/50 and 85/60 with HR of 100 and Saturations of 94 and 95%. [RN E] reports in her statement she then handed over her concerns to the day staff Nurse [RN D] and [another nurse].

There was no documentation that a doctor was called or reviewed [Mr A] but [Dr B] charted a litre of fluid, Brufen and Zophran for [Mr A] at 0700hrs. [Dr B] reports in her documentation that she did review clinically [Mr A] prior to treating him with fluid and analgesia. [Mrs A] states that [Dr B] 'did not review [Mr A]'. [RN E] stated that after she left the hospital 0745 she called back to the ED to [RN D] and said she had 'not documented calling [Dr B]'. [RN E] also states that she did not see if [Mr A] is being reviewed clinically but had other patients to attend to as well as [Mr A]. Clinically [RN D] confirms receiving the call from [RN E] but not documenting the call.

At 0715 a further set of nursing documentation by staff Nurse [RN D] prior to fluid, showed saturation of 91% and HR of 100 and BP 80/50. The notes post the fluid at 0750 show the HR 100 BP 110/80 and saturations of 92%. Nurse [RN D] has also reported that the patient felt better. At 0810 the nurse [RN D] has documented that she tried once again to get the patient up but he became nauseated and pale complaining of abdominal pain. At 0835 [Mr A] attempted to go to the toilet and once again is documented as becoming pale, diaphoretic and nauseated and was assisted back to bed. His saturations were reported as 83% and 92%. The nurse has documented that a further litre of saline was given.

There is no documentation of a doctor review but a litre [of] saline and tramadol was charted by [Dr C] at 0840 and 0850hrs. [RN D] statement says that this was discussed with [Dr C] but he did not review. [Dr C] supports that he did not review [Mr A] but cannot remember [RN D] giving an overview of the patient to him. He states that [Dr B] returned to ED and at handover said that [Mr A] could be discharged and that [Dr C] need not be involved. [Dr C] states that it would not be his usual practice to chart fluid and analgesia without reviewing the patient but he had assumed [Dr B] had reviewed the patient prior to handover and that [Mr A] was subsequently safe for discharge.

At 0925 [Mr A] stood up again and tolerated this with good colour. He was able to walk to the toilet. Nurse [RN D] has documented a set of observation at 0925. HR 95 BP 125/80 and saturations of 97%. This was reported to [Dr C] and thus appeared safe for discharge. Subsequently his IV line was removed and [Mr A] was discharged.

After Discharge [Mr A] [returned home] and attended his GP with SOB and pain. He was initially treated conservatively but on GP review on the 3rd of October a

further CXR was ordered which showed fractured ribs, consolidation of the L chest and a pleural effusion. [Mr A] was referred and admitted to [Hospital 3] where a CT demonstrated fractured ribs with a rib contusion and laceration of the spleen and haemorrhage in the pelvis.

He was discharged from [Hospital 3] on the 9th of October but was subsequently admitted on the 13th of October 2011 as he remained symptomatic with SOB and pain and was discharged on the 16th of October 2011.

Opinion

1. the decision by [Dr B] to discharge [Mr A] at 0230

[Mr A] history has documented pain on breathing and abdominal pain on the L side throughout his admission. [Mr A] history provided a significant mechanism of injury and clinical findings with the low saturations at the scene and in the ED of 92% and RR 22 in a 40-year-old man with no significant past history. [Mr A] abdomen was tender to exam on presentation by [Dr B].

Appropriate investigations were ordered by [Dr B] on arrival of [Mr A], in the setting of the [Hospital 1] ED. I note I have not seen the blood results but they are reported as normal in the notes. The CXR was reported as normal but poor inspiration was noted. This would be consistent with significant pain.

Fractures on a CXR are notoriously difficult to pick up with only 50% often being seen at the time of the first x-ray. Trauma studies indicate that routine chest radiography in stable blunt trauma patients may be of low clinical value. A good and careful physical examination and history taking can accurately identify those patients at low risk for chest injury. Trauma studies say 50% of patients with normal chest radiographs were found to have multiple injuries on chest CT scan — often theses findings are fractured ribs. If a patient is suspected of rib fractures especially in lower ribs there is increased risk of abdominal injuries. A 1.4- and 1.7-fold increase in the incidence of splenic and hepatic injury, respectively, occurs in those with rib fractures.[1,2,3]

Contusions of the lung are also not often seen on x-ray initially. I note in this case an x-ray report by a radiologist of a normal CXR at the time of arrival. However clinical symptoms of SOB and low saturations and high RR can be indicative of underlying lung injury and unseen fractured ribs on x-ray and thereby require further observations.

Following trauma subsequent examination and observations are required. If any ongoing signs of abdominal pain or respiratory distress are noted then further imaging in the form of a CT or USS are required. In this case a transfer to [Hospital 2] is required as per the protocol in ED from [Hospital 1]. Plain abdominal x-ray does not provide information in blunt trauma of the abdominal organs.

On a retrospective review of this case it does appear that the full facts of the case were not carefully considered by [Dr B] in her decision to discharge [Mr A] at

0230. A less experienced clinician may not recognise the ongoing bleeding that may occur following trauma and the subtle clinical signs of hypoxia and increased RR at the time of arrival in the context of normal blood tests. As an ED MOSS, [Dr B] should be experienced in Trauma thus should recognise abnormal observations and clinical findings of LUQ pain and thus at a minimum continued observing [Mr A]. I believe it is a moderate departure from expected standard of care for an ED MOSS.

2. The adequacy of the review of [Mr A] by [Dr B] at 0700am

A blood pressure drop of 0640 to 65/- in the context of trauma has significant implications in the management of trauma. Many papers indicate higher mortality and ICU admission associated with an episode of hypotension in blunt trauma. Patients with multiple episodes of hypotension have a risk of 13% of blunt mortality as a result of the trauma.[7]

At 0700hrs [Dr B] should have reviewed [Mr A] clinically including nursing observations in the period of time which [Mr A] was in the ED. On review of the nursing charts it is clearly documented that [Mr A] had prolonged hypotension (for a man normally hypertensive) and elevated RR and low saturations. He also was symptomatic on standing as observed by the nursing staff and complained of pain in the chest and abdomen. This would be consistent with hypovolemia or blood loss and fractured ribs.

There is no documentation of a clinical exam by [Dr B] and a discrepancy from [Dr B] and [Mrs A] as to whether a clinical review was undertaken by [Dr B] but [Dr B] charted ondansetron and IV fluid. However, the Commissioner has made a finding of fact that [Dr B] did review [Mr A] at 7am and I have given my advice on that basis.

[Dr B] on 6th of April states she had felt this significant hypotension may be related to analgesia and alcohol. [Mr A] had not received morphine since 0135 at which time the dose was 2.5mg. Morphine does cause hypotension but the half-life of morphine IV is 3 hours. Alcohol also can cause hypotension due to vasodilation however at 0640 it was 8 hours post his last alcoholic beverage. I do note that in her letter on 6th of April that [Dr B] does comment that 'in hindsight she may have placed too much emphasis on alcohol and morphine'.

I am not sure of the experience of [Dr B] in Trauma. If [Dr B] had little experience in Trauma it would be appropriate to gain guidance from the consultant on call. I note that the [SMO expectations in ED] states that the [Hospital 1] ED SMO should have a low threshold to contact the [Hospital 2] SMO for advice or referral. It is expected that an ED MOSS would have Trauma experience and thus should have recognised a BP drop to 65 as significant in combination with the clinical description of chest pain and LUQ pain. If she was new to her role then she should have made a call to the ED SMO at [Hospital 2] for guidance in the case this is also a mild deviation from standard of care not to consult a senior colleague if inexperienced.

In summary the adequacy of review of a patient with trauma and significant hypotension in combination with low saturations and elevated RR is below the standard of care and a moderate deviation of that expected by a senior doctor in Emergency medicine.

3. If [Dr C] did not review [Mr A] the decision by [Dr C] not to review [Mr A] when nursing staff had reported to him that he was dizzy and pale and sweaty at 0835

[Dr C] states that he did not review the patient when he charted the fluid and analgesia at 0830. It is still unclear of the timing of [RN D] discussion and fluid charting of [Mr A] and the Dr handover from [Dr B]. However a standard of care for a patient would involve reviewing a patient if he showed signs of cardiovascular instability as [Mr A] did in the setting of Trauma. If [Dr C] believed another Dr would complete this review then he may not proceed with … review of the patient however it would be appropriate to call the responsible Dr to communicate the need for immediate review.

When the patient was handed over he was told that he … 'would not need' to see the patient. [Dr B] acknowledges in her letter 6th of December that a fuller handover to [Dr C] would have been appropriate.

Handover of patients is critical in Emergency Medicine. Adequate handover of patients is well documented as a time when patient error occurs. Evidence shows where handover is inadequate up to 50% of these patients have an adverse event.[4,5] [Dr C] has documented 12/4/2013 that he was asked by a nurse to chart analgesia and fluid as [Dr B] had not reviewed the patient as yet. [Dr B] then subsequently communicated at handover that [Dr C] did not need to be involved with the patient. Formal handover in [Hospital 1] ED did not occur at the time of [Mr A's] presentation.

In summary if a nurse has reported hypotension dizziness and sweat[ing] in a patient then a doctor should clinically review the patient. If [Dr C] believed that another Doctor was going to review and treat the patient it would be reasonable for [Dr C] not to review the patient. If [Dr B] has handed over that no input by [Dr C] was required then [Dr C] did not deviate from the standard of care expected at handover.

4. If [Dr C] did not review [Mr A] the decision by [Dr C] to chart medication for [Mr A] when [Dr C] had not reviewed the patient personally (but had seen the clinical notes)

The Emergency department is a busy place. Often many clinical events are occurring concurrently. Treatment can be charted without initial clinical review especially if a patient is in pain and requires immediate treatment. Providing immediate treatment for patient at the time when the treating Dr, in this case [Dr B], is perhaps tied up reviewing patients is consistent with a standard of care in the Emergency department. However the treatment you are charting should always

be communicated to the responsible doctor and the responsible Doctor should review the patient and the treatment.

[Dr C] has documented 12/4/2013 that he was asked by a nurse to chart analgesia and fluid as [Dr B] had not reviewed the patient as yet. [Dr B] then subsequently communicated at handover that [Dr C] did not 'need to be involved with the patient'.

Formalising handover and responsibility enables the Doctor to understand who is responsible for the case. If [Dr B] says he need not be involved it would not be unreasonable for [Dr C] to leave the completion of care to [Dr B]. In this case there is no deviation in the standard of care.

5. If [Dr C] did review, [Mr A] the adequacy of the review by [Dr C]

[Dr C] has documented that he did not complete a full clinical review of [Mr A] throughout his admission at [Hospital 1]. He has reported that he had made an assumption that [Dr B] had reviewed or would review the patient. Thus in this case, if [Dr C] did review, the adequacy of review is severely below the standard of care expected by an ED SMO.

Once again handover of patients is critical to the ongoing care of patients in Emergency Departments.

6. The adequacy of clinical documentation.

In a busy ED it can often be a difficult environment to provide documentation of events that are happening. The medical documentation in this case does not reflect the clinical review that is stated by [Dr B] in this case to have occurred regularly over the night. There is no documentation by medical staff of the examination findings and how the patient stated he was feeling throughout the night.

Nursing documentation provides clinical information about what was happening over the course of the night with frequent review and clinical concerns but has not documented the requests for Dr review of the patient. The nurses also seem to have handed over their concerns, at handover, about the patient and that he required medical review. It should be noted that [RN E] subsequently rang back to the ED to the Day staff to ask for this to be documented in the notes showing her insight into the lack of documentation on this point.

The adequacy of documentation by Medical staff is less than the expected standard of care by a Doctor. In a busy environment documentation can be very difficult however a patient that has a drop in BP of this significance in the setting of trauma warrants a clinical note and review in response to the call from nursing staff. [Dr B's] lack of documentation is a moderate deviation from the standard of care expected when asked by nursing staff for clinical review and expressions of concern.

1. Paydar S, Johari HG, Ghaffarpasand F et al. The role of routine chest radiography in initial evaluation of stable blunt trauma patients. *Am J Emerg Med*. Jan 2012;30(1):1–4
2. Omert L, Yeaney WW, Protetch J. Efficacy of thoracic computerized tomography in blunt chest trauma. *Am Surg*. Jul 2001;67(7):660–4.
3. Cook AD, Klein JS, Rogers FB, et al. Chest radiographs of limited utility in the diagnosis of blunt traumatic aortic laceration. *J Trauma*. May 2001;50(5):843–7
4. Kachalia A, Gandhi TK, Puopolo A *et al.* Missed and delayed diagnoses in the emergency department: a study of closed malpractice claims from 4 liability insurers. Ann Emerg Med 2007; 49: 196–200
5. Ye K, Taylor DM, Knott JC, Dent A, MacBean CE. Handover in the emergency department: Deficiencies and adverse effect. EMA 2007; 19 (5): 433–441.
6. Jeffcott, SA *et al.* Improving Measurement in Clinical Handover. Qual Saf Health Care 2009; 18: 272–276
7. Hasler RM, Nuesch E, Jüni P, et al Systolic blood pressure below 110 mm Hg is associated with increased mortality in blunt major trauma patients: multicentre cohort study Resuscitation. 2011 Sep;82(9):1202–7."