HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate care provided at after-hours clinic

1. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the care provided to her father, Mr A, by registered nurse (RN) B[1] at an after-hours clinic in Year 1.[2] Mr A has a history of hypertension (high blood pressure), hyperlipidaemia (high cholesterol), right-side rotator cuff injury,[3] and, at the relevant time, he was a smoker.[4] On Day 1, Mr A visited the after-hours clinic with several presenting symptoms and subsequently was discharged with the advice that he had a tooth abscess[5] requiring urgent dental care. However, on Day 3 Mr A presented to Public Hospital 1 Emergency Department (ED), where he was diagnosed with a heart attack (an ST-elevation myocardial infarction (STEMI)).[6] Ms A is concerned that her father did not receive appropriate care at the after-hours clinic, which resulted in the delayed diagnosis of his heart attack.

Information gathered during investigation

2. At approximately 11.25pm on Day 1, Mr A (accompanied by Ms A) presented to the after-hours clinic. The after-hours clinic was operated by Health New Zealand | Te Whatu Ora (Health NZ).

3. On arrival, Mr A was seen by a staff member, Ms C, for initial screening and was moved to a separate waiting room.[7] After informing Mr A of the procedures, Ms C left to attend to another patient.

4. Ms A stated that her father had 'heart attack symptoms', which included a '[t]ight sore chest, sore throat, jaw pain, headache and vomiting'. Mr A stated that he told the staff member: 'I think I am having a heart attack.' In contrast, Health NZ submitted that Mr A's presenting complaint was a sore throat, and that the focus of the consultation was on Mr A's dental pain. Ms C told HDC that she does not recall Mr A's visit to the after-hours clinic and 'can only assume' that she followed the normal process. In response to the provisional decision, RN B stated that had Ms C been notified by Mr A or Ms A that he thought he was having a heart attack, then Mr A would have been immediately referred to the ED as per the normal process.

[1] On-call duty nurse at the time of events.
[2] The after-hours clinic operated between 9pm and 8am, seven nights a week. Patients were referred to the hospital by the triage nurse if they required hospital-based care/treatment.
[3] A tear in one or more of the tendons surrounding the shoulder joint. This may cause pain, weakness, and difficulty with movement.
[4] It was documented that Mr A was a smoker for 40 years and smoked 20–25 cigarettes per day.
[5] A pocket of pus caused by a bacterial infection around a tooth.
[6] A heart attack caused by a sudden and prolonged blockage of blood supply to the heart.
[7] Health NZ stated that Mr A was placed in an isolated room as he had selected 'yes' to having a sore throat.

Nursing assessment

5. Mr A waited for approximately 15–20 minutes to be seen by RN B for the purpose of triaging him.[8] Health NZ accepted that there was a delay between Mr A's presentation and the triaging of his symptoms but noted that this was a nurse-run clinic (not an ED) with a small number of staff present.[9] RN B recalled that the shift was a busy one, and that at the time of Mr A's presentation she was attending to another patient. She said that she attended Mr A as soon as she felt she could leave the patient.

6. During the consultation, RN B documented[10] that Mr A had the following medical history in relation to his presenting complaint:

a) He had been unwell for the past week with a toothache (right upper jaw) and was now complaining of a 'sore throat +++' and right earache.

b) Pain was at times radiating from the throat to the right shoulder tip and across the chest, and Mr A had '[shortness of breath] +++ when lying flat in bed'. He had taken ibuprofen (400mg) at 11pm.

c) One incisor was 'mostly gone', and the very back right molar tooth was 'very tender to touch'.

7. Mr A's medical history was also noted during the consultation, including that he suffered from high blood pressure and high cholesterol and that he was a smoker (20–25 cigarettes a day).

8. RN B told HDC that during the consultation Mr A's standard observations were within acceptable limits, and his airway was patent, he had no shortness of breath, he was speaking clearly in complete sentences and was calm, and he was not restless or wincing in pain. In response to the provisional decision, RN B stated that if Mr A thought he was having a heart attack, or if there had been any reference to heart attacks from Mr A or Ms A during the consultation, she would have called an ambulance and referred him to the ED, as was standard practice. RN B stated that she is 'confident' that she advised Mr A to discuss his shortness of breath with his doctor (as this is her standard practice), although this was not documented in the clinical record.

Triage 4

9. RN B stated that 'on the basis of the information [Mr A] gave [her]', she triaged him as a triage 4 (low acuity),[11] informed her colleague of the triage category, and advised Mr A that she would see him as soon as possible and to let her colleague know if his symptoms worsened.

10. RN B then left the room to attend to another patient. RN B and Health NZ stated that at the time of events there was clear signage in the waiting room that informed patients to

[8] RN B stated that the night of [Day 1] was a 'very busy' night at the clinic with a high number of patients.
[9] Health NZ told HDC that the average number of patients seen during clinic hours (9pm–8am) is between six and eight patients.
[10] Health NZ told HDC that the staff member entered the information into the electronic medical record.
[11] Health NZ stated that this indicated a 'stable low-acuity presentation that could safety wait for assessment/treatment for up to one hour (as per the Australasian Triage Scale)'.

escalate concerns to staff, including chest pain. In addition, Health NZ stated that it was appropriate for staff to leave to deal with another patient under triage 4. However, it agreed that the triage category 'could have been assessed as a "triage 3"[12] in this case.'[13]

Diagnosis of tooth abscess and contact with on-call GP

11. After conducting an assessment and examination of Mr A, RN B considered that a tooth abscess was the 'primary and most likely diagnosis'; however, this was not documented in the clinical record. RN B then telephoned the on-call general practitioner (GP), Dr D, who gave a verbal order for the immediate administration of antibiotics.[14] The content of this discussion was not documented in the clinical record. [15]

12. In the early morning of Day 2, Mr A was advised to seek urgent dental care, and he was given antibiotic tablets and paracetamol. He was also advised to see his own GP or to return to the clinic in the morning for a prescription for a full course of antibiotics.

No ECG performed

13. Mr A stated that the 'first and only medical tests' he received at the clinic were blood pressure and oxygen level tests, which occurred at least 30 minutes after his arrival to the after-hours clinic. RN B did not record an electrocardiogram (ECG)[16] or undertake further tests on Mr A or refer him to the hospital.

14. RN B told HDC that, on 'proofreading' her clinical notes shortly after seeing Mr A, she decided that it would be 'prudent' to perform an ECG on Mr A as he was 'in his 50s, male, a smoker, and he had mentioned experiencing shortness of breath'. However, by this time, Mr A had left the after-hours clinic. RN B stated that she considered telephoning him to return for an ECG but decided against this on the basis that he was going to see a doctor in the morning (who would have access to his clinical records).

15. Health NZ stated that as chest pain was raised during the nursing assessment (documented to have occurred intermittently during the past week), there was an expectation, in accordance with Health NZ guidelines,[17] that RN B would have conducted an ECG and discussed the findings with the on-call GP.

[12] To be seen within 30 minutes due to a potentially life-threatening condition, potential adverse outcomes, or severe discomfort or distress (as per the Australasian Triage Scale).
[13] Health NZ stated that quantitative scoring for pain levels can lead to higher triage scores, and this is part of the Australasian Triage Course (discussed further below).
[14] Dr D told HDC that 'it is not unusual for the overnight nurse to call for permission to administer broader spectrum antibiotics for toothache'. However, he stated: 'I have never to my recollection had the overnight nurse call me for advice on how to manage a suspected myocardial infarction or acute chest pain.'
[15] In response to the provisional decision, RN B stated that the practice at the time of events was to state 'DW [discuss with] on call GP Dr…' with the assumption that the reader would understand that the patient's presenting complaint history, medication, allergies, immunisations and any other findings on examination had been discussed with the on-call GP.
[16] A test that measures the electrical activity (rhythm) of the heart.
[17] Clinical Practice Guideline — Nursing management of chest pain.

Subsequent events

16. Mr A had two upper molar teeth extracted by a dentist on the morning of Day 3. Health NZ considers that this indicates that Mr A did have an urgent dental problem that required attention and treatment, as identified by RN B.

17. Ms A told HDC that her father continued to experience the 'same problems',[18] and at approximately 11.27pm on Day 3 Mr A presented to the Public Hospital 1 ED, where he was diagnosed with a heart attack and underwent treatment. On Day 4, Mr A was transferred to Public Hospital 2 for further treatment. It is documented that the chest pain was '10/10 in severity with associated jaw pain and headache. Associated with [shortness of breath]. Occurred at rest', and that Mr A had had a '[s]imilar presentation on [Day 1] and was seen at after-hours — no ECG performed'.

Adverse Event Review

18. Health NZ completed an Adverse Event Review (AER) relating to Mr A's presentation to the after-hours clinic, which identified the following deficiencies in care:

a) There was no documented diagnosis or differential diagnosis in the clinical record.

b) There was no documented pain assessment for any of the six different pains that Mr A mentioned (jaw, tooth, ear, throat, shoulder tip, and chest) as required by standard practice in triaging and assessing patients with pain.

c) There was no documented record of the substance or content of the discussion between RN B and Dr D.

d) The clinical guidelines for the management of chest pain were not followed, resulting in an 'apparent lack of further questioning/investigation' during the nursing assessment. This may have contributed to a failure to elicit information about Mr A's chest pain. Health NZ stated that it sought expert opinions from two experienced ED nurses, who both concluded that there were sufficient red flags in the triage and assessment notes[19] to indicate that chest pain should have been explored further (including for the nurse to record an ECG and to consider a referral to the ED).

e) While the clinical record showed that appropriate discharge information was provided to Mr A for the dental problem, there was no documented advice provided to Mr A to seek further treatment if his symptoms worsened.[20] In addition, there was no written advice provided to Mr A should he experience chest pain or shortness of breath.

f) There was no documented smoking cessation advice or support provided to Mr A (which was a Ministry of Health target for all consumers who identified as smokers).[21]

[18] This is supported by the ED clinical record, which documented that Mr A initially had a sore throat, headache, and vomiting, and then 'developed crushing pain in the centre of [his] chest'.
[19] Such as chest pain, shortness of breath, current smoking status, hypertension, and hyperlipidaemia.
[20] In response to the provisional decision, RN B stated that she did document the advice she gave to Mr A to follow-up with his GP the next morning. The clinical record indicates that this advice related to Mr A being able to get an antibiotic prescription.
[21] In response to the provisional decision, RN B stated that it was not the practice to offer smoking cession at the time. However, she noted that this has changed since events, with smoking cessation prescription pads being provided at the after-hours service.

g) The clinical governance framework for the after-hours clinic was 'no longer operational' and had resulted in a 'siloed and isolated service that has little to no management or support from the ED or other stakeholders beyond the GPs who provide the after-hours on call service'.

19. Regarding Mr A's subsequent diagnosis of a heart attack, Health NZ stated:

> 'While a more comprehensive assessment that included an exploration of [Mr A's] chest pain and [shortness of breath] and the recording of an ECG may have highlighted an underlying cardiac condition that required further investigation, it cannot be known if this investigation would have highlighted this or even resulted in any altered outcome.'[22]

20. Health NZ stated that it is 'not possible to determine with any degree of confidence or certainty that the diagnosis of acute STEMI made in the ED on [Day 2–Day 3] was a delayed diagnosis.'

21. Health NZ's AER recommended the following:

a) Education and guidance regarding the appropriate standard of clinical documentation.

b) A review of nursing assessment of patients (particularly around presentations that involve any type of pain).

c) Sharing this case with the after-hours clinic staff, with education around policy (management of chest pain) and the need to investigate all chest pain (historical or presenting).

d) Reclassification of this adverse event to a Severity Assessment Score (SAC) 3 (previously a SAC 2).[23]

e) The addition of the after-hours clinic as a 'Major Risk' on Health NZ's Risk Register.

Independent clinical advice

22. Independent clinical advice was sought from clinical nurse manager RN Therese Manning (Appendix A), who advised that there had been several departures from accepted practice:

a) The delay in triaging Mr A — mild departure.

b) The decision to triage Mr A as a category 4 — significant departure.

c) The failure to undertake an ECG — severe departure.

d) If staff were aware that Mr A was experiencing active chest pain on arrival, the decision not to triage him as category 2 — severe departure.

[22] Health NZ cited the expert opinion of a senior cardiologist, who noted that ECGs often do not support the diagnosis for acute coronary syndrome.

[23] This is a rating and triage tool used for adverse event reporting. A SAC 3 indicates a moderate event, whereas a SAC 2 is a major event.

Responses to provisional decision

Ms A

23. Ms A was provided with an opportunity to respond to the provisional decision and had no further comment to make.

RN B

24. RN B was provided with an opportunity to respond to the provisional decision. RN B reiterated that she is apologetic for any distress caused to Mr A and Ms A for her failure to adequately assess Mr A's chest pain and for the absence of clearer documentation. Further comments made by RN B have been incorporated into this report where relevant.

Health NZ

25. Health NZ was provided with an opportunity to respond to the provisional decision. It stated that it accepted my finding of an adverse comment regarding the lack of a clinical governance framework, operational oversight, and clinical support for RNs at the after-hours service at the time of events. However, Health NZ stated that it has since 'implemented significantly improved service delivery and clinical governance models for the after-hours service to mitigate these issues and would support RN B to meet the requirements of any recommendations made in this decision. Further comments made by Health NZ have been incorporated into this report where relevant.

Decision: RN B — breach

26. On the basis of the clinical record and other evidence, I am satisfied that during the consultation on Day 1–Day 2 Mr A communicated to RN B that he had a very sore throat, earache, and toothache. He also disclosed intermittent pain radiating from his throat to his right shoulder tip and across his chest, and that he felt short of breath when lying flat. Based on the evidence (which is conflicting), it is not possible to draw conclusions as to whether Mr A told RN B or another staff member that he thought he was having a heart attack, and nor am I able to determine whether Mr A was actively experiencing chest pain at the time he was being assessed.

27. I am satisfied that Mr A was presenting with dental problems that required assessment and treatment and that this was RN B's focus during the consultation. It appears that, notwithstanding Mr A's other symptoms (chest pain, shoulder tip pain, and shortness of breath) and cardiovascular risk factors (age, hypertension, smoking, and high cholesterol), the potential for another diagnosis, or investigation of those symptoms was not considered by RN B — at least until after he had left the clinic.

28. I concur with my advisor, RN Manning, that while RN B conducted a thorough assessment of Mr A's dental problem, further investigation was needed regarding the cause of the reported pain radiating from Mr A's throat to his right shoulder and across the chest, and his significant shortness of breath. This view is consistent with the expert peer opinions provided to HDC as part of the Adverse Event Review and the conclusions of the review itself.[24] Namely, a more detailed assessment was warranted, and an ECG was indicated,

[24] It is relevant to note that there is somewhat conflicting expert nursing advice in the ACC file. The advisor concluded that, in urgent care settings, the focus would be on treating acutely presenting symptoms and that the care was reasonable and appropriate. The advisor commented that further investigations were not

which may have highlighted an underlying cardiac condition necessitating further investigation. In saying that, it is important to acknowledge that, even if an ECG had been conducted at that time, it may not have identified any issues of concern. At most, an ECG would have offered the *potential* opportunity for an earlier diagnosis, if indeed Mr A was suffering a cardiac event/cardiac ischaemia[25] at that time (which cannot be concluded with any degree of certainty).

29. It is my view that by failing to investigate Mr A's chest pain and shortness of breath further (including exploring Mr A's symptoms and performing an ECG), RN B failed to assess and treat Mr A appropriately.

30. I note that my advisor commented that RN B should have assessed Mr A as a Triage 3, noting that the Australasian Triage Scale guidelines clearly state that '[c]hest pain likely non-cardiac and moderate severity' and '[m]oderate shortness of breath' are clinical descriptors of triage 3.[26] This triage category would have signalled a shorter timeframe within which Mr A should have been seen. However, I acknowledge that there were organisational factors at the after-hours clinic that affected the timeliness of Mr A's triage from arrival (discussed further below), and I am not critical of RN B in this respect.

31. However, I am concerned about an insufficient level of clinical documentation made by RN B, including the lack of diagnosis, differential diagnosis, assessment of pain (in accordance with Health NZ guidelines about the management of chest pain), telephone discussion with the on-call GP, and post-discharge advice. I note that Health NZ also identified these issues in its AER report.

32. I have carefully considered the factors in mitigation for RN B's lapses in care, noting in particular that she was managing several patients and that the care was provided in an after-hours clinic rather than an emergency department setting. I have also considered whether the staff were appropriately supported in terms of the structure, operation, and governance of the clinic.

33. Ultimately, however, I have concluded that the responsibility for the lapses in care must rest with RN B. The adequate assessment of chest pain and standards of documentation are core competencies to be expected of an RN, particularly in the after-hours setting, where the timeliness of such assessment (in terms of escalating care — for example, transfer to hospital) is critical. I note that RN B was trained and up to date regarding ECG interpretation.

thought to be appropriate either by the nurse or the patient. I have preferred the evidence of my clinical advisor, supported by the other opinions provided by Health NZ, and indeed the evidence of RN B, who reached the view (albeit after Mr A had left the clinic) that an ECG was indicated. In my view, the ACC advisor has made assumptions regarding the positions of both the consumer and the provider without evidential foundation.

[25] Reduction of blood flow to the heart.

[26] This requires a response (assessment and treatment) to start within 30 minutes.

34. Accordingly, I find RN B in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) [27] for failing to take reasonable care and skill in the provision of health services to Mr A on Day 1–Day 2.

35. In forming my conclusion, I acknowledge that I am unable to determine whether the failings discussed in this report directly resulted in a delayed diagnosis of Mr A's heart attack on Day 3. However, I note that health conditions may co-exist, and the thorough evaluation of presenting symptoms is crucial to distinguish between possible conditions. I therefore consider that this case highlights the importance of considering, investigating, and documenting differential diagnoses in clinical decision-making.

Decision: Health NZ — adverse comment

36. The after-hours clinic is operated by Health NZ, and therefore it is incumbent upon Health NZ to provide an appropriate level of clinical support, governance, and operational oversight to the clinic and its staff. I am critical of the lack of clinical support provided to RN B and of the clinical governance framework at the after-hours clinic at the time of events.

Clinical support

37. At the time, there was a small number of staff working at the after-hours clinic. Health NZ accepted that this meant that the nurses were 'moderately professionally isolated and ha[d] no easy access to colleagues for informal professional and clinical decision-making conversations'. In addition, Health NZ noted that there was a lack of formal education requirements for RNs to complete (including in conducting a physical assessment and developing diagnostic reasoning skills).

38. My advisor, RN Manning, similarly identified that there was a lack of clinical support provided to RN B at the time of events. RN Manning recommended that in the interests of patient safety, having additional RNs present in the after-hours clinic (ideally triage trained) would be suitable.

39. In response to my provisional decision, Health NZ stated that it has increased RN staffing levels and implemented changes to strengthen clinical oversight and ensure opportunities for professional support (discussed at paragraph 42). I encourage Health NZ to monitor the impact of these changes as part of its ongoing quality improvement initiatives.

Delay in triage

40. I consider that the delay between Mr A's presentation and triage is an example of patient safety risk. As advised by RN Manning, the triaging assessment should have occurred on Mr A's arrival (at the first recorded time of contact between the patient and staff as per the Australasian Triage Guidelines). RN B told HDC that at the time of events, the clinic had started to accept more patients, which likely added to workload pressures. Moreover, her inability to undertake Mr A's triage was a direct result of her focus on another patient requiring her attendance at that time. It is encouraging that Health NZ has identified the

[27] Right 4(1) of the Code states: 'Every consumer has the right to have services provided with reasonable care and skill.'

need for increased staffing levels, which should go some way to addressing the patient safety risks identified in this report.

Changes made since events

41. RN B told HDC that she is apologetic for any distress caused to Mr A and his family, and she has made the following changes to her practice:

a) She conducts an ECG on every consumer who states that they have experienced any chest pain within the past month and scans this into the consumer's clinical notes (which is then emailed to their GP). In addition, if the ECG recording is of a normal rhythm, she provides the consumer with a copy of the ECG for future reference or follow-up care. RN B stated that she has discussed the importance of these steps with other nurses who work overnight at the after-hours clinic.

b) She spent time working at Public Hospital 1 ED as part of a rotating roster that was implemented by Health NZ following this incident.

c) She now offers nicotine replacement therapy quit cards to consumers who are smokers.

d) She scheduled a triage refresher course.

e) Her clinical documentation is clearer in relation to the presenting complaint and the content of discussions with the on-call GP.

42. Health NZ stated that it has made the following changes to its practice:

a) All RNs who work in the after-hours clinic completed the Australasian Triage Course and a triage refresher course in 2024. Nurses are also provided with educational courses run by the ED Nurse Educator.

b) All current and future after-hours nurses are required to complete relevant postgraduate education.[28]

c) Nurses working at the after-hours clinic have a regular rotation through the Public Hospital 1 ED to allow for greater opportunities for practice support.

d) It has developed and implemented escalation pathways to Public Hospital 1 ED and nursing documentation standards and templates. It has refined the standing orders and standing order audit processes. Nursing staff access to the standing orders has been removed.[29]

e) It has introduced a clinical portal and electronic clinical application system to allow for more accurate patient tracking and data capture.

f) It has strengthened the model of care through the inclusion of an extra RN, with clinical oversight and support provided by a dedicated Nurse Practitioner.

[28] The minimum requirement is a postgraduate certificate, comprising two courses — Advanced assessment and diagnostic reasoning and Advanced Pharmacotherapeutics.
[29] Health NZ stated that this did not meet governance requirements.

g) It is in the process of securing a contract to provide virtual medical consultations between 8pm and 8am.

Recommendations

RN B

43. I recommend that RN B:

a) Provide a formal written apology to Mr A for her breach of Right 4(1) of the Code, as identified in this report. The apology is to be sent to HDC, for forwarding to Mr A, within three weeks of date of this report.

b) Undertake a random audit (with the support of her employer) of 15 consumers who presented to the after-hours clinic over the last six months whom she triaged, to determine whether the triage score assigned was appropriate. The findings of the audit, including any corrective actions, are to be provided to HDC within three months of the date of this report.

c) Undertake a random documentation audit (with the support of her employer) of 15 consumers looking at clinical records over a six-month period to confirm that all clinical assessments have been documented fully. The results of the audit, and any corrective actions, are to be provided to HDC within three months of the date of this report.

d) Provide evidence of completion of the triage refresher course, within one month of the date of this report.

Health NZ

44. In accordance with the proposed recommendation in my provisional decision, Health NZ has provided HDC with an update on the implementation of the recommendations in the AER report. I consider that this response was reasonable and have no further recommendations in respect of Health NZ.

Follow-up actions

45. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.

46. A copy of this report with details identifying the parties removed, except Health NZ and the advisor on this case, will be sent to Te Tāhū Hauora Health Quality & Safety Commission and placed on the HDC website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

Appendix A: Independent clinical advice

The following independent clinical advice was received from clinical nurse manager RN Therese Manning:

'**Complaint: [Health NZ]**

Ref: C21HDC02691

I have read the HDC guidelines for Expert Advisors and agree to follow the guidelines.

I have been a Registered Nurse since December 1997. I have a Bachelor of Health Science in Nursing, and a Post graduate Diploma in Health Science in Advanced Nursing. I have completed TNCC (Trauma Nursing Core Course), Advanced Paediatric Life Support, the NZ Triage Course, and the National Burns Course. I was employed at Middlemore Emergency Department from 2002 until 2006 as a registered nurse where I completed the Emergency Care Modular Programme, and I was then employed as a Clinical Charge Nurse in Middlemore Emergency Department from 2006 until 2018. Since May 2018 I have been working as a Clinical Nurse Manager at Taranaki Base Hospital Emergency Department. This is a management role, but also involves supporting the Emergency Department clinically where required, such as assisting at Triage when there are high patient presentations.

I have been asked to comment on the care provided by [Health NZ], to [Mr A] on [Day 1/Day 2] as to whether this care was reasonable under the circumstances.

My report is based on the information provided.

Summary of events:
[Mr A] presented to [the after-hours clinic] at around 2330 hours on [Day 1]. The after-hours service at this clinic is provided by [Health NZ] … At this after-hours clinic, there [are a small number of staff] onsite. There is an on-call General Practitioner who is offsite but available to the onsite staff by telephone. There are electrocardiogram (ECG) machines available at the clinic, and staff have the necessary training to operate them. The complainant states that [Mr A's] presenting symptoms on [Day 1] included a "tight sore chest, sore throat, jaw pain, headache, [and] vomiting". However, the provider asserts that "at no point did [Mr A] complain of having chest pain". The clinical records state "pain at times radiates from throat to R/shoulder tip and across chest." And "Feels SOB +++ when lying flat in bed". [Mr A] waited around 15 minutes after arrival to be seen by the Registered Nurse (RN) on duty. After her consultation and assessment, the RN considered that the primary diagnosis was tooth abscess. She then contacted the on-call GP. [Mr A] was then administered paracetamol and Augmentin. On discharge, [Mr A] was given dental advice and advised to see a GP for a prescription for a full course of antibiotics. He was seen by a dentist on the morning of [Day 3] and had two right upper teeth removed. Then, on the night of Day 3, [Mr A] presented to [Public Hospital 1] with symptoms including severe chest pain. He was diagnosed with an acute ST elevation myocardial infarction. Subsequently, early in the morning on [Day 4], [Mr A] was transferred to [Public Hospital 2] where he remained until [Day 6].

The appropriateness of the triage procedures in place at the clinic

According to the Australasian Triage Guidelines the patient should be triaged on arrival to the Emergency Department (ED); "The arrival time is the first recorded time of contact between the patient and ED staff. Triage assessment should occur at this point" (1). Given the circumstances with [a small number of staff] available overnight in an after-hours clinic setting, I would see this 15-minute delay to triage as a mild departure from recommended practice. My recommendations for improvement would be to have [additional RNs] rostered overnight to ensure availability to triage in a timely manner — ideally on arrival and to be able to assess patients thoroughly following triage, without potential delays for further patients arriving waiting to be triaged. If this is not feasible in the after-hours clinic due to low patient volumes overnight, there should be clear signage advising patients to let staff know immediately if they have an urgent problem such as chest pain, so that patients who potentially have a life-threatening condition can still be triaged quickly.

The appropriateness of the nursing assessment, diagnostic formulation and overall management in this case

The Registered Nurse assessment focused on the dental problem due to the complaint of toothache with poor dentition and enlarged gland in neck. There appears to be a thorough assessment for this dental problem, but further investigation seems to be lacking into the cause of the pain radiating to [Mr A's] right shoulder and across the chest, with documented significant shortness of breath when lying flat. The triage notes documented the main complaint as "toothache R/upper jaw now c/o sore throat +++. and R/earache". Given the documented further history of "pain at times radiates from throat to R/shoulder tip and across chest. Feels SOB +++ when lying flat in bed", I would consider this would have been more appropriate as a triage 3 rather than the decision to make [Mr A] a triage 4, with an ECG included as part of the nursing assessment. This is a significant departure from recommended best practice at triage. As per the Australasian Triage guidelines, "Chest pain likely non-cardiac and mod severity" and "moderate shortness of breath" should be assigned a triage category 3 (1).

Whether further assessment(s) such as an ECG would have been appropriate in the circumstances

I believe an ECG would have been appropriate given the documented history of intermittent pain radiating from throat to right shoulder and across the chest and that not doing so is a severe departure from accepted practice.

The appropriateness of clinical support provided to the nurse

I don't believe there was enough clinical support provided to the [staff] working in the after-hours service. It would be ideal for patient safety to have additional clinical support with [additional Registered Nurses] present — ideally triage trained, in addition to the doctor on call.

Any other matters relating to [Mr A's] care that you consider warrant comment

There are different recollections from the complainant and his daughter and the staff in the clinic; [Mr A] said he told the [staff member] on arrival to the after-hours clinic that he thought he was "having a heart attack" — if this was correct, I would have expected

the [staff member] to notify the [clinical staff] immediately so the patient could be quickly triaged and assessed. If indeed [Mr A] was having active chest pain on arrival to the clinic, he should have been a triage 2, as per Australasian Triage guidelines, and not doing so would be a severe departure from best practice (1). However, there is no documentation of this alleged disclosure by [Mr A] that he was having a heart attack, and neither of the staff who saw [Mr A] in the after-hours clinic support this allegation.

I would also like to note that I have discussed this case anonymously with two of my peers, who work as an Emergency Nurse Educator and as a senior nurse in the Emergency Department. They have advised that with the documented dental and throat pain noted as severe +++, they believe this also may have been appropriate to be a triage 2 for "very severe pain — any cause" (1). They also believe that an ECG should have been obtained due to the documented complaint of pain across the chest and associated shortness of breath, and that this was a significant departure from best practice.

References

1. Guidelines on the Implementation of the ATS in Emergency Departments: G24_04_Guidelines_on_Implementation_of_ATS_Jul-16.aspx (acem.org.au)

TManning

27 April 2023'