Assessment and treatment of young child with fever and respiratory symptoms (14HDC01187, 30 June 2016)

Public hospital ~ District health board ~ Emergency department ~ Consultant ~ House officer ~ Telehealth service ~ Registered nurse ~ Assessment ~ Supervision ~ Coordination ~ Communication ~ Documentation ~ Right 4(1)

A girl, nearly three years old, had a cough and a runny nose which worsened over several days. She awoke with a fever shortly after midnight, and her mother took her to a public hospital's emergency department (ED).

On arrival, the girl had a cough, a temperature of 38.5°C (which soon increased to 39.3°C), and an increased heart rate. She was assessed by two doctors. Following cooling techniques and the administration of paracetamol and ibuprofen, the girl's temperature reduced to 37.4°C and her heart rate also reduced. She was discharged home at 3.35am with the instruction that they should return if there were any concerns. The discharging doctor requested that the Paediatric Department call the family to follow up, but this did not occur.

The girl's condition worsened over the next two days. On the second day, the girl began to make a wheezing noise when exhaling, and her parents took her back to ED.

On arrival, the girl's temperature was 37.3°C, her heart rate was between 170 and 175 beats per minute, and her respiratory rate was 44 breaths per minute. A house officer assessed the girl and discussed her presentation with his supervising consultant. The consultant did not assess the girl personally. The house officer recorded an impression of a viral illness, and the girl was discharged home less than one hour after presentation. The house officer did not document any discharge information provided to the girl's parents, and he did not request a follow-up telephone call from the Paediatric Department.

At 7am the following day, the girl's temperature had increased to 40.2°C and her mother called the ED for advice. She was transferred to a triaging telehealth service, where she spoke with a nurse. The girl's mother told the telehealth nurse her daughter's temperature, and that they had been to ED twice in two days. The girl's breathing is audible throughout the call. The girl's mother ended the call after 3 minutes and 12 seconds, telling the telehealth nurse that she was "going to go". The telehealth nurse did not call back the girl's mother or contact the service's resource nurse for advice.

At approximately 1pm that day, the girl stopped breathing. Her mother called an ambulance and the girl was taken to ED. Attempts to resuscitate her were unsuccessful.

It was held that by approving the girl's discharge home on her second visit to ED without first taking sufficient steps to investigate the cause of her presenting symptoms, the consultant breached Right 4(1).

Adverse comment was made about the house officer for discharging the girl home without further investigation, and for the quality of his documentation.

It was also held that DHB staff inappropriately discharged the girl home on her second visit to ED without first taking sufficient steps to consider her history and investigate the cause of her presenting symptoms; staff failed on two occasions to provide adequate discharge information to the girl's family; the DHB's system for paediatric follow-up was not sufficiently robust to ensure that follow-up would occur when requested; the DHB failed to encourage a culture where staff felt comfortable questioning or challenging decisions; and it lacked a multidisciplinary approach to the girl's care. The DHB team had sufficient information to provide the girl with appropriate care. However, a series of judgement and communication failures meant that it did not do so. Accordingly, the DHB failed to provide services to the girl with reasonable care and skill, and breached Right 4(1).

The telehealth nurse did not rule out all of the girl's relevant emergent symptoms, nor did he triage her clinical presentation within an acceptable timeframe, and therefore did not provide appropriate advice to her mother. Furthermore, he did not advise the girl's mother to take the girl back to ED or verify that she intended to do so, and he failed to take appropriate steps when the girl's mother ended the call. For these reasons, the telehealth nurse breached Right 4(1).

The Commissioner's recommendations included that the DHB:

a) In relation to patients under 5 years, conduct an audit of all unplanned re-presentations to the ED within 48 hours of discharge, to measure compliance with:
   — the requirement for assessment by a consultant or senior registrar prior to discharge;
   — the requirement for nursing/medical consultation prior to discharge; and
   — the requirement for a follow-up telephone call from paediatric staff to families following referral (following both the first and second discharge).
b) Commission an independent review of senior/junior staff rostering to establish whether sufficient levels of supervision are available for junior staff working in ED.
c) Include in its training and induction for all staff, information that the practice in the DHB is that the asking of questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team.
d) Update HDC on the completion of outstanding recommendations from its Serious Adverse Event review, and monitoring of ongoing changes made.
e) Review its Memorandum of Understanding between the Emergency Department and Paediatric Department and its policy for transfer to the national telephone triaging service.

The Commissioner recommended that the house officer undergo training on effective communication, paediatric care, and documentation.

The DHB, the consultant, the house officer and the telehealth nurse were asked to apologise to the girl's parents.