

Care of baby with respiratory issues
16HDC01663, 28 August 2019

District health board ~ Review ~ Consultation ~ Follow-up ~ Right 4(1)

A three-month-old baby was referred to the emergency department of a public hospital by his general practitioner (GP). In the GP notes, it documented a diagnosis of laryngomalacia.

The following day, a consultant paediatrician requested ear/nose/throat (ENT) review. An ENT registrar reviewed the baby and it was documented that he was to have a “scope” (awake flexible fiberoptic nasendoscopy and laryngoscopy).

The district health board’s (DHB’s) policies around senior medical officer (SMO) responsibilities provide that where an SMO opinion has been requested by another SMO, this review cannot be delegated to a resident medical officer (RMO). Reference is made in the clinical notes that an ENT specialist was to be consulted; however, the specialist was not in the region during the time of the baby’s admission and was not consulted.

On the fourth day of admission, the scope was cancelled. The DHB was unable say who made this decision and why, but considered that the baby appeared to be improving. The baby was then discharged back to his GP without follow-up care with paediatrics or ENT planned. Sadly, the baby subsequently died.

The DHB acknowledged that additional and pertinent information was not properly documented in the clinical record. This included a lack of clear documentation at key decision points.

Findings

It was held that the baby did not receive services with reasonable care and skill and the DHB breached Right 4(1) for the following reasons:

- A “scope” did not occur in hospital or shortly after discharge at an outpatient clinic.
- The baby did not receive consultant-level ENT review, even though this was requested by the Paediatrics team. In addition, it is unclear whether there was any form of senior ENT input into the baby’s management.
- There was poor documentation around key decision-making points, including the decision not to “scope” and the decision to discharge. A number of staff, across both the Paediatrics and ENT teams, documented their care poorly.
- The baby was discharged without a formal diagnosis or a plan for specialist follow-up care, either with ENT or Paediatrics.

Recommendations

It was recommended that the DHB:

- a) Provide an apology to the family.
- b) Provide a progress report on its consideration of the use of the Paediatrics/ENT shared care form.
- c) Report on the progress and/or completion of the actions it would take to reduce the risk of similar events.
- d) Provide a written policy or internal guidelines on continuous pulse oximetry investigations.
- e) Report on how infant weight, height, length, and head circumference are currently recorded effectively at each admission, and whether the DHB has considered the use of growth charts to record and plot infant growth.
- f) Carry out an audit of 50 child presentations to the public hospital, where care is shared between Paediatrics and ENT, to ensure that there has been appropriate consultant-to-consultant communication and that documentation is adequate. Where the results do not reflect 100% compliance, the DHB should consider and advise on what further improvements could be made to ensure compliance.