Delays in treatment in emergency department (13HDC00453, 22 April 2015)

District health board ~ Registrar ~ Emergency department ~ Triage ~ Shortness of breath ~ Chest pain ~ Potassium ~ Monitoring ~ Review ~ Delays ~Right 4(1)

A 51-year-old woman with multiple medical problems experienced a sudden episode of shortness of breath. She was taken to the Emergency Department (ED) of a public hospital.

The woman was triaged by a nurse as requiring treatment within 30 minutes. However, she not reviewed by the ED registrar for over an hour. The ED registrar considered it was likely the woman had a chest infection, and requested a chest X-ray, blood tests (including venous blood gas) and an electrocardiogram (ECG). The ED registrar noted the woman was likely to require admission under the medical team. Around two hours later, the ED registrar referred the woman to the medical team. The blood test results showed mildly raised potassium and troponin levels.

A general medical registrar reviewed the woman around six hours later while she was still in ED. The medical registrar concluded the woman was likely to be suffering from an exacerbation of asthma/COPD (chronic obstructive pulmonary disease) and planned repeat venous blood gas tests and a repeat ECG. The medical registrar performed an arterial blood gas test which showed an increased potassium level. However, the medical registrar decided to wait for the results of the venous blood gas test results before commencing treatment for the raised potassium level.

Around two hours later, the medical registrar was called to assess the woman as she was complaining of chest pain. The medical registrar checked the repeat venous blood results which again showed an increased potassium level. Treatment was prescribed for this and the woman was given medication for her chest pain. Approximately ten minutes later, the woman suffered ventricular tachycardia (rapid heart beat arising from improper electrical activity of the heart) and the emergency alarm was activated. However, the woman lost consciousness and cardiac output and sadly, died.

It was held that the care provided to the woman was a serious departure from accepted standards. The Commissioner found that the woman was not monitored adequately by nursing staff while she was in the ED, there were delays in her being assessed by the medical registrar, and the medical registrar's reaction to concerning changes in the woman's condition was inadequate. The district health board failed to provide services to the woman with reasonable care and skill and, accordingly, breached Right 4(1).

It was recommended that the district health board apologise to the woman's family, undertake an audit of compliance with its triage policy, ensure its staff have up-to-date training on its clinical care guidelines, and review the role of its senior doctors in the emergency department to ensure adequate supervision of junior doctors is occurring.