Urgent Care Clinic

Doctor in Urgent Care Training, Dr C

A Report by the

Health and Disability Commissioner

(Case 18HDC01962)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 1
Information gathered during investigation 2
Opinion: Dr C — breach 5
Opinion: Clinic — no breach 7
Recommendation 8
Follow-up actions 8
Appendix A: Independent advice to the Commissioner 9

Executive summary

1. This report considers the care provided to a 64-year-old woman who attended an urgent care clinic after a fall in her home. The woman was seen by a doctor who did not assess her thoroughly, and did not order an X-ray.

2. When being examined, the woman remained seated or standing with support. This meant that the doctor failed to assess the extent of the woman's reduced range of movement adequately, and her inability to weight bear. The doctor concluded that the reduced range of motion was due to muscle spasms. Believing that there was no serious injury, the doctor prescribed analgesia and advised the woman that she could travel by car to a family gathering in another city the following day.

3. In accordance with this advice, the woman journeyed by car the following day. However, on attempting to mobilise she experienced an excruciating level of pain, and attended a nearby hospital. She was diagnosed with an extracapsular fracture of her neck of femur, which ultimately required a total hip joint replacement. Had a thorough assessment been undertaken and imaging obtained, the hip fracture could have been diagnosed earlier and treated more conservatively.

Findings

4. The Commissioner found that by failing to conduct an adequate medical assessment that took full account of the woman's symptoms, and by not obtaining an X-ray of her hip, the doctor failed to provide services with reasonable care and skill and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

Recommendation

5. The Commissioner recommended that the doctor prepare an anonymised case study for training purposes.

Complaint and investigation

6. The Commissioner received a complaint from Ms B about the services provided to her mother, Mrs A, by Dr C at an urgent care clinic (the clinic). The following issues were identified for investigation:

- *Whether Mrs A was provided with an appropriate standard of care by the clinic on 30 August 2018.*
- *Whether Mrs A was provided with an appropriate standard of care by Dr C on 30 August 2018.*

[1] Right 4(1) provides: "Every consumer has the right to have services provided with reasonable care and skill."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

7. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant
Urgent care clinic	Provider
Dr C	Provider

8. Information was also obtained from the District Health Board.

9. Independent expert advice was obtained from in-house clinical advisor, general practitioner (GP) Dr David Maplesden and is included as **Appendix A**.

Information gathered during investigation

Background

10. Mrs A, then aged 64 years, slipped in her kitchen at around 5.30pm on 29 August 2018, landing on her left hip and also injuring her left arm, ribs, and shoulder. The following day, on 30 August 2018, Mrs A presented to the clinic and was provided with a wheelchair.

Triage

11. Initially, Mrs A was seen by a student nurse, who noted that Mrs A was "walking in the house and slipped on to bottom, legs raised in the air and injured [left] hip, ribs, lateral of the body". The student nurse documented that Mrs A did not report any numbness and had a good recollection of the events, and also noted the following:

- Mrs A was in a wheelchair and had a limited range of movement of the left lower limb and shoulder;
- Movement of her left lower limb caused increased pain that radiated to her groin;
- She was experiencing pain in the left shoulder, which radiated to the left pectoral[2] area and worsened when breathing in;
- Her left lateral thigh area was swollen; and
- She was experiencing sharp pain (which she described as being nine on a scale of ten).

Examination by Dr C

12. Subsequently, Mrs A was seen by Dr C. At the time of these events, Dr C was in the Urgent Care Training scheme provided by the Royal New Zealand College of Urgent Care.

13. Dr C had available to her the notes from the triage assessment of Mrs A. When Dr C examined Mrs A, Mrs A remained either seated in the wheelchair or standing with support. Dr C documented further detail on the mechanism of the fall: "[S]he went side ways falling on [left] hip and [left] upper back/shoulder." When Dr C examined Mrs A's hip, she

[2] Relating to the breast or chest.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

documented: "[Left] hip flexed 90 degrees with minimal discomfort but getting muscle spasms of the adductors.[3]"

14. Dr C concluded that Mrs A had a contusion[4] of the hip, and that her reduced range of motion was due to muscle spasms. Believing that there was no serious injury, Dr C prescribed analgesia (paracetamol, diclofenac[5]) and assured Mrs A that she could travel to a family gathering in another city the next day.

Subsequent events

15. Mrs A travelled to the family gathering the day after her presentation at the clinic. Upon attempting to mobilise, she developed excruciating pain in her hip and was taken by ambulance to the public hospital, where she was X-rayed. The X-ray found a displaced[6] intracapsular fracture[7] of her neck of femur.[8]

16. The district health board confirmed that ultimately Mrs A required a total hip joint replacement:[9]

> "X-rays showed a displaced neck of femur fracture. Considering the displacement and time since injury, a Total Hip Joint Replacement was performed. The head was sent for histology considering the atypical history, no malignancy was found. CT Chest, Abdo and Pelvis was negative of malignancy."

Further information — Dr C

17. Dr C acknowledged inadequacies in her assessment of Mrs A, and advised HDC that, in retrospect, she should have performed a more thorough examination, including asking Mrs A to demonstrate her full hip range of motion.

18. Dr C also acknowledged that she should have noted that Mrs A was unable to weight bear and requested an X-ray to further exclude or confirm a fracture. Dr C explained her rationale as follows:

> "Unfortunately, I failed to consider Neck of Femur fracture as a differential diagnosis due to the patients young age, low impact mechanism of injury (fall from standing), and delayed presentation. It is possible on reflection that I also may have been distracted by her other injuries i.e. contusion to her left chest/rib cage …"

[3] Fan-like muscles in the upper thigh that pull the legs together when they contract. They also help to stabilise the hip joint.
[4] A region of injured tissue or skin in which blood capillaries have been ruptured, i.e., a bruise.
[5] A non-steroidal anti-inflammatory medication used to treat pain and inflammatory diseases.
[6] A displaced fracture is a fracture where the broken bones have moved out of their normal position.
[7] These fractures occur at the level of the neck and the head of the femur, and are generally within the capsule. The capsule is the soft-tissue envelope that contains the lubricating and nourishing fluid of the hip joint itself.
[8] A short, constricted, strong bar projecting at an obtuse angle (about 125°) from the upper end of the shaft of the thigh bone and supporting its head.
[9] In a total hip replacement, the damaged bone and cartilage is removed and replaced with prosthetic components. The damaged femoral head is removed and replaced with a metal stem that is placed into the hollow centre of the femur.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

19. Dr C said that she has reflected on the complaint and has learnt from it. She explained the steps she has taken, which include discussion of the matter with her Vocational Training Supervisor, and a literature review. She advised:

> "This case serves as an important reminder of the danger of drawing conclusions and developing tunnel vision when assessing patients, especially those presenting with multiple presenting complaints. I have learnt the critical importance of systematically and comprehensively assessing each of the patient's complaints. What might be considered an atypical presentation requires further conscious and deliberate scrutiny rather than dismissal."

20. Dr C has apologised to Mrs A and her family. Dr C stated:

> "I wish to take this opportunity to again apologise for the upset and distress caused to [Mrs A] and her family. I regret that I did not meet the high standards of care I strive towards in the provision of my care to [Mrs A]. I have reflected at length on what I could have done differently. Regrettably I allowed myself to dismiss the possibility of a fracture and focus on other possible injuries. I accept the criticisms by Dr Maplesden[10] and I have them on board and have amended my practice accordingly."

Further information — the clinic

21. The clinic advised:

> "[The clinic] as a provider of health care, understands the importance of learning from complaints relating to clinical care or service provision. In doing so we acknowledge, as has [Dr C] … that in the case of [Mrs A], an X-ray of her hip should have been requested at the time of her presentation which would have provided a definitive diagnosis of fracture. There is a radiology provider [nearby].
>
> For this reason, and in support of [Dr C's] response to your office (and [Mrs A]) we extend our own apologies to [Mrs A], her husband and her family for the distress this missed diagnosis has caused."

22. The clinic also advised that it is reviewing its clinical guidelines for suspected fractures, and is looking at the nature of the handover between the nurse who triages a patient, and the doctor. It has identified the importance of a verbal handover, in addition to triage notes.

23. The clinic further advised that at the time of the events, the following procedures were in place:

- All senior nurses in urgent care complete triage training through the College of Emergency Nurses New Zealand, and three-monthly auditing of triage takes place by both the Medical and Nursing Directors.
- Urgent Care Doctors can contact the orthopaedic team at the public hospital, should they need to discuss a case or treatment options, and this has become a well-established practice.

[10] In-house clinical advisor.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Regular onsite and peer review meetings are being held, chaired by the medical director, and have included case reviews of fracture management.
- All staff receive a comprehensive induction programme, which includes the use of Health Pathways,[11] ACC Read Codes (including high/thigh sprains),[12] and approved clinical texts, to guide their practice decisions. Of note, at induction, staff complete a clinical competency checklist with the medical director, which involves topics relating to triage and orthopaedic care, including clinical signs for a fractured neck of femur.

24. The clinic also provided documentation to HDC in support of the practice's good governance and medical standards. This documentation included:

- Australasian College of Emergency Medicine guidelines for the implementation of the Australasian triage scale.
- The clinic's urgent care triage nurse guidelines.
- Head of Department meeting minutes for two meetings at which complaints and other incidents were tabled.
- The clinic's urgent care doctors orientation pack.
- The clinic's competency criteria for medical officers in urgent care.

Response to provisional opinion

25. Mrs A was given an opportunity to respond to the "information gathered" section of the provisional opinion. Mrs A reiterated that the sequence of events following the missed diagnosis of her hip fracture has impacted her life greatly, and has caused her a great amount of hardship and stress.

26. Dr C was given an opportunity to respond to the relevant sections of the provisional opinion, as it related to her. Dr C advised that she accepted the provisional opinion and had no further comments to make.

27. The clinic was given an opportunity to respond to the provisional decision. The clinic also advised that it had no further comments to make.

Opinion: Dr C — breach

28. On 29 August 2018, Mrs A slipped in her kitchen, landing heavily on her left hip and also injuring her left arm, ribs, and shoulders. On 30 August 2018, Mrs A was having difficulty

[11] An online manual used by clinicians to help make assessment, management, and specialist request decisions for over 550 conditions.
[12] Read Codes record an injury diagnosis, and are used by ACC to keep track of the injury type and determine a client's entitlement to treatment and help.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

mobilising and presented to the clinic, where she was assessed by Dr C. Dr C's assessment involved noting that Mrs A's hip could be flexed, and that she was getting muscle spasms.

29. There were deficiencies in Dr C's assessment of Mrs A. My expert adviser, Dr David Maplesden, stated:

> "An accepted basic hip examination is summarised under the following components: inspection (including assessment of gait); palpation (for localised pain or swelling); neurovascular; range of movement. Additional special tests/manoeuvres might be indicated depending on the history and physical findings. … I would expect the basic assessment of inspection of the leg while supine[13] (?shortening/external rotation), noting of gait and full range of movement determination to have been undertaken by any GP and particularly by an emergency medicine trainee."

30. Dr Maplesden concluded that Dr C's assessment of Mrs A's left hip was "significantly deficient". He considered that this was particularly so given the presenting history of a fall onto the hip with subsequent difficulty mobilising, an inability to weight bear in a previously active patient, and the recorded triage findings of reduced range of movement, groin pain, and lateral hip swelling.

31. I agree with Dr Maplesden. I am critical that Dr C failed to complete the necessary and basic elements of a hip examination. Had an adequate examination of Mrs A's hip occurred, a more accurate clinical picture would have emerged, and Mrs A's fracture may have been identified earlier.

Failure to obtain an X-ray

32. In addition to, and resulting from, the deficiencies in Dr C's assessment of Mrs A, Dr C failed to suspect a possible hip fracture and organise appropriate imaging by X-ray.

33. Dr Maplesden opined:

> "[I]nability to weight bear following lower limb trauma, in conjunction with a complaint of hip pain, I believe should have been investigated with hip X-ray despite the somewhat 'atypical' features evident (relatively low impact fall and comparatively young age of patient) … a Royal College of Emergency Medicine reference reviewed emphasises the importance of having a very low threshold for X-raying the hip if there is the slightest possibility of a fractured neck of femur (as I believe there was in this case based on the history with or without more detailed assessment findings)."

34. I agree with Dr Maplesden. I am critical that Dr C failed to investigate Mrs A's symptoms further by ordering a hip X-ray. Dr C's failure to obtain appropriate imaging fell below the required standard.

Conclusion

35. I consider that Dr C failed to provide Mrs A with reasonable care and skill by failing to:

[13] Lying face upwards.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

a) Conduct an adequate medical assessment that took full account of Mrs A's symptoms; and

b) Obtain an X-ray of Mrs A's hip.

36. As a healthcare provider, Dr C is responsible for providing services in accordance with the Code. In this case, I consider that Dr C failed to assess Mrs A systematically and comprehensively.

37. Accordingly, I find that Dr C breached Right 4(1) of the Code by failing to provide services to Mrs A with reasonable care and skill.

Opinion: Clinic — no breach

38. The clinic is responsible for the operation of the clinical services it provides, and can be held responsible for any service failures. In addition, it has a duty to ensure that patients receive quality services.

39. Dr Maplesden advised that the clinic did not have deficiencies in its processes or policies that contributed to the inadequacy of Mrs A's assessment. I accept Dr Maplesden's advice.

40. The clinic provided HDC with comprehensive evidence around its induction of staff. Staff are oriented to the appropriate health pathways and to ACC Read Codes (including those about hip/thigh sprains). Staff also complete a clinical competence checklist with the medical director, on topics relating to triage as well as the clinical signs of a fractured neck of femur.

41. Dr Maplesden advised that the triage assessment of Mrs A was comprehensive and well documented. He stated that it is clear from the documentation that Mrs A was not weight bearing and had reduced range of movement of her left hip, and that movement exacerbated her hip pain.

42. The clinic has sought to make improvements to the verbal handover from the triage nurse, and I consider those improvements to be appropriate. The clinic has been comprehensive in both its response to the complaint and its review of Mrs A's treatment.

43. In this case, I am satisfied that Dr C was individually responsible for the errors that occurred, and that there were no broader systems or organisational issues at the clinic. For these reasons I find that the clinic did not breach the Code.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendation

44. I recommend that within three months of the date of this report, Dr C prepare an anonymised case study for sharing with colleagues for training purposes.

Follow-up actions

45. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of Urgent Care, and they will be advised of Dr C's name.

46. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent advice to the Commissioner

The following advice was obtained from in-house clinical advisor GP Dr David Maplesden:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Ms B], daughter of [Mrs A]; response from [the clinic]; response from [Dr C]; [the clinic's] clinical notes; statement from [the] DHB.

2. [Ms B] states her mother (aged 64 years) slipped in her kitchen around 1730hrs on 29 August 2018, landing heavily on her left hip and also injuring her left arm, ribs and shoulder. No immediate medical assessment was made but the following day [Mrs A] was having difficulty mobilising and was in a lot of pain and an ambulance was called. There was to be a long wait for ambulance transport so [Mrs A's] husband transported her to [the clinic]. A wheelchair was provided at [the clinic] and [Mrs A] was assessed by [Dr C]. [Ms B] states her mother *remained seated in the wheelchair apart from when* [Dr C] *asked Mum to stand up to examine her, she felt around her hip, inner thigh and ribs and concluded Mum had a contusion of her hip. At no time was Mum X-rayed or asked to lie down to check the length of her legs, or the lump raised in her hip.* On the understanding there was no serious injury, [Dr C] reassured [Mrs A] she could travel to a family gathering in another city the next day. Analgesia was provided (paracetamol, diclofenac). However, on attempting to mobilise the next day [Mrs A] developed excruciating pain in her hip and was taken to [hospital] by ambulance. The [public hospital] response indicates [Mrs A] was X-rayed and found to have a displaced intracapsular fracture of her neck of femur. *Considering the displacement and time since injury, a total hip joint replacement was performed.* [Ms B] is concerned that [Dr C's] examination of [Mrs A] on 30 August 2018 was inadequate and contributed to a missed diagnosis of fractured neck of femur (NOF). The delayed diagnosis caused [Mrs A] significant physical and emotional distress and might have led to more extensive surgery being required (hip replacement rather than internal fixation).

3. The [clinic's] response addresses a separate issue of availability of wheelchairs. The response notes [Dr C] has apologised for failing to organize an X-ray of [Mrs A's] hip on 30 August 2018 when such an investigation should have been requested. Remedial actions planned include development of in-house guidelines for suspected hip fracture, staff education sessions on hip injuries and review of triage nurse handover procedures (verbal as well as written handover).

4. [Dr C] states: *Unfortunately I failed to consider neck of femur fracture as a differential diagnosis due to the patient's young age, low impact mechanism of injury (fall from standing), and delayed presentation. It is possible on reflection that I may also have been distracted by her other injuries ie contusion to her left chest/rib cage … I should have performed a more thorough examination which should have included asking the patient to demonstrate full hip range of motion (and not just hip flexion) … I am now aware I also should have noted that [Mrs A] was not able to weight bear on her left leg and hence requested an x-ray of her hip to further exclude or confirm a fracture.*

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. [The clinic's] nurse triage notes dated 30 August 2018 record [Mrs A's] fall the previous evening (*slipped onto bottom, legs raised in the air and injured L hip, ribs, lateral of the body*). There was no history of head injury or loss of consciousness. The nurse has recorded *Nil WB* [not weight bearing] — *in wheelchair … Limited ROM with the L lower limb and L shoulder … any movement in the L lower limb increased pain/discomfort. Radiates to the groin area … slight swelling noted to the L lateral thigh.* Left shoulder and rib pain were also noted. Basic neurovascular assessment of the left lower limb was normal as were vital signs.

Comment: A comprehensive and appropriate triage assessment was performed and well documented. It is clear from the assessment that [Mrs A] was not weight bearing, had reduced range of movement of her left hip and any movement of the hip exacerbated hip/groin pain.

6. [Dr C's] notes provide further detail on the mechanism of the fall (fell sideways onto left hip, upper back and shoulder) with history suggesting a mechanical cause. Notes include *L) hip was initially sore but not pain radiating to the L) groin and muscle spasms coming and going* [given the nursing notes, I wonder if this should be 'now pain radiating to the left groin']. Examination of the chest, left shoulder and neck is documented. Hip assessment is limited to: *L) hip flexed to 90 degrees with minimal discomfort but getting muscle spasms of the adductors.* Provisional diagnosis is: *fall with contusion to L) hip and L) shoulder/upper back. Treatment: pain relief, rest, warm pack for muscle spasms, avoid morphine.* Follow-up was: *review with GP or UC over weekend if pain relief not adequate or any new concerns.* Diclofenac and paracetamol were prescribed and ACC documentation completed.

7. An accepted basic hip examination[1] is summarised under the following components: inspection (including assessment of gait); palpation (for localised pain or swelling); neurovascular; range of movement. Additional special tests/manoeuvres might be indicated depending on the history and physical findings. I believe [Dr C's] assessment of [Mrs A's] left hip was significantly deficient, particularly given the presenting history of a fall on to the hip with subsequent difficulty mobilising/inability to weight bear in a previously active patient, and the recorded triage findings of reduced range of movement, groin pain and lateral hip swelling. I would expect the basic assessment of inspection of the leg while supine (?shortening/external rotation), noting of gait and full range of movement determination to have been undertaken by any GP and particularly by an emergency medicine trainee. I think deficiencies in [Dr C's] assessment of [Mrs A] are directly related to the failure to suspect possible hip fracture and therefore to organise appropriate imaging. However, inability to weight bear following lower limb trauma, in conjunction with a complaint of hip pain, I believe should have been investigated with hip X-ray despite the somewhat 'atypical' features evident (relatively low impact fall and comparatively young age of patient). The classical deformity of leg shortening and external rotation may be absent in the 15% of fractures that are impacted (as [Ms B's] fracture likely was initially) and a Royal

[1] https://www.orthobullets.com/recon/5037/hip-physical-exam--adult Accessed 14 January 2019

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

College of Emergency Medicine reference reviewed[2] emphasises the importance of having a very low threshold for X-raying the hip if there is the slightest possibility of a fractured neck of femur (as I believe there was in this case based on the history with or without more detailed assessment findings). I think the failure by [Dr C] to carry out an appropriate assessment of mobility and hip movements in [Mrs A's] case (taking into account the nurse triage findings and patient history), and therefore to consider the possibility of hip fracture and organise appropriate imaging, would be met with at least moderate disapproval by my peers. Remedial actions undertaken since this incident appear appropriate and have included an apology by [Dr C] to [Mrs A]."

The following additional in-house clinical advice was provided by Dr Maplesden:

"[T]here isn't really any new information provided specific to [Dr C's] assessment of [Mrs A]. However, the additional background information suggests this was a 'one-off' lapse in [Dr C's] usually very high standard of practice, and occurred almost immediately on return to practice after maternity leave … Other mitigating factors were discussed in my original advice including atypical features of the presentation (relatively young patient, low impact fall, not known to be osteoporotic), the fact an examination was performed (albeit not as comprehensive as it should have been), and appropriate safety netting advice was provided and heeded. [Dr C] individually, and [the clinic] as an organisation, have certainly undertaken appropriate remedial measures and I cannot see there were any deficiencies in [the clinic's] processes or policies (as an organisation) that contributed to the incident."

[2] https://www.rcemlearning.co.uk/references/fractured-neck-of-femur/ Accessed 14 January 2019

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.