Inappropriate discharge from ED
15HDC00417, 24 November 2017

Senior medical officer ~ Emergency physician ~ District health board ~ Emergency department ~ Discharge ~ Diagnosis ~ Pneumothorax ~ Right 4(1)

A 58-year-old woman with a recent history of a chesty cough, chest tightness, and shortness of breath awoke with a dull ache in her left shoulder, tight chest, and inability to catch her breath. An ambulance was called and she was taken to hospital.

The woman was seen by a consultant emergency physician, who ordered a chest X-ray "for when available". The consultant emergency physician had not documented his clinical impression and the diagnoses he considered and/or excluded. When the shift changed, the woman's care was handed over to a senior medical officer (SMO).

The SMO reviewed the X-ray and thought that no new abnormalities had been shown. He made a decision to discharge the woman. At the time he made the decision, the formal radiologist review of her X-ray had yet to be reported. The SMO discharged the woman without any known cause as to her presentation.

Shortly after the decision had been made to discharge the woman, the formal radiology review of her X-ray identified a large left pneumothorax. The report was sent electronically to the ordering clinician's inbox (the consultant emergency physician) and the woman's general practitioner (GP).

As the X-ray report was sent only to the ordering clinician and the GP the SMO was not aware that the X-ray report was ready for review and so did not read it prior to discharging the woman.. Therefore, the SMO discharged the woman home with advice to follow up with her GP or to "come back if any concerns".

The woman's GP practice saw the discharge summary and X-ray result from the ED, and contacted the woman to advise her to return to ED. The woman returned to the hospital and was seen by a different SMO. The pneumothorax was drained however the woman later passed away.

Findings

For discharging the woman from her initial ED visit, without any known cause as to her presentation, the first SMO was found to have breached Right 4(1). Adverse comment was made regarding the consultant emergency physician's documentation, which did not assist in ensuring continuity of care for the woman.

Recommendations

It was recommended that the first SMO undertake an audit of the last three months of his clinical documentation, in order to identify any patients who may have been discharged without a presumed diagnosis, and to ascertain whether adequate discharge instructions were provided. It was also recommended that he provide a written apology to the woman's family. It was recommended that the DHB evaluate the mechanisms by which follow-up and review of results occur.