Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Documentation and clear understanding of responsibilities and processes for consultant handover vital for patient care
19HDC02396

The importance of having clear systems in place to ensure emergency department (ED) clinicians are aware of which consultant has responsibility for each patient, and processes for consultant handovers was highlighted in a decision published by Deputy Health and Disability Commissioner Dr Vanessa Caldwell.

Dr Caldwell also emphasised the importance of resident medical officers recording and communicating a patient's symptoms accurately, and recognising when care should be escalated to a senior medical officer (SMO).

A woman, in her eighties at the time of the events went to an ED with acute kidney failure and obstruction of her single functioning kidney, but was discharged five hours later with a diagnosis of a kidney stone. She re-presented to the ED three days later and sadly passed away.

In her decision, Dr Caldwell considered the adequacy of the care provided to the woman by the ED at her first admission, including whether the discharge was appropriate, and the system in place at the hospital regarding overall consultant responsibility.

Dr Caldwell concluded the consultant handover processes in place at the ED were inadequate, with no clear identification and delineation of which consultant had oversight of care for the woman. She therefore found Taranaki District Health Board (TDHB), now Te Whatu Ora Taranaki, in breach of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services with reasonable care and skill.

Te Whatu Ora Taranaki was referred to the Director of Proceedings for consideration of further proceedings.

Dr Caldwell further concluded a senior house officer (SHO) should have recognised the seriousness of the woman's condition and admitted her to hospital, and therefore also found the SHO in breach of the Code.

"I consider the failures in this case were the result of both an individual error in clinical decision-making, and an inadequate system within the ED, for which TDHB had responsibility.

"At the time of events, TDHB ED did not have a system that clearly identified or allocated a supervising consultant for each patient. TDHB had overall responsibility for these system failures that contributed to the tragic consequences of this case.

"Actions and omissions of the SHO to recognise the seriousness of the woman's condition contributed to her being discharged from the ED inappropriately. While the SHO was a junior doctor at the time of events, I note her significant prior experience. I consider my criticisms of her care for the woman were well within her capabilities," says Dr Caldwell.

Te Whatu Ora Taranaki and the SHO were both asked to provide a written apology to the family.

Dr Caldwell made multiple recommendations to Te Whatu Ora Taranaki including; developing a more formal system for consultant handover in ED, providing training to all ED SHOs on the revised guidelines/system for handover, and highlighting the importance of communication between nurses and senior medical officers.

Dr Caldwell recommended the SHO undertake further training and also recommended the Medical Council of New Zealand consider whether a review of the SHO's competence is warranted.

Following the events, Te Whatu Ora Taranaki have implemented changes to its processes including the use of an electronic whiteboard to record and identify the consultant with responsible authority, and ensure that one senior doctor is clearly focused on the patient's care, changes to the consultant staffing model for the ED, and changes to its escalation procedures by nurses.

"I am pleased to see the significant work and changes undertaken in the hospital to improve patient care to prevent a similar occurrence in the future," says Dr Caldwell.

-ends-

28 November 2022

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media and HDC's naming policy can be found on our website here. HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).