Co-ordination of care of patient admitted to hospital with acute breathlessness (05HDC11908, 22 March 2007)

Public hospital ~ District health board ~ Physician ~ Registered nurse ~ Enrolled nurse ~ Asthma ~ Chest infection ~ Pneumonia ~ Handover ~ Test follow-up ~ Nicotine patches ~ Smoking ~ Oxygen therapy ~ X-ray reporting ~ Communication ~ Documentation ~ Scope of practice ~ Clinical observations ~ Supervision ~ Respiratory rate ~ Respect ~ Duty of candour ~ Coroner ~ Director of Proceedings ~ Rights 1(1), 4(1), 4(2), 4(3), 4(5)

A 50-year-old man was admitted to a public hospital with classic signs of a chest infection. His chest X-ray and blood tests were not reviewed for almost 30 hours, despite an assessment during that time by a senior registrar and a consultant physician. He was inadequately monitored by nursing staff, with virtually no clinical observations performed during the last 12 hours of his life. He was found dead by nursing staff just over 40 hours after his admission to hospital. At post-mortem, the cause of death was found to be respiratory failure and pneumonia.

It was held that the public hospital breached Rights 1(1), 4(1), 4(2), 4(3), and 4(5) by a lack of care planning, ineffective communication, and discontinuity of care; an inadequate response to shortages in nursing and medical staffing; allowing an enrolled nurse to work outside her scope of practice; not treating the patient and his family with respect and compassion; and failing to respond appropriately to the patient's nicotine addiction.

The public hospital's response to queries from the patient's relatives after he had died was criticised. A medical registrar failed to review the X-ray (or arrange for it to be reviewed) and did not commence antibiotic treatment in the presence of clear signs of infection, breaching Right 4(1). A consultant physician did not ensure that the X-ray was reviewed, failed to review blood test results, and failed to commence treatment for chest infection, breaching Right 4(1).A registered nurse failed to monitor the patient's condition adequately and gave an inadequate handover to the night staff, and an enrolled nurse failed to undertake any clinical observations, breaching Rights 4(1) and 4(5).

The DHB was referred to the Director of Proceedings, for the purpose of determining whether any further proceedings should be taken. This was the first time the Commissioner had specifically referred a DHB to face a potential civil claim before the Human Rights Review Tribunal. No individual doctor or nurse was referred to the Director of Proceedings.

The Director entered into discussions with the DHB and the family. A confidential agreement was reached. Taking this into account, along with the ongoing commitment by the DHB to implement changes as a result of the events, the Director of Proceedings decided not to issue proceedings against the DHB.