Patient admission to ED with signs of sepsis
15HDC01504, 28 June 2017

Registered nurse ~ Senior ED doctor ~ District health board ~ Emergency department ~ Abnormal vital signs ~ Monitoring ~ Laboratory results ~ Discharge ~ Standard of care ~ Right 4(1)

After being unwell for four days, a man presented to the Emergency Department (ED) at 11.03am with an abnormal heart rate, temperature, and respiratory rate. Following his initial triage assessment, the man was monitored by a registered nurse, who recorded his blood pressure and oxygen saturation levels at 11.45am, 12.03pm, and 2.30pm. The registered nurse did not document the man's pulse, respiratory rate, or temperature over this time. The man's oxygen saturations were low enough to be indicative of significant hypoxia, but no actions were documented in response to the issue.

At approximately 11.30am, the man was reviewed by the senior doctor on duty in the ED. The doctor ordered a number of laboratory tests, the results of which included a lactate result consistent with cellular hypoxia. The doctor acknowledged the man's laboratory results electronically at 1.08pm. At 2.45pm, the doctor ordered the urgent administration of IV fluids. No observations were documented after that time.

The doctor diagnosed the man with bilateral basal pneumonia and discharged him at 3.28pm. The doctor told HDC that the man's oxygen saturation levels and blood pressure were not brought to his attention, but said he could not recall whether or not he was aware of the lactate level at the time he discharged the man.

The man was found dead in his bed the following day.

Findings
It was held that the registered nurse breached Right 4(1) by failing to: record the man's pulse, respiratory rate, and temperature during the period she was monitoring him in the ED; inform the doctor of the man's low oxygen saturations; administer oxygen to treat the man's hypoxia; and take vital sign recordings to assess the man's response to further IV fluids administered at 2.45pm.

It was held that the doctor breached Right 4(1) by failing to review the man's observations before making decisions about his discharge.

It was held that the district health board was not vicariously liable for the registered nurse's and doctor's breaches of Right 4(1).

Recommendations
It was recommended that the registered nurse: arrange for a peer to conduct an audit of her documentation in the ED in the last month, with a particular focus on the frequency of patient observations, and actions taken in response to abnormal observations; undertake further training on the monitoring of patients with abnormal observations, or provide proof that further training in this area has been

undertaken since the man's presentation to the ED; and provide a written apology to the man's family for her breach of the Code. It was also recommended that the Nursing Council of New Zealand consider undertaking a review of the registered nurse's competence.

The doctor provided a written apology to the family for his breach of the Code. It was recommended that he provide HDC with evidence of further training undertaken on monitoring and managing patients in the ED. The Medical Council of New Zealand resolved that the doctor would be required to undergo a performance assessment.

It was recommended that the district health board undertake an early warning score audit to ensure appropriate use of the escalation protocol for all patients (or a sample of patients) who triggered an early warning score of 3 or more in the last month.