Monitoring of man with cardiac issues
16HDC01028, 2 September 2019

District health board ~ Heart attack ~ Medication ~ Monitoring ~ Right 4(1)

A 68-year-old man was admitted to the emergency department of a public hospital with chest discomfort. Blood tests and an electrocardiogram showed that he had suffered a heart attack. At 1am, the man was admitted to a general medical ward, where he was monitored via remote cardiac monitoring, and commenced on blood-thinning medications.

The following failings occurred:

- Medication administered to the man was recorded inaccurately in MedChart; software issues contributed to this.
- The man was left alone in the bathroom despite having recently been administered GTN sprays.
- Task Manager, the electronic notification tool, was used inappropriately to notify medical staff of clinical issues.
- Nursing staff failed to follow up Task Manager messages with the medical staff.
- There was poor clinical judgement by the overnight house officer, who decided not to review the man despite his chest tightness and having required GTN sprays, and later having experienced a fall.
- The house officer did not look at the man's patient notes before deciding not to review him.
- Documentation was poor, including the overnight house officer not recording his decision not to review the man.
- There was poor communication between staff about the man's fall, particularly at the nursing and medical handovers.
- There is evidence that it was not uncommon practice for doctors not to document in the notes when they had attended patients.
- Nursing staff did not notify the house officer of the subsequent discovery of the man's head injury following the fall.
- There was no flag or warning system to identify patients on antiplatelet/ anticoagulation therapy, including in the electronic falls form.
- There was a lack of critical thinking by nursing staff, who continued to administer the man's blood-thinning medication, and stopped neurological observations despite being told that the man might have hit his head.
- There is no evidence that a falls assessment was undertaken following the man's GTN use or after his fall.
- There was no face-to-face handover to the medical team from the night house officer.
- The nursing notes were not reviewed by the medical team during morning rounds.

- It appears that the man's knock to the head was not relayed verbally to the afternoon staff during the nursing handover.
- The nursing notes were not always reviewed by the incoming nursing staff.
- Additional medication would have been available for the man when he was in palliative care, but the nurse was not aware of this.

Findings

The cumulative effect of these failings was that overall care was of a very poor standard. Consequently, it was found that the district health board (DHB) breached Right 4(1). The DHB was referred to the Director of Proceedings.

Recommendations

It was recommended that the DHB:

a) Undertake an evaluation of the impact of the interventions put in place following its Serious and Sentinel Event Analysis.
b) Provide an update in relation to the remainder of the recommendations made in the Serious and Sentinel Event Analysis regarding what has yet to be implemented, and when this will take place — including, but not limited to, the recommendations in relation to the review of patient notes and the documentation of clinical decision-making to ensure appropriate communication.
c) Undertake an audit for the last six months, to assess whether patients who were diagnosed with a non-ST elevation myocardial infarction were admitted to the CCU in line with recommended practice.
d) Undertake an audit for the last three months, to assess the appropriateness or otherwise of the use of the electronic notification tool. The DHB is to provide a report that identifies whether clinical matters that normally require face-to-face discussion or a telephone conversation are being actioned adequately in this way, as opposed to via the electronic notification tool.
e) Undertake a review of its communication tools to ensure accurate handover between shifts. As part of this review, consider whether it should introduce a system such as the ISBAR sticker format, in line with the expert advice.
f) Provide evidence of its new alert system(s) flagging patients who are receiving antiplatelet and anticoagulation medications.
g) Develop training for new doctors on how to prioritise their tasks when on call, and provide evidence of this training.