Management of weekend hospital admission
(09HDC02089, 4 July 2012)

Provincial public hospital ~ Physician ~ Out-of-hours services ~ GI bleeding ~ Gastroscopy ~ Deteriorating patient ~ Haematemesis ~ Locum consultant ~ Junior doctors ~ Systems issues ~ Right 4(1)

A 69-year-old man was admitted to a provincial public hospital's emergency department (ED) in the early hours of a Saturday with suspected coronary problems. Investigations were undertaken, including a chest X-ray. The x-ray was not able to be formally read by a radiologist until the following Monday.

The man was admitted to the medical ward on Saturday afternoon, after experiencing blood-tinged vomiting. He was assessed as having an upper gastrointestinal (GI) bleed. From Saturday to Sunday, the man was noted to be nauseated, vomiting, and suffering from back pain.

The man was reviewed by a locum consultant physician on Sunday. The consultant confirmed that the man was suffering an upper GI bleed, and referred the man for a gastroscopy. There is no record in the clinical notes of a physical examination, consideration of differential diagnoses, or other clinical investigations at that time. The man was placed on the list for gastroscopy the following day. The man's observations remained stable for the rest of the day; however he was noted to be experiencing severe back pain and vomiting.

The consultant reviewed the man again during the morning ward round on the Monday. Despite the clinical notes recording ongoing vomiting of blood, the consultant continued with the diagnosis of GI bleeding and the plan for gastroscopy. The man began to deteriorate. It was considered that he may have aspiration pneumonia, and the gastroscopy was deferred. The following day the man collapsed, vomited more blood and died.

It was held that the consultant's care was significantly below the standard expected of a consultant physician. The ongoing vomiting and severe back pain should have alerted the consultant and the medical team to consider alternative diagnoses and other clinical investigations, including surgical review. The consultant was held to have breached Right 4(1).

The DHB did not have clear guidelines or clinical criteria for gastroscopy referral. Further, it did not have a protocol in place to sufficiently assist and guide its staff to review and manage the risk to an acute patient thought to have an upper GI bleed, whose management may require medical and surgical team co-operation. The man's deterioration was not fully recognised by hospital staff, who gave insufficient consideration to other diagnoses once the initial diagnosis was made. The care provided by the DHB was suboptimal, highlighted systems issues, and was a moderately severe departure from expected standards. The DHB was held to have breached Right 4(1).