Diagnosis and management of paediatric fever (09HDC01190, 4 June 2010)

Accident & medical clinic ~ Public hospital ~ Emergency department ~ District health board ~ Paediatric fever ~ Meningococcal septicaemia ~ Standard of care ~ Information provided ~ No breach

A family complained about the care provided to their 23-month-old son, who died of meningococcal septicaemia. The mother took her son to an after-hours accident and medical clinic because she was concerned that he had been sick for three days and had started vomiting that evening. He was triaged shortly after arrival by a registered nurse, who found his temperature markedly elevated at 39.6°C and assigned him as needing to be seen by a doctor within 20 minutes of arrival. He was not seen by a doctor until over an hour later. The doctor noted that his temperature was 39°C but, despite a thorough examination, could not determine the cause of his illness, and referred him to the public hospital's Emergency Department (ED), which was next door to the after-hours accident and medical clinic.

The baby was admitted and seen immediately by a registered nurse, who triaged him as semi-urgent, to be seen by a doctor within an hour. Half an hour later he was seen by the paediatric resident medical officer, who found he was improving, with a temperature of 36.8°C. She noted a number of small red spots on his back. A consultant paediatrician also examined the baby, and advised the family that the spots were probably insect bites, and that the baby had a viral infection. The mother was told that she could take the baby home, but if she was concerned about him in any way, or if his temperature went up, she should bring him back to the ED. They went home at 11.20pm.

The next morning the mother woke to find the baby lethargic and covered in a non-blanching rash. An ambulance was called, and the baby was admitted to the ED at 7am. At 7.48am he went into respiratory arrest and was not able to be resuscitated. His cause of death was determined to be meningococcal septicaemia.

It was held that the staff at both the accident and medical clinic and the ED provided appropriate care, and did not breach the Code.

The clinic conducted a significant event review into this incident and found that there was no evidence that the management influenced the outcome. However, the review found areas where improvement could be made. As a result, the clinic has added a "task reminder" into the computer patient record system to alert staff to patients waiting to be seen, and as a reminder for nursing staff to record the triage times accurately. There is also a new computer prompt for staff to ensure that parents are provided with a pamphlet regarding the management of fever in a child.

The DHB conducted an internal Root Cause Analysis review of the care provided to this child. The review found that there were inadequacies of communication and documentation. The DHB made a number of changes to the information it provides to parents of sick children, and has reviewed its pamphlet for parents on managing fever in children, and revised its guidelines regarding the management of fever in paediatric patients presenting to the ED. A specific paediatric observation chart was introduced.