Lack of communication during transfer of seriously injured patient (02HDC05825, 23 April 2004)

Hospitals ~ Emergency Department ~ Standard of care ~ Communication ~ Co-operation among providers ~ Rights 4(2), 4(3), 4(5), 6(1)

A woman complained about the care provided to her 26-year-old son following a serious accident. He suffered multiple injuries as a result of a digger rolling and trapping him underneath. He was stabilised at a regional hospital, but his right shoulder injury was of particular concern, and arrangements were made to transfer him to a city hospital for further management. The man's mother complained that the hospital he was transferred to did not admit him directly to the Intensive Care Unit (ICU), and he was left for several hours in the Emergency Department. During this time he was left unattended by medical staff, without pain relief, and was not made comfortable.

The Commissioner's independent expert advised that as the patient had been reasonably stabilised at the regional hospital, he did not meet the necessary requirements for being admitted directly to the Intensive Care Unit. Likewise, as the patient was transferred by ambulance and not the hospital's ICU transport team, it was appropriate and in line with hospital policy for the patient to be assessed in the Emergency Department. Accordingly there was no breach of Right 4(2).

There was a divergence of views as to the patient's transfer destination, as the general surgeon at the regional hospital did not speak directly to the director of ICU at the city hospital. There was considerable confusion about the team to which the patient was assigned. There was also a lack of documentation of conversations between the two ICU teams and the orthopaedic team to which the patient was eventually assigned. This was regrettable given the circumstances and severity of the patient's injuries.

It was held that since the orthopaedic team at the city hospital had accepted the patient's transfer, he should have been admitted to the High Dependency Unit as soon as he had been assessed by the orthopaedic registrar. This would have avoided the delay and cross-team referrals that occurred in the Emergency Department. The city hospital was held in breach of Right 4(5).

The hospital was also found in breach of Right 4(3) in a number of respects. First, assessment by a number of surgical teams did not amount to the provision of services in a manner consistent with the patient's needs. Secondly, after the cardiothoracic registrar assessed him and documented that he was to be admitted under the orthopaedic team, the patient was still left in the Emergency Department for another three hours, during which it appears that he was left unattended for long periods. This was unacceptable, as the patient required close monitoring of his pain and comfort.

In addition, the city hospital was found in breach of Right 6(1), as staff did not keep the patient informed of what was happening to him. He was not told the estimated time within which a further assessment would occur each time this was scheduled. The triage nurses had not been told by the orthopaedic team (who knew of the patient's impending arrival) that the patient was en route. Furthermore, the process of a triage nurse carrying out an initial assessment and then handing over care to other providers was not explained. The fact that a provider is busy does not lessen the obligation to comply with the Code in imparting information to a patient.