Assessment of baby in Emergency Department
16HDC01594, 14 June 2019

District health board ~ Emergency Department doctor ~ Assessment ~ Referral ~ Right 4(1)

A woman took her six-month-old son to the Emergency Department (ED) at the local hospital as the baby had flu-like symptoms. He was triaged by a registered nurse, and the observations taken were outside the normal limits for his age. He was seen by a doctor, who noted that his temperature was reducing. The doctor diagnosed a viral illness and the baby was discharged.

Two days later, the woman returned to the ED with the baby, who had an elevated temperature and had developed a bleeding nose and a rash. A nurse recorded some of the vital signs, and he was seen by a doctor, who diagnosed viral exanthema. A full set of observations was not undertaken, and no observations were repeated. The baby was discharged.

Three days later, the woman took the baby to a GP, who referred him to the ED. The baby had an ongoing fever and had developed new symptoms. The baby's vital signs were recorded, and were outside the normal limits for his age. He was reviewed by Dr B, who diagnosed a viral infection. The baby was prescribed amoxicillin and discharged following repeat observations.

Two days later, at 2am, the woman returned to the ED with the baby, who had developed further symptoms. A doctor examined him and discussed her concerns with a paediatrican at a main centre hospital. The doctors agreed to transfer the baby to the Paediatric Service at the main hospital, and at 3am the woman drove him there.

Findings
The baby presented at the ED on four occasions and was seen by a number of staff. At one presentation, a full set of observations was not undertaken, and on two occasions, repeat observations were not undertaken. The Child Emergency Assessment Chart was not used by staff appropriately. Staff did not consult with the Paediatric Service at the main centre hospital until the baby's fourth presentation. The district health board (DHB) failed to provide services with reasonable care and skill and, accordingly, breached Right 4(1).

Adverse comment was made about the DHB's communication with the mother regarding the transport of the baby at 3am. Other comment was made about the manner in which a nurse in ED communicated with the mother.

The baby was significantly unwell when he presented at ED on the third occasion. Dr B did not refer the baby for specialist paediatric assessment, and therefore breached Right 4(1).

Recommendations
It was recommended that the DHB undertake an audit of staff compliance with the Child Emergency Assessment Chart. It was also recommended that the DHB provide staff with training on making referrals to the Paediatric Service at the main centre hospital, and on taking and documenting observations for paediatric patients.

It was recommended that both the DHB and the ED doctor provide a written apology to the baby's parents for the breaches of the Code identified. In addition, it was recommended that should the ED doctor return to medical practice, his competence be reviewed by the Medical Council of New Zealand.