Emergency department care and management of an incomplete spinal fracture (07HDC17769, 28 November 2008)

Regional public hospital ~ District health board ~ Emergency department ~ Emergency department consultant ~ Emergency department medical officer ~ Incomplete spinal fracture ~ Mobilisation ~ Communication ~ Discharge ~ Documentation ~ Rights 4(1), 4(2), 4(5)

A man fell five metres whilst snowboarding. He was reviewed by a locum medical officer working in the ski fields and airlifted to an emergency department at a public hospital. Over that afternoon and evening, two emergency department doctors had input into his care — a locum who first reviewed him and ordered chest and spinal X-rays to investigate whether he had sustained a spinal fracture, and an emergency department consultant who took over care in the evening.

There was a very high demand for emergency department and radiology services that evening. Being the only emergency department doctor on duty, the locum did not review the man personally, and instead issued instructions through nursing staff about mobilising and discharging him. Due to a misunderstanding about mobilising and returning home, the man left the hospital before he was formally discharged. Overnight, he experienced increased pain and numbness in his body. Shortly afterwards, he was transferred to a public hospital, where he was found to have sustained a T3 fracture. He underwent orthopaedic surgery, and was transferred to a spinal unit for rehabilitation.

It was held that most aspects of the locum medical officer's care were appropriate. However, he should have returned to review the man when he began experiencing numbness in his left leg. In this respect, even as a relatively junior locum emergency department doctor, he should have taken more care. The numbness was a significant new symptom in a young man who had suffered a back injury, and he should have been re-assessed. In failing to do so, the medical officer breached Right 4(1). In addition, his documentation did not comply with professional standards, and he was held to have breached Right 4(2).

Although the heavy workload was a significant mitigating factor, it was held that the emergency department consultant did not meet the standard expected. He did not review the man personally, and did not recognise and respond to the red flags of a case of high-risk spinal injury. It was held that he did not provide an appropriate standard of care and breached Right 4(1). After reviewing the man's X-rays, the consultant noted that there was nothing abnormal detected, and recorded a brief plan. Apart from this, he did not document any other information about the man's care. It was held that the consultant's record-keeping did not comply with professional standards and he therefore breached Right 4(2).

A public hospital is responsible for the quality of documentation by its medical and nursing staff. Staff need to be trained to keep good records. They need appropriate support and sufficient time to do so, and audits of the quality of documentation should be undertaken on a regular basis. There was no indication that the public hospital took these steps and, in these circumstances, it breached Right 4(2).

Communication between clinical staff fell below acceptable standards, in breach of Right 4(5). Clear advice about discharge was important — in particular, advice to the man that he had to be reviewed by medical staff before he was allowed to leave the hospital — since the man was returning to an area where access to medical help was limited. The lack

of clear discharge advice compromised the man's care and highlighted a systems failure at the hospital. In this respect also, the public hospital breached Right 4(5).

A shortage of junior and senior medical officers does not excuse a district health board from its duty to provide an emergency department that has sufficient staff and robust systems to withstand fluctuating demands and ensure that good communication occurs between staff and patients.