Transfer of trauma patient
(13HDC00046, 14 December 2015)

District health board ~ Rehabilitation provider ~ Trauma ~ Enoxaparin ~ Transfer ~ Communication ~ Documentation ~ Rights 4(1), 4(5)

A 58-year-old man was involved in an accident. He sustained multiple injuries and was taken to hospital in a critical condition, and underwent multiple surgeries. He spent time in the Intensive Care Unit (ICU) and was placed under the care of a DHB Trauma Service. Treatment included deep vein thrombosis (DVT) prophylaxis. He was transferred to the High Dependency Unit, and later to a surgical ward and encouraged to mobilise. His medications on discharge from ICU included 40mg enoxaparin (Clexane) prophylaxis, once a day.

The man made good progress. Hospital staff considered a transfer to a rehabilitation provider for further rehabilitation closer to the man's home.

DHB policy stated that discharge from the public hospital to another facility would occur only when discharging medical staff gained verbal acceptance from an admitting medical team. There were two co-existing rehabilitation provider admission documents in place, neither acknowledging the existence of the other, and each document providing a different process regarding medical review: the policy stating that a doctor should review the patient within 24 hours of admission, and the procedure making no reference to a timeframe for medical review after admission.

The DHB said that it was advised by the rehabilitation provider that a doctor would admit the man on arrival. The rehabilitation provider said that at no stage did it indicate that the man would be admitted by a doctor. No medical staff were contracted to work at the rehabilitation provider at the time of the man's transfer.

The final arrangements for discharge and transfer were made late on a Friday. Public hospital staff met with the man and his wife prior to discharge. Three syringes of enoxaparin and a prescription for analgesia were given to the man's wife to take with them. DHB staff also met with the transfer flight nurse. The meeting details were not documented by DHB staff. The flight nurse's transport record does not refer to being advised of the thromboprophylaxis regimen.

The public hospital discharge summary did not refer to discharge medications or thromboprophylaxis, and nor did it refer to supplementary documentation which outlined discharge medications. At 8.15pm, the man arrived at the rehabilitation provider. He was not reviewed or admitted by a doctor on arrival. He was mobilising appropriately. On Saturday morning, the man's wife took the hospital prescriptions for analgesia to a pharmacy to be filled.

The enoxaparin was not on the discharge summary, and was not given by the staff at the rehabilitation provider. The man and his wife enquired why the man had not yet been given enoxaparin. A rehabilitation nurse telephoned the public hospital for clarification. The nurse was given erroneous advice that enoxaparin was no longer needed.

For two days the man was given inadequate pain relief. Confusion had arisen for rehabilitation nursing staff in the absence of information on the public hospital

discharge documentation regarding the man's ongoing medications. The man developed chest pain and suddenly collapsed. Sadly, he could not be revived.

It was held that the man's co-ordination and continuity of care was compromised for the following key reasons:

- The transfer by the DHB without obtaining verbal acceptance by a doctor from the rehabilitation provider was not in accordance with DHB policy.
- Transfer documentation did not contain all the relevant and important clinical information.
- DHB staff did not ensure that there were clear written instructions passed on about the man's enoxaparin regimen.
- The man was transferred late on a Friday.

The DHB did not ensure adequate quality and continuity of services for the man and, accordingly, breached Right 4(5).

It was also held that it was the responsibility of the rehabilitation provider to have adequate oversight and systems in place to support its staff and ensure its policies were clear and understood by all staff. Having two documents (one a policy and one a procedure) regarding admission, and ineffectively communicating that information to staff resulted in very unclear direction to its staff about the requirements for admission and the timing of medical review. Accordingly, the rehabilitation provider failed to provide services to the man with reasonable care and skill and breached Right 4(1).

Adverse comment was also made that the man had less analgesia than he needed for a period of approximately 48 hours.