Systemic and individual deficiencies in care and support provided to girl with asthma symptoms
19HDC00853

Health and Disability Commissioner, Morag McDowell has released a report finding a GP, a rural medical centre and district health board (DHB – now Te Whatu Ora) in breach of the Code of Health and Disability Services Consumers' Rights (the Code) for multiple failures in care provided to a young girl in 2019.

Aged three at the time of events, the girl developed a worsening cough and wheezing that was not responding to medication. Her mother took her to the rural medical centre, where a doctor gave her medication to open up the airways via a nebuliser. Her coughing settled and she was given an inhaler and spacer to take home.

The following day the girl and her mother returned to the medical centre with worsening symptoms of asthma. She was struggling to breathe and had low oxygen saturation levels. While she was immediately given medication via a nebuliser, she was not given oxygen as required. When she failed to respond the on-call doctor gave her adrenalin. The girl became increasingly agitated, collapsed and stopped breathing.

An emergency button in the room was pressed and the doctor began resuscitation immediately. During the next one and a half hours and the concerted efforts of clinical staff to resuscitate her, multiple errors were made in the girl's care, including two staff members trying to use the wall oxygen, forgetting that it had been turned off due to a leak; the doctor directing incorrect resuscitation procedures for a child; technical issues when staff tried to make a video call to the ICU of the public hospital; and the girl being given an overdose of adrenalin.

Intensive care paramedics who arrived by helicopter helped with the resuscitation but sadly the girl died.

As the medical centre provided an integrated health service with the public hospital, Ms McDowell considered the two providers were jointly responsible for the failures in care provided to the girl in this case.

"I acknowledge the level of stress under which clinicians were operating at the time of the girl's collapse, and their earnest, best efforts to resuscitate her. Nonetheless, I consider that such a facility should have appropriate processes and supports in place to assist staff to manage emergency situations, particularly when the facility deals with after-hours, acute emergency situations.

The report highlights the importance of ensuring that facilities are fit for purpose, and that staff are trained and supported to provide appropriate care in stressful emergency situations such as this."

Ms McDowell also considered that the on-call doctor's actions in this case also amounted to a breach of the Code.

"I consider that by failing to arrange for the girl to be given oxygen prior to her collapse, giving her an overdose of adrenaline that amounted to almost six times the dose she should have received, and by coordinating the CPR effort with multiple inaccuracies, the GP failed to provide services with reasonable care and skill."

Ms McDowell acknowledged that the doctor had since reflected on what happened in this case and committed to learning from this event and doing everything he can to avoid such an outcome in the future.

Ms McDowell also acknowledged that the DHB initiated a Serious Event Review, which was driven by the need to identify systemic errors and to identify areas for improvement.

"I strongly encourage both entities to take on board the recommendations and feedback from this Review, at a systems level, to ensure future improvement in the joint service they provide."

Ms McDowell made a number of recommendations for Te Whatu Ora and the medical centre, including:

- Provide HDC with an update on progress made with changes outlined in the Serious Event Review, and continuous updates on the effectiveness of these changes every three months.
- Consider having a supply of printed resources (such as asthma management plans) available.
- Provide evidence of a co-designed governance structure with clear roles and responsibilities agreed upon.
- Develop a training plan for each clinical staff member that is to be reviewed and amended each year to identify and fix gaps in staff training and knowledge.
- Develop a clear communication pathway on processes for staff to contact external support in emergencies (such as the public hospital, Starship Hospital or the ambulance service).
- Undertake a review of the emergency information and equipment currently at the medical centre to ensure there is appropriate signage and reference charts available in emergency situations; and ensure all staff are familiar with the equipment, able to find it quickly and know how to use it.
- Consider sharing specific information about staff skill sets on daily staff rosters to ensure staff are familiar with each other's abilities and skills in the event of an emergency.
- Provide the family with a written apology.

Although the GP has attended a course on Advanced Paediatric Life Support, Ms McDowell went on to further recommend that he report back to HDC on any further training he has undertaken, or changes he has made to his practice since the events of this case, and to provide the family with a written apology for the failures in the care he provided.

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