Dr C, General Practitioner

A Report by the

Health and Disability Commissioner

(Case 03HDC16186)

Parties involved

Miss A	Consumer
Mr A	Complainant/Consumer's father
Ms B	Consumer's mother
Dr C	Provider/General Practitioner
After Hours Medical Centre	Provider

Complaint

On 30 October 2003 the Commissioner received a complaint from Mr A about the services provided to his daughter, Miss A. The issues investigated by the Commissioner arising from Mr A's complaint were identified as follows:

Dr C

- *Whether Dr C appropriately assessed and treated Miss A at the consultation on 9 August 2003.*

After Hours Medical Centre (the Centre)

Whether the After Hours Medical Centre provided Miss A with services of an appropriate standard on 9 and 10 August 2003. In particular, whether the After Hours Medical Centre:

- *took appropriate action after Miss A's mother sought advice by phone on the night of 9/10 August in relation to Miss A's symptoms which included vomiting;*
- *had in place a system when Miss A presented on 9 and 10 August which ensured that her priority for assessment was adequately determined in view of her symptoms and previous presentations.*

An investigation was commenced into the involvement of the Centre on 14 January 2004 and Dr C on 12 July 2004.

Information reviewed

- Information from:
  - Mr A
  - Ms B
  - The After Hours Medical Centre
  - The public hospital
  - Telecom

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- Independent expert advice obtained from Dr Steven Searle, general practitioner.

Information gathered during investigation

Background

Mr A advised that on 9 August 2003 his daughter, Miss A, aged six, was sensitive to sound, had not been moving freely, was hot, had vomited, and had a sore head and diarrhoea. Mr A took her to the Centre for assessment.

The Centre advised that it is not a member of the Accident and Medical Practitioners Association but, at the time Miss A was treated, provided 24-hour "GP-type" services to patients whose surgeries are closed or who are unable to obtain appointments during working hours. The Centre does not have X-ray facilities on site or an appointment system but patients are assessed on a "first come first served" basis.

Mr A and Miss A were recorded as presenting at the Centre at 1.41pm (although Mr A states that he actually arrived at 1.30pm). Mr A informed the receptionist that Miss A might have a serious condition but Mr A could not recall whether he mentioned meningitis. Mr A was concerned because Miss A was not assessed by Dr C until after 3.00pm (there is no record of the exact time as the Centre did not have the facility to record this information on its database) and during the waiting period Mr A did not notice any triage taking place.

Triage procedures
The Centre did not have a formal triage process because only one nurse is on duty each shift. However, it advised that the triaging procedure (which was unwritten) was as follows:

"1. Receptionist liaises with nurse if any patients look very unwell or say they feel they are very unwell. Also, if parents/caregivers/relations express their concerns re the patient's condition.

2. Nurses to scan waiting room at regular intervals as often as possible, ideally every 15 minutes.

3. Nurse to assess patients as above using the triage protocol, and to ensure receptionist and doctor are aware of their priority, i.e. next in line for consultation etc."

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The Centre further advised that the receptionist did not refer Miss A urgently to a nurse for assessment because she did not appear acutely unwell. The scan of the waiting room every 15 minutes by the nurse often does not occur when the Centre is very busy. It was "reasonably busy" on 9 August with 19 patients presenting between 12.00pm and 2.00pm.

Assessment by Dr C

Dr C, one of the GPs rostered to work at the Centre, recorded that in addition to her other symptoms, Miss A had full neck flexion, raised red papules on her arms and legs and an annular lesion on her left shoulder (for which she was treated with cream). Dr C's diagnosis was a viral illness. He prescribed paracetamol and advised Mr A to return with Miss A "here or own GP SOS".

Dr C advised that he checked Miss A's entire skin surface and she did not have a suspicious rash or a stiff neck (he considered the raised papules were "clearly" insect bites). Dr C does not recall whether he informed Mr A that Miss A could have meningococcal disease but in his view he gave Mr A clear instructions in the event that she failed to improve or deteriorated.

After the consultation with Dr C Mr A took Miss A to her mother, Ms B, for a scheduled period of access.

Telephone calls

Ms B advised my staff that during the night Miss A complained she could not move her body and her bones ached. She vomited at least three times. Ms B recalled telephoning the Centre once between 1.00am and 2.00am. She spoke to a person she thought was a nurse and informed her about Miss A's symptoms. The nurse noted that Miss A had presented to the Centre on 9 August with a virus which could resolve within 24 hours. The nurse advised Ms B to administer Pamol to Miss A every four hours and, if she deteriorated, to return.

The Centre advised me that all phone calls requesting medical advice are referred to the nurse on duty who is also provided with any recent doctors' assessments. The nurse documents all such calls. The nurse on duty during the night in question does not recall Ms B's phone call and there is no documented record of this call in the Centre's records. An outward call trace by Telecom shows that no phone call was made to the Centre from Ms B's telephone number (the number from which she said she called) on the night of 9/10 August 2003.

Second presentation to the Centre

Ms B recalled that sometime after 8.00am on 10 August she noticed Miss A had a rash which was similar to bruising. She thought Miss A had meningitis. Ms B took Miss A to the Centre at 12.26pm where there were a lot of patients. She informed the receptionist that her daughter was still "very sick".

The receptionist recalled that at the time Miss A presented she was very busy and Ms B informed her that Miss A was "no better". The receptionist placed her "in the

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queue" for a medical assessment because, although Miss A appeared pale, she was not distressed. Ms B also did not look anxious or worried. The receptionist attached the record of Miss A's presentation on 9 August to a doctor's consultation form on which she recorded "2nd visit".

The Centre acknowledged that it is not acceptable to have a gravely ill child waiting for an hour to be assessed. It advised me that the receptionist did not refer Miss A to a nurse at her second presentation on 10 August because it was recorded at her presentation the previous day that she had a viral illness. It is also not unusual for patients to re-present to the Centre within 24 hours – about 1 in 20 patients re-present within this period.

Ms B and Miss A waited for approximately an hour before she was assessed by a doctor but the exact time of the consultation is not recorded. During the waiting period Ms B recalled that Miss A was nauseous, hot and scratched the rash which covered her body.

The nurse on duty recalled that at the time Miss A presented she was completing a very busy shift. Between 12.30pm and 1.00pm she was mostly "out the back" attending to patients and phone calls. However, during this period she would also have checked the condition of patients in the waiting room twice. In the nurse's view none "obviously" required attention. The Centre confirmed that it was a busy day with 23 patients presenting between 11.00am and 1pm, and that the nurse was busy with two "quite ill patients".

Assessment by Dr D

Miss A was assessed by Dr D who recorded that Miss A had vomited three times during the night and twice that day. She had been unwell for 48 hours, had a rash over her body and was weak. Dr D diagnosed Miss A with meningococcal septicaemia and prescribed oxygen and intramuscular penicillin. He discussed her presentation with the paediatric registrar at the public hospital and referred her urgently to the Emergency Department.

Public Hospital

Miss A was assessed by a doctor at the Emergency Department at the Public Hospital on 10 August. The doctor recorded that Miss A had been unwell since 9 August with fever and vomiting which had kept her up during the night. She had also developed one to two spots on her "body/a[bdomen]". The doctor further recorded "progressive/rapid increase in rash overnight". Miss A's skin was observed to be diffuse and she had a non-blanching "maculopapular rash/pupura" and a "disc/round lesion with dark/purpuric centre".

Miss A was admitted to hospital and diagnosed with meningococcal septicaemia. She fortunately made a good recovery and was discharged from the Public Hospital on 15 August.

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Subsequent actions
The Centre advised me that in light of the incident it has implemented a policy and advised its staff that all second visits within 24 hours should go to the front of the queue. The importance of scanning the waiting room for patients of concern, including children, has been stressed to the nurses. The Centre has also emphasised to doctors the importance of seeking a second opinion in appropriate cases. Furthermore, all staff are required to attend triage courses as part of their induction.

The Centre further advised that the specific time a patient is assessed by a doctor is sometimes recorded by a receptionist but this "quite often" does not occur when the Centre is very busy. Nonetheless, since the incident almost all of the doctors complete their notes on the computer which automatically records the time an entry is made (which provides an approximate time of the assessment). The time an invoice is generated by computer is also automatically recorded except for patients from a local cultural provider, which directly reimburses the Centre for after-hours consultations.

My investigator conducted a site visit to the Centre on 20 June 2005 to confirm steps the Centre has taken since the incident. My investigator reported that there were two black and white signs in English in the waiting room requesting patients to ask to see the nurse if their condition needs prioritising.

Furthermore, there were cards placed in racks at both ends of the reception desk. The cards, which are relatively small (5.7cm x 9cm), provide information (including a photograph) about the symptoms associated with meningococcal septicaemia (Miss A's diagnosis) in adults, children and babies and are distributed in the name of the Meningitis Trust. The phone number of a 24-hour helpline is also provided on the cards. The cards are in several languages, including Tongan (Ms B is Tongan), Fijian, Cook Islands, Samoan and Maori. In this respect, 12% of the Centre's patients also receive services from the local cultural provider.

My investigator also reported that there was also one multi-coloured sign (in English) in the waiting room about meningitis.

Response to my provisional decision

In Mr A's response to my provisional decision, he stated that he remained concerned about the standard of the triaging taking place during Miss A's presentations to the Centre, particularly on 10 August 2003 when she was not assessed in a timely fashion by a doctor and was seriously ill. Mr A also noted that the Centre did not have a system in place to record the time a patient was assessed by a doctor (only the time of presentation) in order to monitor overall waiting times.

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Furthermore, Mr A is concerned that the steps the Centre has taken since the incident may not adequately address the fact that cultural shyness or language are barriers to effective triaging, for example the signs in the waiting room about meningitis and priority for assessment are in English only. Mr A was particularly concerned that the Centre had not discussed the management of this important issue with cultural providers.

Mr A further responded that the Centre should clarify with patients that it does not provide trauma and emergency services. This is necessary because an Urgent Pharmacy is located next door, 24-hour telephone triage is available and there is "publicity" about the Centre in the Emergency Department at the Public Hospital. Furthermore, the Centre's website states that it provides "quality after hours *accident and medical* care" (emphasis added) and trauma and medical emergency services are not listed on the range of services that the Centre does not provide, for example childhood immunisation.

Independent advice to Commissioner

The following expert advice was obtained from Dr Steven Searle, general practitioner:

> "**Report on complaint file 03/16186**
>
> This report has been prepared by Dr S J Searle, under the usual conditions applying to expert reports prepared for the Health and Disability Commissioner. In particular Dr Searle has read the guidelines for Independent Advisors to the Commissioner (Ref. 1) and has agreed to follow them. He has been asked to provide an opinion to the Commissioner on case number 03/16186.
>
> He has the following qualifications: MB.ChB (basic medical degree Otago University), DipComEmMed (a post graduate diploma in community emergency medicine – University of Auckland), FRNZCGP (Fellow of the Royal New Zealand College of General Practitioners – specialist qualification in General Practice which in part allows him to practice as a vocationally registered practitioner). As well as the qualifications listed Dr Searle has a certificate in family planning and a post graduate diploma in sports medicine. He has completed and renewed a course in Advanced Trauma – ATLS (Advanced Trauma Life Support). He has a certificate (Nov 2003) in Resuscitation to Level 7 of the NZ Resuscitation Council. More recently he has completed a PRIME course (May 2004). He has worked in several rural hospitals in New Zealand as well as in General Practice and accident and medical clinics and currently works in his own practice as well as in the Emergency Department in Dunedin Hospital.

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Dr Searle works regularly as part of a roster at his local after hours medical centre. He is also actively involved in local search and rescue missions and training.

Dr Searle is not aware of any conflict of interest in this case – in particular he does not know the health provider(s) either in a personal or financial way. Dr Searle has not had a professional connection with the provider(s) to the best of his knowledge.

Basic Information:
Patient concerned: [Miss A], complaint received from her father [Mr A]
Nature of complaint: Possible delay in assessing the severity of illness on the two occasions she presented to [the After Hours Medical Centre (AHMC)], possible inadequate management of her first presentation, and possible problems with a phone call seeking advice that might have occurred after [Miss A] was first seen.
Complaint about: [Dr C] and the [AHMC]
Also seen by: [Dr D] at AHMC and by Staff at [the Public Hospital].

Introduction:
I will attempt to summarise the time course of the illness here to help clarify things for readers of this report. Of note there was considerable information that was reviewed for this report and a simple summary will always be problematic but I have provided one to help make the report easier to read and use.

Summary of events: [Miss A] was taken by her father, [Mr A], to [the AHMC] on Saturday 9th of August 2003 as she was unwell. There was a period of waiting before she was seen. She was seen by [Dr C] who considered she had a viral illness and allowed home with advice and paracetamol. [Miss A] was cared for by her mother, [Ms B], later that day. Overnight [Ms B] recalls making a phone call seeking further advice, this phone call was possibly to [the AHMC] but no record of the call has been found. [Miss A] was taken back to [the AHMC] on Sunday 10th of August 2003. There was a period of waiting before she was seen again. She was seen by [Dr D] and probable meningococcal septicaemia was diagnosed, and she received intramuscular antibiotics before being transferred to hospital where she had further treatment and this diagnosis was confirmed.

Other Introductory Comments
Whilst fortunately, as far as I am aware no serious adverse consequence has occurred from a possible delay in diagnosis and treatment, obviously there are concerns that a diagnosis might have been able to be made sooner. There is also a concern that there is a problem with the standard of care with respect to the procedures in place at [the AHMC] for initially assessing patients in a timely manner. Neither one of these issues may in fact have, or potentially have had an impact on the end result in this case but this does not mean that things should or should not have been done differently. It is possible that these issues could have had a small impact on the duration of [Miss A's] illness, but more importantly in a more serious case the respective time delays could have been more life

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threatening. A key principle of giving advice to the Health and Disability Commissioner is that the "outcome of the care is irrelevant" – it may be that there was no departure from the accepted standards but the care still resulted in an adverse outcome for the consumer. Conversely there may have been no adverse outcome for the consumer but the care may have been substandard (Ref. 2).

The standard of care will be assessed in this report bearing the above principle in mind and just because [Miss A] did not have serious complications, or did not die, does not mean that there has not been a problem with the standard of care.

Documents and records reviewed:

Information from:

1. Complainant (pages 1–16)
2. Notification letters (pages 17–22)
3. Centre (pages 23–55)
4. [Dr C] (pages 56–62)
5. [Ms B] (pages 63–64)
6. [Public Hospital] medical notes for [Miss A].

Possible missing information

Information about a possible telephone call

Various attempts have been made to clarify if the telephone call to the AHMC did in fact take place – (various parts of supporting information including pages 3, 7 (AHMC letters to [Mr A] dated 26/8/03, 18/8/03), pages 9, 11 (copy of emails between [Mr A] & [the AHMC]), page 18 (HDC letter to [the AHMC] asking re phone numbers), page 24 letter to HDC from [the AHMC]) pages 35 & 38 (re statements from Nurse on duty who would have taken the phone call), pages 42, 43 (letters involving lawyers trying to seek Telecom records of calls), pages 44, 45 (copies of previously mentioned page 9), page 48 (copy of page 3) page 53, 54 (copy of phone call log of [the AHMC] for the relevant time period where all phone calls asking for advice are usually recorded).

It is clear that extensive attempts have been made to clarify if and when the phone call took place and if there was any record of the call. I do not think there is likely to be anything further that can be done about this.

Also of note in the letter of complaint from [Mr A] (dated 26 Oct 2003 – supporting information pages 1 and 2) he states with respect to this call "I am unable to take that any further and it is not the focus of this complaint."

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Hence overall I think that not having this information will not change my opinions and that in any case opinions can be given allowing for the phone call either having occurred or having not occurred.

Information about the shoulder rash and the pre-existing use of a cream

It could be interesting to know if, and when, this rash had been seen by a doctor prior to the 9/8/03 and if so what diagnosis was made, and exactly what the prescribed cream was. It could well be that there is evidence that the rash was unrelated to the meningococcal disease and pre-existing – in other words supporting [Dr C's] view that "It had no significance as far as her ultimate diagnosis was concerned and was completely unlike the rash of meningococcal disease" (point 6 of [Dr C's] letter 1/8/04). The other possibility would have been a rare form of slowly developing meningococcal rash. There is an unusual form of meningococcal sepsis (blood poisoning/infection) that can grumble for weeks and months before suddenly developing into the more usual illness (Ref. 3) and this form of meningococcal disease can have more unusual (unusual for meningococcal disease) rashes including maculopapular rashes. I have heard of a case of this where it took some two weeks before the condition was diagnosed and fortunately the patient never converted to the full blown life threatening form (Ref. 4). I have carefully considered asking the HDC to obtain this information but regardless of what the information, if it exists, shows then it would not change my opinions. It may well be that the rash was diagnosed by parents or relatives and over the counter medication obtained in any case. I bring up this issue as it may be a possible learning point for doctors who read this report, but I do not intend to over emphasise this as it is very rare, and in any case probably should not change the standard approach for similar presentations – namely advising patients to represent if they become unwell or the rash changes or spreads beyond what is expected. Even if the rash in this case was a rare form of meningococcal disease I do not think a doctor could have been expected to pick this up at the time of [Miss A's] first presentation to [Dr C]. Hence overall I do not think seeking information about other health providers having seen [Miss A] before [Dr C] would change my opinion about his standard of care.

Quality of provider's records

[Dr C's] note from 9/8/03 is of a good standard – it notes the history, past history, immunisation status, allergies and medications already in use. It also notes the examination findings, diagnoses, treatment and follow-up advice. It is particularly pleasing to see that the record has standard headings for all these aspects of the consultation and that [Dr C] has written notes about all of these aspects – good standard of care both at a procedural level from [the AHMC] and from [Dr C's] own handwritten notes.

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Describe the care as documented and describe the standard of care that should apply in the circumstances

Taking a full history – this should include current symptoms, past medical history including medications and allergies. This was done and is a good standard of care.

Do an appropriate full examination

The examination was full and in particular the skin was examined, and a check for neck stiffness was made, which is particularly relevant when checking for meningococcal disease. This was a good standard of care.

There is the possibility that the rash was recognisable as a meningococcal rash at the time of [Miss A's] consultation with [Dr C]. This seems unlikely as he described a rash in technical terms (raised red papules) that is not the usual appearance of a meningococcal rash. Even if [Dr C] did mistake the rash the other aspects of his assessment were of an excellent standard and I note that [Mr A] stated in his letter of complaint (26 October 2003) that "... the examination when we finally got to see a doctor was fairly thorough".

The shoulder rash probably was a "tinea" or fungal rash as [Dr C] documented the pre-existing use of a cream for this.

Order appropriate investigation at an appropriate time It is often forgotten that investigations have harms – in other words they have some risks and should not be ordered without due considerations of the risks and benefits. Harm can include finding minor abnormalities that need explanation that require further more invasive tests. It is not unheard of for patients to die from direct or indirect results of investigations for something that in hindsight might never have caused a significant problem. Another problem can be if tests are done early on in an illness they can be falsely reassuring and make patients or their relatives hesitate before coming back for reassessment. Early tests can also falsely reassure doctors who re-examine patients after these tests have been performed.

In my opinion no particular investigation was needed given the type of rash described in the notes. Early on meningococcal rashes can be unusual in appearance which might have been the case here, or it might have been that [Miss A's] meningococcal rash that was clearly present later on was new and different to the rash present at the time of her seeing [Dr C]. If testing was done at the time of her seeing [Dr C] or shortly thereafter it would have had some risk of being falsely reassuring – a blood count and C reactive protein for example could have been normal at this time (or occasionally with some forms of meningococcal sepsis they can be normal (Ref. 3)), and blood

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cultures early on might not have been positive and take 12 to 24 hours for a preliminary result and much longer for a definitive result. In the absence of signs of involvement of the meninges (membranes which cover the spinal cord and brain) a lumbar puncture (test involving putting a needle in the patient's back to obtain spinal fluid) was not indicated and appropriately from what I can tell from the hospital notes never performed or contemplated whilst she was in hospital.

Decide on appropriate management and implement this or seek advice and/or refer on for such management. Given [Dr C's] diagnosis of a viral illness the management plan of paracetamol was reasonable.

Give the patient or caregivers appropriate advice on follow-up, and any complications to watch out for that might need earlier follow-up. As the complications of viral illness, or the development of meningococcal infection can be quite variable the follow-up advice of coming back or seeing their own GP (General Practitioner) "SOS" as needed (if things were worse) was a good standard of care. [Mr A's] letter of complaint (26 October 2003) confirms that this advice was given – "... the instructions from the doctor to bring her back in should there be any deterioration". I also note that in [Dr C's] letter to HDC (1/8/04) that he states "... I always advise the parents to monitor the child and to return if the child deteriorates, shows any of the worrying signs, or even just if they remain, or become more concerned."

Have appropriate systems in place to reduce errors

This is where there is great potential to improve the management for all patients. Doctors are human and errors can occur – however they can be minimised and/or the effects of these errors reduced or mitigated by having systems in place to check for errors and if possible to take action to prevent harm or to prevent sub-optimal outcomes for patients. Systems ideally should be studied to check that they work and do not cause side effects – just like any medical treatment. Unfortunately we are still in relatively early stages of developing safety systems in medicine and more research is needed. With this in mind the below suggestions should be used with careful clinical judgement to see if they might be safe and appropriate for each clinical situation and each different patient.

The possible safety systems relevant to this case could have included:

To send copies of the notes to the usual GP (this probably did occur as I note that the standard notes format used by [the AHMC] includes a "Dear Dr ..." space for easily sending a copy of the notes to the usual GP). This aspect of care did not come in to play in this case but it could have been important if the second doctor's assessment was with the usual GP rather than back at [the AHMC].

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1. Having standard forms for doctors to write up notes on. This should include headings to "prompt" doctors to check they have covered all the aspects of assessment and management that are required – [the AHMC] did have such a form in place and this is a good standard of care.
2. Giving copies of the notes to the patient or caregivers or to at least document a specific and non-ambiguous follow-up plan and to verbally and/or in writing give such a plan to the patient or caregivers. This can be important if for example the patient goes to the GP before the above mentioned copy of the note is delivered to the GP, or if the patient is travelling, or if the patient becomes much more unwell and decides to call an ambulance or go directly to a hospital.
3. Giving out more specific verbal and written advice on when to get seen by another doctor if needed. I note in [Dr C's] letter (to HDC 1/8/04) that he states that since this case he now gives each patient with a fever a card advising them of what the symptoms and signs of meningitis are – this is probably a good idea but as stated above this could falsely reassure patients who develop something else, such as say a pneumonia, who might not have some of the things on the meningitis card but have a serious illness that needs review. A reasonable approach could be to estimate the time course of the illness based on the provisional diagnosis and tell patients something to the effect of "to see a doctor if they are not 100% back to normal in 10 (example only of estimated maximal duration of the illness) days time, in 2 to 3 days time if they are not improving, or after that if they subsequently deteriorate after getting better, and sooner at any stage if they are worse than they are at the time of assessment or develop new symptoms". Further specific advice can be given based on the particular case for example in this case being advised to return if the rash changes or spreads. I would note here that there has been some research suggesting patients only tend to remember the first few things doctors tell them and the last few – so there is a considerable risk that if too much information is given it could be remembered selectively and other parts of the advice given ignored. On this basis I think the approach of [Dr C] to keep the advice given as relatively straight forward may in fact be a better approach – in any case the whole issue of giving out appropriate advice to the public on what to look out for before they see a doctor and for what to do after they have seen a doctor needs more research. Whilst cards giving advice on meningococcal disease features are available to give out to the public and appear to be good advice I am not aware of any research that studies the risks and benefits of giving out these cards. All this is important when considering the future aspects of this disease in New Zealand once the use of the meningococcal vaccine becomes more widespread – see my advice on this in the concluding section of this report.
4. To have specific review policies in place for patients who come back for the same illness – for example faxing the note to the usual GP asking for

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them to review the patient's need for further follow-up more urgently than for those patients who have only attended once for the same illness, or having another doctor at the clinic review notes on patients who represent. In this case the second doctor did not need assistance in making the correct diagnosis, or having the correct management plan, so these things were not needed but if the second doctor had considered sending [Miss A] home then such systems would have helped prevent further error. Of note in this case second presentations at [the AHMC] are now going to be seen more urgently than patients with a first presentation with respect to the waiting time in the waiting room before a doctor and/or nurse initially sees them – this is probably a reasonable policy change for [the AHMC] to have made. Having said this I note in their meeting minutes (Board Meeting Monday 25th August 2003 – supporting information page 39) that one person noted the problem that confusion could arise when determining the order of consults with triaging sick first presentation patients vs second presenting patients who did not appear to be as sick as the first presentation patients – I trust that [the AHMC] has considered this issue and sorted it out.

5. For doctors to have a method of thinking about their decision making that helps pick up errors (Ref. 4). In this case [Dr C] could have stepped back and thought what could go wrong here? Febrile child with a rash – possibly the rash is not typical of anything just yet but might develop into something that would be more diagnosable – response could have then been to either arrange for [Miss A] to come back for a review in a few hours time or to be specific that as well as coming back if their was any deterioration to have also said to bring her back if the rash spread or changed even if she did not appear more unwell. However as already discussed above there are problems with for want of a better term "long winded" or complicated advice.
6. Triage – or systems of sorting out which patients should be seen first when there is a waiting time. This is not necessarily a good idea and I comment on this more extensively later in the report.

Having such systems in place to reduce errors is not yet that common in medicine but more and more research on this is being done. Such systems are gradually being developed at present and I think this will be of considerable benefit to both the public and health professionals. The absence of such systems can not be seen to be a breach in a reasonable standard of care at the time of [Miss A's] presentation. In any case there were some systems in place which showed a good standard of care. I include this information on systems to prevent errors to give options for improving the standard of care, and for reducing future errors for those who might read this report.

Describe in what ways if any the provider's management deviated from appropriate standards and to what degree

I have already discussed this above. [Dr C] provided a good standard of care and I do not think he deviated from the appropriate standards.

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Answering Questions put to me by the Commissioner's office

[The After Hours Medical Centre]

The Centre did not have a formal triage process but advised that:

'1. Receptionist liaises with nurse if any patients look very unwell or say they feel they are very unwell. Also, if parents/caregivers/relations express their concerns re the patient's condition.'

'2. Nurses to scan waiting room at regular intervals as often as possible, ideally every 15 minutes.'

'3. Nurse to assess patients as above using the triage protocol, and to ensure receptionist and doctor are aware of the priority i.e. next in line for consultation etc.'

1. *Were the Centre's triage procedures adequate?* This is not a simple question to answer. There is some reason to consider not having any triage at all. The short answer is that we probably don't have enough research to answer this question. The answer would have to be that either no triage was needed, or the informal triage that they had in place was adequate or that we just don't know if more formal triage was appropriate. Having more formal triage could actually worsen patient care and not improve it. These issues are discussed in some detail in the appendix to this report titled 'Sorting out what to do – when & where and the concept of triage'.

2. *If the triage procedures were not adequate, what procedures should have been in place?* Because there is not enough evidence in my opinion to answer this, this question is not simple – see discussion above about the previous question. I can not give specific recommendations. At the time of the event anything from no triage to full formal triage as per an Emergency Department was acceptable. This probably remains the case but hopefully more research will be done to clarify this. The other problem we have in New Zealand is that the provision of urgent and after hours care is under extensive review and until the funding and other issues are sorted out it is difficult to make recommendations on this.

3. *If the Centre's triage procedures were adequate, was [Miss A] properly triaged for assessment by a doctor when she presented to the Centre on 9 and on 10 August?* As already stated I can not simply say that the triage procedures were adequate or not. I think further discussion as to if the 'procedures' were properly used is not helpful – the procedures were more informal suggestions of how to overcome the possible problem of patients waiting too long when they are in need of more urgent care.

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4. *The nurse on duty on 10 August recalled that she checked the waiting room twice between 12.30pm and 1.00pm in light of her other commitments. Was this frequency reasonable?* In my opinion there is no easy way to check the waiting room without diverting doctors and nurses from other tasks (which could potentially increase the overall wait for all patients), hence not checking the waiting room was acceptable and anything more than this was OK. I discuss this issue to some extent in my appendix titled 'Sorting out what to do – when & where and the concept of triage' (some of the references within this appendix discuss this issue in more detail but essentially similar concepts apply as to the decision to triage anyone in the first place). The issue of how often to re-triage patients or to reassess them once they have been triaged to wait is one of the problems with triage in that patients' conditions can become more serious whilst they wait and it is not simple to decide on how much resources are allocated to re-assessing patients before they are finally seen and how often this should occur. I do not think there is yet enough evidence available for this question to be answered in a simple or meaningful way.

5. *Should the Centre's triage procedures have been written?* No. At the time it was reasonable to have no triage at all. It may well be that the Centre has to make some decisions on having some sort of triage policy written down to clarify things for both patients and staff. Although the policy may be very low level (for example relying on patients to bring to the staff's attention that their problem is urgent) it probably is important to document the policy and the reasons behind it. This is so that the expectations of staff and patients are understood and if these are different then either patients and/or staff can then make decisions that allow for this – this might for example mean that if the policy is known some patients might go to the emergency department of the local hospital in the first place rather than to the Centre. Or it may mean that patients are more aware that there can be a wait and if they consider the wait is too long (because of the perceived urgency of the problem rather than convenience reasons) that they know they can bring this to the attention of the Centre's staff.

6. *Please advise on the adequacy of the steps the Centre has taken in light of the incident.* The steps the Centre has taken seem reasonable. They will have to review these in the light of evidence that becomes available (further research will occur), and also bearing in mind the local practicalities and other health services available. They will also have to review this as health policy and funding changes.

Note: Please give your advice on the above questions in the alternative on the basis that (a) [Ms B] contacted the Centre during the night of the 9 and 10 August (b) she did not do so. It is hard to allow for this in the above questions although I have discussed the issue of phone call advice elsewhere in this report. The above questions mostly focus on patients that have arrived at the Centre. I would not change my answers to the above questions based on the phone call having occurred

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or not. However in considering possible options for future prioritisation of patients one possibility is that if a phone call has taken place prior to a first or subsequent visit that a message can be left at reception suggesting the patient should be seen straight after arrival if it is considered that they have an urgent problem – this is a variation of the suggestion that patients who come back should be seen more urgently – however if a phone call has suggested there could be an urgent problem it may well be that alternative care such as an ambulance or direct referral to an emergency department will occur instead.

[Dr C]

7. *Did [Dr C] appropriately assess and treat [Miss A] at the consultation on 9 August? If not, what should [Dr C] have done?* He did appropriately assess and treat [Miss A] – this has been discussed earlier in my report.

8. *Should [Dr C] have referred [Miss A] immediately to hospital for assessment?* No his management plan was appropriate – see earlier in my report.

9. *In a letter dated 26 August 2003 to [Mr A], the Centre stated that [Dr C] was 'thinking of meningococcal meningitis…' If so, should [Dr C] have recorded this?* I think this refers to the fact that [Dr C] recorded in his notes various findings such as 'full neck flexion' that showed that he had considered the possibility of meningitis. It was not necessary for him to have recorded anything beyond his examination findings as any subsequent review of [Miss A] by another doctor would have allowed the doctor to compare findings based on his notes without listing all the possible things [Dr C] was trying to rule in or out. The facts are that [Dr C] did document a thorough examination and this is the standard of care required. It is not usual practice to list all the rare possibilities for each patient at the time they are seen even though the doctor might think of some or all of these.

10. *[Dr C] recorded that he advised [Mr A] to return with [Miss A] 'here or own GP SOS'. Was this advice adequate? Yes the advice was adequate. I have* discussed at some length the various options for advice with the pro's and con's of more or less specific advice. [Mr A's] letter of complaint (26 October 2003) confirms that this advice was given – '... the instructions from the doctor to bring her back in should there be any deterioration.' Hence this advice was understood and shows a good standard of care.

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General

11. *If, in answering any questions, you believe that [Dr C] did not provide an appropriate standard of care, please indicate the severity of departure from that standard.* I have already discussed this above. [Dr C] provided a good standard of care and I do not think he deviated from the appropriate standards.

12. *Are there any aspects of the care provided by [Dr C] and/or the Centre that you consider warrants additional comment*? There is nothing specific to them that I wish to comment on but there are some general comments I make in my conclusions – see below – that may apply to them as well as others.

Conclusion

Whilst there was no breach of the standard of care in my opinion this case does highlight issues in the health system that needs ongoing review and future research. What, if any, 'triage' should occur at different health facilities will need more evaluation in future.

For 'After Hours' or Accident and Medical Clinics and possibly any General Practice

The concept that people who come back for the same problem might have a need for urgent care is interesting. I think this needs more research before simple policies are put in place about them being seen more urgently. I note second presentations at [the AHMC] are now going to be seen more urgently than patients with a first presentation with respect to the waiting time in the waiting room before a doctor and/or nurse initially sees them – this is probably a reasonable policy change for [the AHMC] to have made – but as stated above ideally some research needs to be done to confirm that it is a good idea. Having said this I note in their meeting minutes (Board Meeting Monday 25th August 2003 – supporting information page 39) that one person noted the problem that confusion could arise when determining the order of consults with triaging sick first presentation patients vs second presenting patients who did not appear to be as sick as the first presentation patients – I trust that [the AHMC] has considered this issue and sorted it out. I would also draw their attention to the fact that 'triage' is not simple and that the complex issues are involved – see the appendix to this report titled 'Sorting out what to do – when & where and the concept of triage'.

For the Ministry of Health

Further discussion and development of the whole issue of how best to provide and fund after hours medical care is currently taking place and it is beyond the scope of this report to discuss this. However of note if it is considered desirable to have formal 'triage' systems in place at after hours centres then this needs to be considered at the present time as part of the general discussion on after hours care issues.

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Whilst the meningococcal vaccination programme is currently being implemented there are possibilities that this may not solve any or all of the problems that we are having with this terrible disease in New Zealand. It may in fact create other problems. One of the dangers of the vaccine programme is that whilst good antibody responses have occurred in the preliminary studies to the best of my knowledge there is not yet good evidence that in the real world it will actually be of benefit. Possible reasons for this include the following:

- The antibody response might not turn out to reflect the true immunity to the disease.
- That there are problems with implementation such as the side effects of the vaccine meaning that many people might not return to get a full course of the vaccine.
- That other strains of meningococcal disease the vaccine does not produce immunity might develop.
- That people who have had the vaccine might be falsely reassured, or doctors seeing them might be put off the scent so to speak – "Vaccination has been given so this illness can't be meningitis or meningococcal disease" - i.e. False reasurrance.
- If people who have not received a full course of the vaccine should develop the illness then they might get a low grade or unusual vaccine modified course of the illness that is even harder for doctors to detect. This may also be possible in those fully vaccinated – with most vaccines there are people who either get no response or only a partial response.

My point about all this is that we see cases where the diagnosis and/or treatment of meningococcal disease does not go well at present. Having the above possible factors coming in to play, as well as all the usual difficulties with detecting and treating this disease, may mean, that at least in some cases, patients could be worse off with more cases not being diagnosed and/or not being treated early. There is good evidence that early diagnosis and treatment is critical (Refs. 5, 6, 7). Until recently NZ can pride itself in that over the last ten years or so that although we have had a large number of cases of meningococcal disease we have also managed to treat it well and have a lower death rate compared to overseas statistics.

Winston Churchill, I believe, noted that when his "boffins" were showing him the aeroplanes that returned shot up by the enemy that they had studied where all the holes were (and were going to reinforce the armour in these parts of the planes), that they should perhaps put the armour plates everywhere else – that might be where the other planes that did not come back had been shot! In the case of persons with meningococcal disease that don't go well we usually have the advantage of being able to study what went wrong – my experience is that the problem is usually with inadequate follow-up advice having been given – or that even if it has been given sometimes for various reasons patients are reluctant to

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come back. My understanding is also that many cases of complaints about doctors feature communication problems. Bearing all this in mind it is reasonably clear to me that research into how best to communicate follow-up advice to patients is needed, and perhaps also how best to communicate what to watch out for in the first place. One initiative that the government has put in place is the 'Healthline' phone advice system which has a good evidence base behind it. However this system is designed for answering questions patients might have where the person answering the phone does not have access to their medical record. There is good evidence for continuity of care (Ref. 8) and phone advice given by health professionals who have access to their records may well be better than the Healthline system but research is needed (see appendix on telephone advice).

It is understandable that a considerable amount of money has been put into the meningococcal vaccine programme however governments need to consider funding research into communication issues. Clearly this is not something the drug companies are likely to fund and thus I think the onus is on government funding. They also in their review of after hours medical services need to look at the barriers for patients coming back for the same illness. One of the key debates about after hours care is that in most parts of NZ direct presentation to Emergency Departments (EDs) incurs no charge to the patient but is problematic (e.g. some people don't live near an ED, or the ED is too busy and there are long waits). The other side of this is that getting to see a doctor other than at an ED incurs a cost (in most situations). One way of reducing the barriers to care is to better fund after hours services in general so that the part charge patients pay is not too large, and another issue might be to have a one illness, one fee (within a certain time period) approach – thus if a fee has already been paid in the last few days to any one doctor or health centre then another presentation to an ED or After Hours Centre or a GP should be funded so that it is nearly or actually "free" of part charge to the patient (this could then be combined with a charge to be seen at ED if the patient had not been seen elsewhere for the same thing within the last few days). It is worthy of note that in the HDC discussion with [Mr A] that he advised "that the After Hours Medical Centre now requested patients to pay before being assessed ... and that the ED at [the Public Hospital] use it as a "safety valve" in view of its workload. He said there was a sign in the ED referring patients to the Medical Centre (supporting information page 15 – complainant contact record). Clearly there is a barrier to care that exists that consists of at least two factors – cost and either the medical centre and/or the ED having, at least at times, workloads that exceed their capacity or mean that there is a long wait for patients. Workforce planning is a major issue in the health sector and beyond the scope of this report but of note when considering a "reasonable" or "appropriate" standard of care in the context of HDC issues it may well be increasingly appropriate for the HDC to point out to the government that appropriate standards of care are not always able to occur at times due to the contribution of funding and workforce issues. Whilst all health professionals would like to do a good job and to try to be culturally appropriate it is hard to do this in the context of current funding and workforce

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issues because increasingly there is not enough time available for health professionals to do the "nuts and bolts" so to speak of what they have always done, without having to face increasing pressures to meet other standards.

Could anything different have been done that would have changed the outcome?
Whilst this type of question is hard to answer I think it is useful to discuss it in this case to help bring some closure for everyone involved. The short answer is probably not. It is hard to say at what point after the first visit [Miss A] should have been seen – too soon after the first visit and possibly not enough signs would have developed and the diagnosis might not have been able to be made at the second presentation. Fortunately it was not too late and the correct diagnosis and management did occur. I still think it is good that this case was reviewed so that everyone can think about the complex issues related to the timely presentation and assessment of patients both at first and subsequent visits. These issues need more thought and research and funding.

References

1) Guidelines for Independent Advisors – Office of the Health and Disability Commissioner – Appendix H of the Enquiries and Complaints Manual – effective date: 1 September 2003.
2) Statements about Health and Disability decisions: One of the principles of giving advice to the Health and Disability Commissioner is that the "outcome of the care is irrelevant" – it may be that there was no departure from the accepted standards but the care still resulted in an adverse outcome for the consumer. Conversely there may have been no adverse outcome for the consumer but the care may have been substandard.
3) Copyright© 2001 McGraw-Hill. All rights reserved. Harrison's Principles Of Internal Medicine 15th Edition; Copyright 2001, 1998, 1994, 1991, 1987, 1983, 1980, 1977, 1974, 1970, 1966, 1962, 1958 by The McGraw-Hill Companies, Inc ISBN 0-07-007272-8
4) Personal communication with a doctor whose son had meningococcal sepsis in a rare unusual form for two weeks before he could convince other doctors of the diagnosis (meningococcal low grade sepsis with a rash) in the absence of severe unwellness – this rare form of meningococcal infection can convert to the more rapidly life threatening form (Ref. 2 above).
5) *BMJ* 1992; 305: 143–147 Cartwright K, Reilly S, White D, Stuart J. Early treatment with parenteral penicillin in meningococcal disease.
6) Clinical Microbiology Reviews, January 2000, p. 144–166, Vol. 13, No. 1 – Update on Meningococcal Disease with Emphasis on Pathogenesis and Clinical Management
7) BMJ 2000; 320: 1290 (13 May) Editorial – Guidelines for managing acute bacterial meningitis. This includes reference to meningococcal disease without meningitis – and contains extensive references to other medical literature.

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8) The Value of General Practice – the key role general practice plays in the provision of Primary Health Care – publication by RNZCGP (Royal New Zealand College of General Practitioners), NZ 2002, ISBN 0-9582272-4-1 – this reviews some of the evidence for General Practice Care."

General Comments on Telephone Advice

There is a lot more to telephone advice than simply using the phone. A number of issues arise including the following:

- The use of the telephone in the context of general practice.
- What should the telephone be used for in general practice?
- What about simply not giving phone advice?
- Comments on Evidence/Disclaimer.
- Comments on appointment systems.

The use of the telephone in the context of general practice

A 'Telephone Guidelines' manual has been developed in New Zealand to assist nurses in giving advice on a variety of conditions over the phone (Ref 8.) – a new edition is about to be published and I have been involved in developing this. However when using the phone in general practice the advice given can not be looked at in isolation. For example if the conclusion of the advice is to see the doctor today this will not work well if no appointments are available. The way receptionists answer calls, the way patients are used to asking for (or not asking for) advice over the phone, the processes in the practice for dealing with requests for repeat prescriptions, all have a big impact on the use of the phone. External factors such as access to after hours clinics, emergency departments, and ambulance services are also likely to influence patients reasons for calling. Cost of care may also be a factor – some patients may not want to pay for an appointment even if they need one and would like to try and get (often free) advice over the phone.

What should the telephone be used for in general practice?

There is increasing evidence that the phone can be used effectively and safely for some problems and conditions. However the evidence is still in its early stages of development and practical problems can arise. It is important to note that often advice given over the phone can mean that you still eventually see the patient and the total time spent on the phone and seeing the patient may well be more than if the patient was just seen.

Trying to use the phone for following up patients is also problematic. One study can suggest such an approach works and then further studies can reveal problems (Ref. 1.) At least in a secondary care setting trying to follow up patients with chronic diseases showed no impact on admission rates, total number of clinic visits, laboratory or radiological tests requested, or mortality. Instead of providing

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an alternative means of maintaining contact with patients, telephone appointments became simply an additional service, and many people have expressed concern that national strategies for delivering telephone based care may represent little more than an additional mode of service delivery. We need to know about the appropriateness and method of delivery of telephone care for each disorder and setting.

The evidence on the use of the telephone has been looked at using systematic search methods to identify original research studies and systematic reviews evaluating the role of telephone communication as a means of delivering health care (Ref. 7) and this is worth reading for those interested at looking at the evidence.

<u>What about simply not giving phone advice?</u>

This is problematic in that patients may try and seek this anyway from receptionists or the nurse or doctor. They may be phoning the patients for some other reason and get asked for advice on the same or an unrelated matter about the same or a different patient. The alternative to not giving advice is that the patients seek it elsewhere or simply make their own decision about as to when or if to see the doctor or nurse at all. There could also be medico-legal risks involved if there is a failure to provide advice and/or timely care but I am not sure if such cases have ever occurred or been tested.

<u>Comments on Evidence/Disclaimer</u>

The New Zealand 'guideline' was developed as a 'consensus' based document 'originally. It is a 'guideline' using the combined knowledge of various practice nurses and general practitioners. Some evidence has been directly used for the review of this guideline but a thorough search of all the evidence on every topic in the guideline is beyond the resources available for the present review. It is designed to be used by nurses (and doctors) who already have medical knowledge and training which should be combined with the information in the guideline to give better advice. Should the nurse or doctor be aware of problems with the advice in this guideline then they should of course give safe advice based on what they already know and bring the problem with the guideline to our attention. The policy information and disclaimer at the start of this guideline should also be referred to.

Ideally a telephone advice guideline should be tested in a proper controlled trial comparing it with current practice to ensure it is safe and effective and to evaluate other aspects such as ease of use and cost effectiveness. This has been done to some extent with trials of computerised advice algorithms or other computerised systems aimed at guiding nurses or other health professionals in giving advice over the telephone (Ref. 2). These systems are mainly aimed at after hours and/or

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urgent requests for advice and thus only include some of the types of phone calls nurses might have to answer in a typical general practice. Such systems would not for example deal with specific non-urgent questions about a recent consultation or a request for a repeat prescription. One review of phone consultations in the UK showed "half the encounters were for new problems; others were requests for information on treatment options, side effects of drugs, queries on the organisation of care, and follow up of acute and of chronic problems'. (Ref. 2)

Computerised systems that aid nurses and other health professionals in accurate and safe triage are also not likely to be available within practices in the near future, in my opinion, and even if they were to become available might be difficult to use in day to day general practice. This is because of a number of reasons including:

1. The systems are aimed at patients calling where there is no background health information available other than what the patient can provide – in general practice this information is usually available and interfacing this with computerised systems that are different to the practice information systems would be problematic.
2. Other additional information available about the person calling such as personal knowledge of the caller and/or access to their notes both from a medical and nursing perspective would probably make a different decision process more desirable than following a standardised algorithm.
3. There is good evidence that continuity of care improves outcomes (Ref. 3). It seems likely that this continuity of care may well involve telephone advice and not just face to face consultations but further evidence is needed.
4. Cost – it would not be clear who would fund this for normal hours use – the government in New Zealand has indicated nation wide funding but as I understand it is for "after hours" use.
5. Even if funded the nursing and medical workforce is at a point where finding extra time to train to use such systems would not be possible unless there was a rapid pay back in terms of saving time elsewhere. Most studies on phone use are indicating the opposite – i.e. more total staff time is needed (Ref. 4).
6. A recently published study comparing off site triage with practice based triage showed that patients in the NHS Direct group (similar to the Healthline system in New Zealand) were less likely to have their call resolved by a nurse and were more likely to have an appointment with a general practitioner (Ref. 5). This in my opinion is probably because the practice has the advantage of knowing the patient and/or having access to some of their medical records but more research is needed to clarify this.

Telephone consultations are being used in many overseas after hours services (Ref. 6). However the exact basis on which a decision is made to have a telephone consultation rather than a face to face one is not always clear. Statements are made such as "Patients would always have direct telephone access to a general

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practitioner, who would determine the need for telephone advice, consultation, or home visit" (Ref. 6) – exactly how this would be determined is not clear.

I include a letter to the BMJ here as I can not really put some of the issues any better and it importantly points out some possible harms in using the telephone that are not obvious such as reduction in opportunistic screening:

'BMJ 2002; 325: 1242 (23 November), Letters, Telephone consultations may not save time – Brian H McKinstry, senior researcher.

Department of Community Health Sciences, University of Edinburgh, Edinburgh EH8 9ER brian.mckinstry@ed.ac.uk;

EDITOR Oldham describes how telephone consultation has apparently reduced the need for face to face consultations for patients requesting same day appointments in general practice. But on the basis of his own figures (if as I assume all such requests were triaged), almost half of those spoken to on the telephone went on to be seen by a doctor anyway. Depending on how long the telephone contact took, added to the follow-up appointment, savings in time on those managed by phone alone would have been minimal.

My colleagues and I performed a small randomised control trial of telephone versus face to face consultation for requests for same day appointments. We found, as did Oldham, that around half could be managed by telephone alone. We timed all contacts and found that the average time spent phoning and in discussion with patients was 5.2 minutes, the average face to face appointment was 8.2 minutes, and the average time taken for combined telephone triage followed by face to face was 10.9 minutes. In addition, and more worryingly, patients dealt with by telephone alone re-consulted 1.5 times more than those dealt with face to face (P=0.01), probably wiping out any small gains made. We also found that the process of telephone consulting led to a notable reduction in opportunistic health promotion (using blood pressure measurement as a marker). While the idea of using telephone triage for same day appointments is seductive and superficially seems to be cost effective, further research is required before its widespread adoption."

Comments on appointment systems

If the appointments are all used up for the day and a nurse and/or doctor has to deal with the call, it may be that practices have to control how often this happens. Whilst patients can simply be turned away there are problems with such an approach and someone in the practice has to deal with requests for urgent appointments. It is tempting to think that there is little that can be done to control patient workload, however the way appointments are set up and used can influence this. It becomes very time consuming if the practice has no

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system for keeping a number of slots free that can be used only on the day and not booked up from the days before. From a business point of view a practice is running sub-optimally if some appointment slots in the week are empty on some days and taken up completely on other days with patients being turned away. Practices should consider having at least three types of appointment slots:

1. Routine slots that can be booked in advance.
2. 'Today' only slots that the receptionist can only use on that day only.
3. 'Today only urgent' slots that the nurses and doctors can use if they have to fit in urgent patients who have phoned or they have phoned and assessed as needing to be seen on the day.

Other appointment slots can be developed for follow-up appointments, and special treatments (e.g. liquid nitrogen etc.) but these have to be managed carefully as rigid systems can cause loss of flexibility in the appointment system – sometimes just annotating an appointment with what it is for is more useful. Of course with the current lack of doctors and nurses even systems such as the above can break down and become unworkable however most of the time the options suggested above can work well.

References:

1) BMJ 2003; 326: 966-969 (3 May), Information in practice, Telephone consultations Josip Car, Aziz Sheikh
2) BMJ 2002; 324: 1230-1231 (25 May), Editorials, Using telephones in primary care - A significant proportion of consultations might take place by phone; Peter D Toon
3) The Value of General Practice – the key role general practice plays in the provision of Primary Health Care; Royal New Zealand College of General Practitioners, 2002 ISBN: 0-9582272-4-1
4) BMJ 2002; 325: 1214 (23 November), Primary care: Nurse telephone triage for same day appointments in general practice: multiple interrupted time series trial of effect on workload and costs, David A Richards, et al.
5) Published online 17 Sep 2004; *BMJ,* Evelyn Dutton et al. cluster randomised controlled trial for same day appointments in primary care: NHS Direct versus general practice based triage.
6) BMJ 1994; 309: 1624–1626 (17 December), General practice: Out of hours service: the Danish solution examined; Frede Olesen, Jacqueline V Jolleys
7) BMJ 2003; 326: 966–969 (3 May) Information in practice: Telephone consultations, Josip Car & Aziz Sheikh
8) Telephone Guidelines in a General Practice Setting; Produced by THE OTAGO DIVISION OF THE NEW ZEALAND COLLEGE OF PRACTICE NURSES NZNO, Correspondence to: Telephone Guidelines Otago Division, NZ College of Practice Nurses P.O. Box 1120 Dunedin

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Women with simple urinary tract infections may be able to be treated over the phone if the woman's doctor is agreeable to this approach.

Criteria would be as follows (Ref The Journal of Family Practice • JULY 2001 • Vol. 50, No. 7

A Randomized Controlled Trial of Telephone Management of Suspected Urinary Tract Infections in Women; Henry C. Barr et al.).

Nonpregnant women, 18 years or older with an uncomplicated UTI.

Suspected uncomplicated UTI defined as:

- a complaint of dysuria, pain on urination, complaint of urinary urgency and frequency, or the patient is saying, "I think I have a bladder infection."

Exclude patients with (i.e. these patients probably need to be seen or an alternative approach taken)

- symptoms compatible with pyelonephritis (fever, chills, sweats, back or flank pain, or vomiting)
- vaginitis, or cervicitis (presence of a new or changed vaginal discharge)
- diabetes
- previous history of pyelonephritis or other complicated UTI
- a UTI in the preceding month
- symptoms lasting longer than 14 days
- known kidney disease, anatomic abnormalities, or previous renal surgery
- recent history or currently receiving chemotherapy
- a recent history of antibiotic use in the preceding month.

Sorting out what to do – when & where and the concept of triage

Sorting out if a person should be seen, and how quickly a person should be seen, for a particular problem and by whom (e.g. ambulance officer, doctors of various types, nurse of various types), and at what location (e.g. GP surgery, accident and medical clinic, or a hospital emergency department, or some other option), is not as straight forward an issue as it might at first seem. The first decision for any given illness/injury or health problem is usually made by the patient themselves or their friend(s) or relatives. The next step may be to go to a health provider at some point in time convenient to the patient within the perceived necessary time period (in other words a decision is made about how urgent the problem is and how soon they should seek attention). At this stage they may even have decided to call an ambulance. If there is doubt they may choose to phone a doctor or nurse or a service such as "Healthline" (Ref. 6) in order to help with their decision. At the time of this case Healthline may

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not have been available and I am not suggesting that the service should necessarily have been used but I am trying to illustrate the range of options that either were available then or are available now, and the various contributions to delay in assessment that can occur.

In fact simply rushing to the doctor early in the course of an illness may in fact be unhelpful – it is well recognised that earlier on meningitis can be like many other illnesses – for example viral flu like illnesses. Seeing the doctor earlier will result in symptomatic treatment and advice on what to watch for in case a more serious illness does develop – it may be that patients already have this knowledge and may prefer to wait and see doctors at a later point in time. There are various risks of course such as waiting too long and certainly if there is doubt patients should see a doctor sooner rather than later – but sometimes if they are told at a particular point in time when they are seen that there does not appear to be a serious complication they may be falsely reassured and despite advice being given to return should things get worse or change for various reasons they may not want to return – this is not necessarily what happened in this particular case but needs to be discussed in the context of the complicated issue and process of patients being seen once or several times in the course of an illness and preferably at the right time and in the right place by the right health professional. Sometimes there is an overlap between different health professions and facilities. This overlap is probably a good thing so that patients don't fall into the gaps – for example many illnesses are seen either at an Emergency Department or a GP surgery or in accident and medical or after hours clinics and there is much discussion on trying to get patients to go to the "right" place – however it may be that until the patients are seen and fully assessed that is simply not possible to do so – it is well recognised that assessment/triage to prioritise a patient's care within a facility is different to that needed to send them away to another facility (Ref. 8) and to do so safely requires a lot more time, effort and resources. Even Healthline (Ref. 6) will not always recommend patients go to the correct facility when compared to their final diagnosis – but this is because it appropriately has a cautious approach to avoid patient harm.

Another consideration when thinking about triage both before arrival at a health care facility and triage after arrival is the concept of "barriers" to health care. Barriers to care include cost of service, physical access to services (e.g. transport availability and cost), waiting times (both to get an appointment, and the wait to be seen once at the health facility), knowledge of when to be seen or not for a particular illness and knowledge about self care, and perceived reactions of health professionals to the presentation – for example some patients are concerned that doctors will be upset if they come in too early or too late for any given illness – and paradoxically the longer they wait the less likely they are to want to come in, or sometimes they are worried the doctor will think they are a "hypochondriac" – these are all complex issues and can include the influence of past experience with doctors. My own personal

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experience with a couple of significant illnesses tells me that even with a lot of medical knowledge it is fairly easy to seek medical attention both too early and too late both initially and with subsequent visits for the same health problem. The other point here is that I am not trying to say it is the patients or relatives at "fault" – but rather that complex issues occur – for example if every time you seek medical attention you have to go to a clinic or emergency department and wait for hours it is likely that you will think twice about going back the next time – it may be that the health system has to come up with better alternatives than the currently available forms of health care (this would need careful research and piloting to avoid making things worse) and ultimately we may have to find ways of getting around the current problem of a shortage of both doctors and nurses.

Having discussed briefly the complexities of the decision about when and where to get seen it should be apparent that many delays can occur before the patient arrives at the clinic – these may often outweigh the delay that occurs once they arrive at the health facility. However once the patient arrives at a health facility there is clearly some responsibility for the health facility and its staff to treat patients in a timely manner. Decisions about this usually refer to the concept of "triage". It may be that the type of patients that present at a health facility mean that triage is usually not necessary but at just about any health facility an emergency case can arise and there should be some method of dealing with this. If there is regularly the possibility of a wait beyond a reasonably safe period of time for the type of conditions that present to a health care facility then formal triage may well be required – but deciding as to if this is the case is not clear cut. Which system of triage is best in which facility is not a simple thing to decide upon. These issues will be discussed in the next section.

Triage Issues

"Triage" has various definitions but a reasonable one is "the sorting of patients based on the need for treatment and the available resources to provide that treatment" (Ref 7). As a result of triage patients may be seen straight away or wait for some time depending on what the triage process suggested was their level of urgency and depending on what resources (nurses and doctors) are available. Whilst it may seem like a good idea that triage should always occur it may not be a good idea or it may have to be applied in a different manner for a number of reasons including:

- If there is no waiting time to see a doctor it is not really needed and/or it may cause further delays.
- If all the patients are likely to not be emergencies it is probably best to get on and see them rather than diverting resources to "triage" when they could be used to instead to see people more thoroughly and finish the job.

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For example in an accident and medical clinic it is likely that more urgent cases have either called ambulances and been taken to the local hospital emergency department or that they have gone their directly themselves.

- It may increase the overall resource needed to see patients and not actually improve overall patient care – you may need extra staff and/or rooms and equipment to do the triage. This can have adverse consequences including cost of the service to the patient, increased waiting time for some patients and subsequent reluctance of patients to re-attend for the same or a different problem in future.
- Nurses and doctors are trained to see people in a thorough manner (for example taking histories and examining patients in some detail and ordering tests when necessary to come up with a likely final diagnosis and treatment plan) and asking them to change and assess patients in a rapid manner for a different purpose is problematic and requires different special training.
- Triage may have to be different in different situations – for example if there are multiple casualties (where the number of patients and the severity of their conditions do not exceed the ability of the facility to render care) there is a different approach to triage than when there are "Mass Casualties" where the patients and the severity of their conditions do exceed the capability of the facility and staff.
- It may well be a reasonable assumption that patients who present to New Zealand accident and medical clinics are patients who have decided not to go to an emergency department and not to call an ambulance and that triage may not usually be needed. It may be that simple questions at reception or posters on the wall advising patients that if they have an urgent health problem they should bring it to the staff's attention rather than simply waiting in turn to be seen – we need more research and evidence to make decisions about this. It may also be that the way "triage" is done after the patient arrives in each facility depends on local issues such as availability of other services and historical patterns of patient behaviour – some clinics may need formal triage and others may not.

It is problematic to decide what is the best way to see patients and what type of triage if any should occur. Most of the evidence on triage is based on studying patients in emergency departments attached to or within public hospitals rather than in accident and medical or after hours clinics that are separate to hospitals – however some of the evidence is likely to be applicable to such clinics. For example patients who walk into emergency departments are more likely to be similar to accident and medical or after hours clinic type patients than those who are taken to emergency departments by ambulance.

In emergency departments the way triage works for patients who walk in is under extensive review. For example instead of having all patients who walk into emergency departments being seen at the triage area first, if they are

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directed to reception first more timely patient flow occurs and there is less confusion and it is also safe provided delays at reception are not more than 15 minutes (Ref. 1).

Another approach is to try and see patients first at triage rather than have staff used later on after patients have been triaged (Ref. 2) – this approach found that by using a senior clinical team (an experienced senior doctor and an experienced senior nurse) for initial patient consultation, the numbers of patients waiting fell dramatically throughout the ED. This suggests that taking staff away from work seeing patients after they have been triaged and instead getting them to see patients as they are triaged may be a more effective use of staff resources and benefit all patients in terms of waiting time. A New Zealand study along similar lines that controlled for overall staffing levels showed that the rapid management of patients with problems which do not require prolonged assessment or decision making, is beneficial not only to those patients, but also to other patients sharing the same, limited resources (Ref 5).

Even if Triage does take place there is then a further problem of trying to get the triage "correct". Triage is problematic in that patients can be prioritised as too urgent or not urgent enough compared with what more full medical assessment finally shows. This problem of under or over "triaging" can lead to direct consequence for the individual patient if under triaged (being made to wait too long) or indirect consequences to other patients who might be made to wait longer because the patient was over triaged.

With telephone triage, attempts to have standardised computer aided systems of triage do not necessarily overcome this problem – a comparison of different systems showed there were large differences in outcome between nurses using different software systems to triage patients (Ref. 3). Some of these problems just end up being accepted (it is generally accepted that it is safer to send a few patients unnecessarily to urgent medical care than to miss an urgent patient and tell them to wait for less urgent care) and studies have been done to show that the current NZ Healthline type phone advice system is safe (Ref 4). Healthline is useful for patients where they can not get in touch with their own GP in a timely manner (for example after hours) – what we don't know is if they should use Healthline when they can get hold of their own GP – it is possible that their own GP who has the advantaging of knowing the patient and/or access to their medical record could "triage" phone calls better than Healthline but we can not be sure about this at present. What is now needed are a number of good research studies to show what, if any, triage systems should be used outside of hospital emergency departments, and outside of phone call advice when usual health care providers are not available. Similar research also needs to be done for triage occurring at health care facilities that

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are not emergency departments as well as those that are emergency departments.

When patients turn up at GP surgeries or after hours surgeries or accident and medical clinics with apparently urgent problems there may need to be systems to deal with the problems. If such problems are rare then common sense may be enough – for example if a serious injury occurs just outside the facility then the duty of care over-rides the care of booked in or routine patients and the facility will direct doctors and nurses to the patient(s) and providing care until it is clear that either the facility can deal with the patient or they can be sent elsewhere or an ambulance arrives etc. It is not clear if receptionists can recognise patients ultimately triaged to emergency categories but it seems likely for walk in patients that harm is unlikely to occur from having them see patients first (Ref. 1).

It may be that the best approach is to only triage walk in patients who state their problem is urgent – but we need good research on this topic. At present this approach is reasonably common in accident and medical clinics and after hours clinics around NZ. It occurs every day in general practice when patients either phone general practice surgeries or walk in and ask for appointments. Thus it is established practice and to change this needs great care. The health system would become overloaded if every appointment was required to be triaged by nurses for example. For patients who do not state their problem is urgent it is reasonable for them to wait in the manner that is usual for the health care facility concerned. Some approaches taken for bringing it to patients' attention that they need to tell staff if they have an urgent problem such as chest pain or they are very unwell include having large signs up at reception and in the waiting area advising them of this fact. It is not reasonable or appropriate in many of the health care facilities to triage everyone – there are many reasons including:

- Staff could be better used doing tasks other than triage.
- Lack of physical space for triage to occur and risks of breach of privacy – some patients may not want to tell another person (nurse at triage) about their condition (e.g. sexually transmitted infection) and just want to see a doctor, some facilities may not be able to have a confidential area for triage without using up a room that is already used at busy times for seeing patients.
- Staff trained in triage may not be available. Staff trained in triage may have been trained for triage that is appropriate in one setting (e.g. emergency departments) that is not necessarily appropriate in another setting (in accident and medical or after hours clinics).
- As already discussed it may worsen care at the time (more overall delay for all patients) and put patients off coming back due to the extra waiting overall.

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- We may not improve patient outcomes beyond the decision they have already made – in other words for the few times that patients have come to the wrong place at the wrong time adding in triage may not actually improve overall care.

Other Approaches

Waiting times can be addressed by a variety of measures that include better matching of staff to patient workload. It is well recognised that patients attend more between the hours of 10am and 2pm than earlier in the morning for example – staffing rosters can be made to reflect this and help reduce waiting times (Ref 9). It is noted that in this case the patient attended at times that were likely to be busy. It is beyond the scope of this report to consider the matching of staff to patient workload but the clinic may want to consider this in their review of this case.

At present after hours care is being reviewed nationwide and it is possible that if different "rules" or "policy" is applied to emergency departments in terms of access to care for patients with apparently less urgent conditions that problems could occur and the nature and type of patients presenting at other clinics could change. Also the funding of care may change which may either increase or decrease the work load of clinics or it might change the type of workload. This may well mean that current or future policies of clinics with respect to staffing arrangements, physical facilities and equipment and triage might have to change.

Second visits for the same problem may need more urgent priority than first visits. I am not aware of any research on this approach. It seems like a good idea but care is required. Other possibilities could include reducing the fee the patient pays for second visits but this is problematic as they often take longer than first visits and take more staff and resources (Ref. 9) and hence cost more. Each clinic would need to review this based on re-attendance rates and types of patient problems involved but it may be this provides a good safety net for doctors giving advice for patients to self monitor their conditions over time – if patients are reluctant to come back because of cost this could over ride the safety net value of such follow-up advice.

References

1 Emerg Med J 2001; 18:441–443; Should ambulant patients be directed to reception or triage first?

S Goodacre1, F Morris, B Tesfayohannes and G Sutton

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2 Emerg Med J 2004; 21:537–541 Making an IMPACT on emergency department flow: improving patient processing assisted by consultant at triage; J Terris, P Leman, N O'Connor and R Wood

3 Emerg Med J 2003; 20:289–292; NHS Direct: consistency of triage outcomes; A O'Cathain, E Webber, J Nicholl, J Munro and E Knowles

4 NZMJ, 11-July-2003, Vol 116 No 1177;

Giving emergency advice over the telephone: it can be done safely and consistently; Geoffrey Hughes

5 NZMJ, 02-July-2002, Vol 115 No 1157; Effect of a rapid assessment clinic on the waiting time to be seen by a doctor and the time spent in the department, for patients presenting to an urban emergency department: a controlled prospective trial;

MW Ardagh, J Elisabeth Wells, Katherine Cooper, Rosa Lyons, Rosemary Patterson, Paul O'Donovan

6 Healthline 0800 611 116; http://www.moh.govt.nz/healthline

Healthline provides:

- an assessment of medical problems with advice on the most appropriate level of treatment and a recommended timeframe for doing so
- advice on selfcare and symptom management
- advice on the prevention of illness
- health information, for example information about diseases
- information about availability and location of services
- referral connection to other emergency services.

7 Advance Trauma Life Support for Doctors, American College of Surgeons Committee on Trauma, Student Course Manual, 1997, ISBN 1-880696-10-X

8 Triage; http://www.emedicine.com/emerg/topic670.htm#top; Robert Derlet, MD,

9 Personal experience with local after hours clinic and discussion with management."

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Opinion — No Further Action

Reasons for decision to take no further action

In reaching my decision to discontinue my investigation, I took into account all the information (including Mr A's response to my provisional decision) obtained during the investigation and the advice of my independent advisor, Dr Searle.

Dr C

Dr Searle advised that Dr C's examination of Miss A on 9 August for meningococcal disease demonstrated a good standard of care, particularly because he examined her skin and checked her neck for stiffness. The raised red papules that Dr C noted on Miss A's skin were not typical of meningococcal rash. Dr Searle advised that no other investigations for meningitis, including a lumbar puncture, were warranted. Dr C was also not obliged to record that Miss A might have meningitis as this possibility was "rare" (although I accept in hindsight that this may have led to an earlier assessment by a doctor when she presented the following day). Dr C's advice – that if Miss A's condition deteriorated or failed to improve she should be assessed by her GP or return to the Centre – was adequate.

I find Dr Searle's advice persuasive. It is well known that meningococcal disease can be difficult to diagnose in the early stages. The evidence suggests that in this case Miss A's condition deteriorated significantly and her rash became more evident after her assessment by Dr C on 9 August. Further, Ms B, acting on Dr C's advice (which Mr A passed on to her), returned with Miss A the following day for reassessment.

After Hours Medical Centre

The Centre was an "after hours Medical Centre" rather than an "Accident and Medical Clinic" and was not covered by the Standards New Zealand Standard for Accident and Medical Clinics in place at the time.[1]

My advisor, Dr Searle, advised that there is insufficient evidence, particularly the lack of research based evidence, that the triage procedures at the Centre on 9 and 10 August 2003 were inadequate. I accept Dr Searle's advice which clearly demonstrates the complexity of the issues surrounding triage at after hours medical centres. It is unlikely that a continuation of the investigation will resolve this issue.

Nonetheless, I note Dr Searle's comment that triage issues may become clearer as a result of the recommendations awaited from the After Hours Primary Health Care

[1] Since 1998, Accident and Medical Clinics have had the option of seeking ACC accreditation. In the accreditation process clinics are audited against a written Standard, administered by Standards New Zealand. The Standard addresses a number of areas fundamental to good Accident and Medical Practice.

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Working Party (Working Party), which is jointly chaired by the Ministry of Health and District Health Boards and consists of representatives from the Royal New Zealand College of General Practitioners, Primary Health Organisations, ACC and other interested parties. The Working Party's objective (according to the Ministry of Health website) is to develop and recommend a national policy framework that clarifies the responsibilities of those involved in providing after hours primary health care and creates an environment that promotes locally developed solutions to the provision of overnight services. I understand that the Working Party will consider the issue of triaging during its processes.

I have also decided to take no further action on Mr A's complaint because there is no documentary evidence (from Telecom or the Centre) to support the claim that Ms B contacted the Centre by telephone during the night of 9 and 10 August.

I acknowledge Mr A's concern about the standard of triaging taking place at the Centre, particularly on 10 August 2003 when Miss A waited for an assessment by a doctor for at least an hour despite her serious condition. In my view, although the nurse advised that she scanned the waiting room twice prior to Miss A's assessment by Dr D, it is probable that she would have detected only conditions requiring relatively obvious priority in light of her workload. The Centre has also advised that the scan of the waiting room every 15 minutes by the nurse often does not occur when the Centre is very busy.

The above gap in the triage coverage at the Centre is of concern. However, I do not consider further action on my part is warranted because I am reassured by the constructive steps that the Centre has taken in response to the incident to ensure that there is an improvement in the triaging of gravely ill patients, particularly those patients whose conditions are not obvious. It is likely that Miss A would have been assessed by a doctor earlier on 10 August 2003 if the policy that all second visits within 24 hours are a priority had been in place.

I do, however, believe that Miss A's experience (including the issues of accurate recording and overall monitoring of waiting times for assessment by a doctor) and Dr Searle's extensive advice should be brought to the attention of the Working Party, the Royal New Zealand College of General Practitioners and the New Zealand Accident and Medical Practitioners' Association. I propose to send an anonymised version of my final decision letter to these organisations and a copy naming the Centre to the Public Hospital.

I have also recommended that the Centre review the clarity and accessibility of its promotional material (including its website) and other publicly available information for patients.

Cultural issues

I acknowledge Mr A's concern that the steps taken by the Centre since the incident may not fully address the issues of cultural shyness and language barriers in triaging,

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for example the signs in the waiting room about meningitis and priority for assessment are in English only. As I explained in my letter dated 22 June 2005 (and emphasised at our meeting), my Office shares Mr A's concern regarding the importance of cultural sensitivity in the provision of health care and the need for health professionals and others to be aware of and respond to the differences in communication styles and conduct arising from cultural norms and expectations. I am particularly aware that some cultures demonstrate a great deference to authority and trust in medical professionals.

It appears that in this case cultural shyness did not prevent Ms B from requesting that Miss A be seen immediately on 10 August 2003. It is more likely that Ms B was not fully aware of the grave extent of Miss A's illness. Nonetheless, in light of Mr A's concern I have recommended that the Centre liaise (as you suggested) with two local cultural providers about the cultural issues associated with its triaging, including appropriate information and signage. The Centre has indicated that it would welcome suggestions concerning this issue.

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