Continuity of care of woman with cardiac issues
16HDC00984, 26 June 2019

District health board ~ Emergency department ~ Cardiac arrest ~ Discharge ~ Right 4(1)

A woman in her forties presented to the emergency department (ED) of a public hospital with shortness of breath and atrial fibrillation. An ED consultant performed a point-of-care echocardiographic examination, which he interpreted as "relatively poor left ventricular contractions" and documented as "relatively poor squeeze". Later that night, the woman was admitted to the high dependency ward.

The following morning, the woman was discharged home with a prescription for anticoagulant medication. No future hospital appointments were made for either an echocardiograph or cardiology follow-up.

Six weeks later, the woman was admitted to the ED via ambulance with an elevated pulse rate of 160bpm. A house officer reviewed her and spoke to the on-call consultant physician/cardiologist, and the woman was administered flecainide. However, the woman suffered a flecainide-induced cardiac arrest. Following a successful resuscitation procedure, she was transferred to another hospital.

Six days later, the anticoagulant medication was stopped to enable an angiogram to be performed. The woman was discharged home but her anticoagulant medication was not restarted.

Findings

The first DHB was found to have breached Right 4(1) for the following reasons:

a) There was no record of a full cardiac history and examination having been undertaken while the woman was in the high dependency ward, and nor was a follow-up echocardiogram arranged, and those responsible did not pick up on the previous ED assessment of the woman's cardiac function.

b) Documentation regarding a cardiac history having been taken was inadequate.

c) Key information in the woman's past ED discharge summary was not received by the physician/cardiologist, and so was not considered when prescribing flecainide, which was contraindicated in the woman's situation.

Adverse comment was made in relation to the second DHB not restarting the anticoagulant medication when the woman was discharged.

Recommendations

It was recommended that the first DHB (a) provide evidence that the recommendations set out in its Event Investigation Report have been implemented, and of any further changes made following implementation of the recommendations; and (b) demonstrate that it has established a comprehensive electronic record system, and provide details of how this has affected the DHB's services.

It was recommended that the second DHB provide evidence of the workgroup it established, and its electronic discharge summary form, and how this has improved the discharge summary process.