Emergency department assessment
17HDC00975, 21 June 2019

District health board ~ General medicine consultant ~ Emergency department ~ Collapse ~ Neurological assessment ~ Investigation ~ Right 4(1)

A woman was transferred by ambulance to the Emergency Department (ED) at a public hospital following multiple collapses and vomiting that day. The woman was reviewed by an ED registrar, who referred her to the general medicine team for further assessment.

The woman was seen by a medical registrar, who admitted her for observation and discussed her presentation with a general medicine consultant. The consultant reviewed the woman on the morning ward round, and considered that there were insufficient concerning features to warrant further investigation. The consultant's impression was that the woman's symptoms were unlikely to have a serious cause, but he did not have a firm diagnosis. The woman was discharged home with advice to see her GP if she started to feel worse.

A few months later, the woman had a seizure and lost consciousness. She was transferred by ambulance to the ED. On arrival she was reviewed by an ED house officer, who documented a physical assessment and further tests, but did not perform a neurological assessment. The house officer considered psychological causes for the woman's symptoms, and discussed a psychological assessment with her, but she declined this and any further medical assessments. The house officer discussed the woman's care with an ED consultant on several occasions during her three-hour admission to ED.

Pursuant to the consultant's advice, the house officer referred the woman to the general medicine team for further assessment and review, but the general medicine team declined the referral without undertaking an assessment. The house officer referred the woman to the general medicine team again, and this was accepted, but there are no records of any review of the woman in response to the referrals.

The woman made a decision to leave the hospital against medical advice. There is no documentation of the clinical decision-making by staff about the woman's discharge, or any advice given to her to inform her decision-making. The woman was later found to have a brain tumour.

Findings

It was held that there was a pattern of poor care across the woman's two presentations. In particular, at her first presentation the woman was not offered a CT scan or referred for an urgent neurology review, and she was discharged with inadequate follow-up arrangements. At her second presentation, a neurological assessment was not performed in the ED before the referral to the general medicine team was made. The general medicine team did not assess the woman before declining the first referral. In addition, documentation was inadequate in respect of recording advice from the consultant, recording a referral to the general medicine team, the decision-making by the clinicians in response to the woman's request to leave the hospital, and any advice given by ED staff in respect of this.

Accordingly, it was found that the DHB failed to provide services to the woman with reasonable care and skill, and breached Right 4(1).

It was also held that the consultant failed to arrange a CT scan or provide the woman with adequate follow-up advice about when and why to seek help after discharge. Accordingly, it was found that the consultant breached Right 4(1).

Recommendations

It was recommended that the consultant and the DHB provide written apologies to the woman.

It was also recommended that the DHB give consideration to (a) the instigation of consultant sign-off documenting oversight/review of junior doctors' cases; (b) routine involvement of consultants in cases where patients re-present to ED, and where patients wish to leave the hospital contrary to medical advice; (c) a periodic real-time or retrospective review of ED clinicians' documentation, to ensure that the written chart accurately reflects the patient's visit, addresses key medical decision-making issues, and meets best practice recommendations; (d) adequacy of formal consultation requests, performance, and documentation in cases where a patient requires a specialist consultation; and (e) easy-to-access criteria for urgent CT head scans, with "red flag" symptoms highlighted, together with a rolling process of education of emergency and medical doctors in relation to this.