Assessment, monitoring and transfer of woman following road accident
14HDC01598, 22 June 2018

Ambulance service ~ Rural hospital ~ Rural general practitioner ~ Registered nurse ~Car accident ~Head injury ~ Transfer ~ Observations ~ Assessment ~ Communication ~ handover ~Policies ~ Retrospective clinical notes ~ Rights 4(1), 4(2)

In the early hours of the morning, an 18-year-old woman was involved in a single-vehicle car accident with another occupant. Two ambulances and staff attended the scene as well as police, fire service staff and some members of the public. An emergency medical technician paramedic (EMT) transported the woman without assistance. An intermediate life support (ILS) paramedic met up with the ambulances but did not assess the woman. Both ambulances stopped in a rural township and met with a further ambulance which took the other patient to a city hospital. The EMT took the woman to the rural township's hospital at approximately 4.45am.

The woman was transferred from the ambulance into the hospital on a wheelchair. During the transfer she was unable to weight-bear, was expressing pain, and was reported to be drunk. The patient report form (PRF) stated that the woman was a status 2 patient (i.e. having a potential threat to life), but the EMT reported verbally the woman was status 3 (i.e. not having a condition that is likely to be a threat to life). The PRF was not provided to the rural hospital. The EMT stated that during handover she was told by the rural general practitioner (GP) at the hospital that the woman would not be transferred to the city hospital because she was drunk.

A registered nurse (RN) performed baseline observations but not neurological observations. The GP assessed the woman and recorded that she was inebriated, had no obvious head injury, no tender spine, and was moving her arms and legs freely. The GP's plan was to "observe and send home when alert". At approximately 6.45am the GP took a blood sample at the request of the Police and then examined the woman's left ear and observed that it was inflamed. At approximately 7.45am–8.10am the GP handed the woman over to another rural GP. The first GP stated that she told the second GP that he needed to assess the woman, but the second GP denied this and said he was told that she could be sent home once alert. He left the hospital to attend another clinic. During the morning shift the glass on the woman's back was not removed fully and her hygiene needs were not attended to.

The RN stated that she attempted, but failed to provide, a handover to another RN at approximately 7.30am. The second RN did not conduct observations or commence cooling cares until approximately 1.30pm, did not offer the woman any food or hydration and did not address her hygiene needs. Following concerns raised by the woman's whānau at approximately 1pm, the second RN contacted both GPs. After assessing the woman, the GPs arranged for an immediate transfer to the city hospital. Blood tests showed no blood alcohol content. Upon arrival at the city hospital, the woman received a head CT scan, which showed multiple brain injuries. The woman was transported to the intensive care unit (ICU) at a large main centre hospital and later died in the ICU.

Findings
The ambulance service breached Right 4(1) because staff failed to recognise the seriousness of the woman's condition; failed to have someone in the back of the ambulance to provide reassurance; the staff manager (the ILS paramedic) failed to undertake further assessment of the woman; the woman was inappropriately transferred from the ambulance; staff failed

to provide an adequate handover or a PRF to hospital staff; staff failed to complete the PRF to an adequate level; and staff failed to advocate on behalf of the woman for a transfer to the city hospital.

The first GP breached Right 4(1) for failing to recognise that the woman's neurological examination was significantly abnormal, and that her failure to improve over time suggested that alcohol could not be the explanation. The GP also failed to follow the admissions policy appropriately. The first GP also breached Right 4(2) for failing to record clearly that an additional clinical note she made about her assessment of the woman was retrospective. Adverse comment was made regarding the ambiguity in the medical handover between the GPs.

Adverse comment was made in respect of the second GP regarding the ambiguity in the medical handover between the first GP and himself, and also regarding his failure to discuss with nursing staff a discharge plan for the woman.

The first RN breached Right 4(1) for failing to include neurological observations and assess the woman's blood glucose level as part of her initial nursing review; conduct further observations (including neurological observations) over the course of her shift, or attend to the woman's hygiene needs. The first RN also breached Right 4(2) for failing to record clearly that additional clinical notes she made were retrospective. Adverse comment was also made regarding the RN's failure to ensure that she had communicated salient information to the second RN before completing her shift.

The second RN breached Right 4(1) for failing to conduct nursing assessments and monitor the woman's vital signs prior to 1.35pm; check the woman's blood glucose level; or conduct an objective neurological assessment. Criticism was also made regarding the way she managed the woman's hygiene, food, and hydration needs, and the effectiveness of the cooling cares provided. The second also RN breached Right 4(2) for failing to record clearly that additional clinical notes she made were retrospective, and for removing original clinical notes from the file. Adverse comment was made regarding the second RN's failure to ensure adequate communication with the first RN, and in particular that she received a complete handover.

Adverse comment was made regarding a third RN's failure to identify clearly that amendments in her clinical notes were made retrospectively, and her failure to raise concerns about another colleague's documentation.

The rural hospital breached Right 4(1) because both medical and nursing staff did not provide an appropriate standard of care, including the failure of staff to provide the woman with basic personal cares; there was a lack of clinical leadership; there was poor communication between nursing and medical teams; staff failed to comply with policies; and staff failed to document accurately that some clinical notes were made retrospectively.

Recommendations

It was recommended that the ambulance service and the rural hospital provide HDC with a report confirming the implementation of the recommendations and actions following their internal investigations into the events. It was also recommended that the ambulance service report to HDC on any associated education provided to its paramedic staff in the region and the rural hospital undertake an audit of its clinical records and practice management system to ensure that patients have been assessed and transferred to the city hospital

appropriately, and meet with all clinical staff to discuss the findings of the case and relevant organisational policies.

It was recommended that the GP undertake an audit of her clinical records of all patients who have been involved in a motor vehicle accident, to demonstrate that she has assessed all patients appropriately. It was also recommended that the GP arrange for further training regarding record-keeping, and provide HDC with evidence of the training she has completed since the time of these events regarding triage and the assessment of patients who have been involved in a motor vehicle accident. The Medical Council of New Zealand had already ordered that the GP undergo a performance assessment.

It was recommended that the first, second and third RNs arrange further training in specific areas. It was recommended that the Nursing Council of New Zealand consider undertaking a review of the competence of the first and second RN.

It was recommended that the rural hospital, the ambulance service, the GP, and the nurses apologise to the woman's family for their breaches of the Code.

The ambulance service and the owner of the rural hospital were referred to the Director of Proceedings. The Director decided not to take proceedings.