Failure to undertake timely review of woman with hip pain (11HDC00532, 13 December 2013)

District health board ~ Public hospital ~ Orthopaedic review ~ Ultrasound-guided aspiration ~ Appropriate treatment ~ Communication ~ Rights 4(1), 4(5)

A woman complained about the care provided to her elderly mother at hospital. The woman had presented to the hospital's emergency department on a Thursday with pain in her hip, where she was initially diagnosed with musculoskeletal pain. It was noted that she had been taking roxithromycin in the community, however this medication was not reconciled and she missed two doses.

On Friday (11 hours after presentation) the woman was reviewed by the medical team. The woman's temperature and respiratory rate increased and, by the afternoon, a medical house officer identified a possible diagnosis of septic arthritis. The medical house officer contacted the orthopaedic team, however they were too busy to review the woman and recommended an ultrasound and an ultrasound-guided aspiration. The house officer therefore contacted a radiology registrar, who recommended other sources of infection be excluded before radiological investigations were undertaken. Early that evening a radiology registrar performed an ultrasound but did not perform an aspiration as an orthopaedic review had not yet occurred. The medical house officer again contacted orthopaedics, but they were still too busy to review the woman. During the weekend handover, inadequate information about the woman was passed between outgoing and incoming doctors in the medical team.

On Friday evening the medical team again contacted the orthopaedic team, who were still too busy to review the woman. An orthopaedic registrar recommended that the medical team contact radiology to request an ultrasound-guided aspiration or an MRI, and advised delaying administration of intravenous (IV) antibiotics until further radiological investigations had been undertaken.

Because of a series of delays and miscommunications between the orthopaedic and medical teams, an aspiration was never performed and IV antibiotics were not commenced until Saturday evening – over 24 hours after a possible diagnosis of septic arthritis had been first considered. It took five requests and 32 hours before someone from the orthopaedic team reviewed the woman on Sunday morning. On Sunday afternoon, the woman was diagnosed with septic shock and palliative care was deemed appropriate.

A number of systemic failures at the hospital led to the woman receiving suboptimal care and treatment. The DHB therefore breached Right 4(1) for failing to undertake a timely orthopaedic review of the woman, failing to undertake an ultrasound-guided aspiration, and failing to provide her with appropriate antibiotic treatment in a timely manner. The DHB also breached Right 4(5) for failures within the medical team to communicate the woman's condition to one another, failures between the medical and orthopaedic teams to communicate the woman's condition to each other, and the lack of clarity regarding the process for requesting an ultrasound-guided aspiration.