Taranaki District Health Board
(now Te Whatu Ora Taranaki)

Emergency Medicine Consultant, Dr C

Senior House Officer, Dr D

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC02396)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman who presented to an emergency department (ED) with acute kidney failure and obstruction of her single functioning kidney but was discharged five hours later.

2. The case highlights the importance of having clear systems in place to ensure that every clinician in the ED is aware of which consultant has responsibility for each patient, and clear processes regarding consultant handovers. The report also emphasises the importance of resident medical officers recording and communicating a patient's symptoms accurately, and of recognising when care should be escalated to a senior medical officer.

Findings

3. The Deputy Commissioner considered that the handover processes in place in the ED were inadequate, with no clear identification and delineation of which consultant had oversight of the woman. Accordingly, the Deputy Commissioner found that Taranaki District Health Board (TDHB) breached Right 4(1) of the Code.

4. The Deputy Commissioner considered that a senior house officer (SHO) should have recognised the seriousness of the woman's condition and admitted her to hospital, and found the SHO in breach of Right 4(1) of the Code. The Deputy Commissioner was also critical of the SHO's inadequate record-keeping, and found the SHO in breach of Right 4(2) of the Code. The Deputy Commissioner made adverse comment about the SHO's communication.

Recommendations

5. The Deputy Commissioner recommended that Te Whatu Ora Taranaki provide a written apology to the family; develop a more formal system for consultant handover that includes clear guidelines for allocation to a supervising consultant; consider whether the "consultant in charge" model is appropriate for the ED, and explore alternatives used in other EDs; devise an ordering system whereby SMOs are not reviewing test results of a patient for whom they are not responsible, or transferring test results to another SMO; provide training to all ED SHOs on the revised guidelines/system for handover and laboratory or imaging ordering, and ensure that the guidelines are provided to staff at orientation; and send a memo to ED staff highlighting the importance of communication between nurses and SMOs and emphasising the importance of nurses raising concerns when necessary.

6. The Deputy Commissioner recommended that the SHO provide a written apology to the family; undertake further training on keeping clear and accurate patient records, in particular in relation to risk assessment, diagnosis, and formulation of a treatment plan; and undertake the Medical Protection Society course "Mastering Professional Interactions". The Deputy Commissioner also recommended that the Medical Council of New Zealand consider whether a review of the SHO's competence is warranted.

7. Te Whatu Ora Taranaki was referred to the Director of Proceedings for consideration of further proceedings.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her late mother, Mrs A, by Taranaki District Health Board (TDHB) (now Te Whatu Ora Taranaki).[1] The following issues were identified for investigation:

- *Whether Taranaki District Health Board provided Mrs A with an appropriate standard of care in 2019.*
- *Whether Dr C provided Mrs A with an appropriate standard of care in 2019.*
- *Whether Dr D provided Mrs A with an appropriate standard of care in 2019.*

9. This report is the opinion of Deputy Health and Disability Commissioner Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's daughter
TDHB	Provider
Dr C	Emergency medicine consultant
Dr D	Senior house officer (SHO)

11. Further information was received from:

Dr E	Emergency medicine consultant
Dr F	Emergency medicine consultant

12. Also mentioned in this report:

RN G	Registered nurse (RN)
Dr H	Emergency medicine physician
RN I	Registered nurse

13. Independent clinical advice was obtained from Dr Gary Payinda, an emergency medicine specialist, pre-hospital and retrieval medicine specialist, and sonologist (Appendix A).

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all 20 district health boards. Their functions and liabilities were merged into Te Whatu Ora — Health New Zealand. All references to Taranaki District Health Board in this report now refer to Te Whatu Ora Taranaki.

Information gathered during investigation

Introduction

14. Mrs A (in her eighties at the time of events) presented to the Emergency Department (ED) at a public hospital with symptoms of severe right-sided pain in her lower abdomen. Mrs A had various existing health issues, including Type 2 diabetes, a single functioning right kidney, and hypertensive heart disease.[2]

15. During this presentation, it was identified that Mrs A had impaired left kidney function,[3] a kidney stone in her right kidney that was causing a blockage,[4] a possible urinary tract infection, and abnormal vital signs. However, despite this, she was discharged approximately five hours later with a diagnosis of a kidney stone.

16. Mrs A re-presented to the ED three days later and, sadly, she passed away as a result of acute kidney failure and obstruction of the single functioning right kidney.

17. This report focuses on the care Mrs A received at the ED at her first admission, including whether the discharge was appropriate, and the system in place at the DHB regarding overall consultant responsibility.

Background — Day 1[5]

18. Mrs A presented to the ED via ambulance at around 2.58pm on Day 1, and was discharged at 7.45pm.

ED staffing levels and consultant care

19. The ED was experiencing usual levels of patient demand[6] on Day 1. From 3pm to 5pm — the first two hours of Mrs A's presentation — three consultants were working (senior medical officer (SMO) Dr E,[7] SMO Dr C,[8] and SMO Dr F[9]). Dr E's shift ended at 5pm, and Dr C and Dr F continued to be on shift.

20. Usual practice in the ED was for one SMO to be "consultant in charge". On Day 1, Dr C became the consultant in charge at 3pm, and this was recorded on Mrs A's clinical notes.

ED electronic systems, and test ordering and accepting

21. As discussed below, it is not clear which consultants were involved in Mrs A's care that day.

22. Dr C told HDC that the doctor named on Mrs A's notes was not necessarily her supervising consultant. Dr C said that every patient who was admitted to the ED was automatically

[2] Heart conditions caused by high blood pressure.
[3] Left renal cortical scarring and atrophy, with pelvicalyceal dilation to the level of the pelviureteric junction.
[4] At the junction where the ureter attaches to the kidney.
[5] Relevant dates are referred to as Days 1–4 to protect privacy.
[6] The ED had 92 patient presentations over a 24-hour period, which was a usual level of patient presentations.
[7] 7am to 5pm.
[8] 3pm to 1am.
[9] 12pm to 10pm.

allocated by the ED computer system to the consultant who was in charge during the shift. Dr C stated that all laboratory tests were automatically ordered under the name of the SMO in charge unless a senior house officer (SHO) ordered a test in a particular SMO's name.[10]

23. Dr C explained that the official results of laboratory and imaging studies must be signed off by the "ordering clinician", which is complicated by the way in which the "ordering clinician" is assigned. In the ED, the "ordering clinician" was often not the clinician who was responsible for the clinical care of the patient, and therefore, often the results were sent to the wrong clinician for sign-off.

24. Dr C said that reassigning the result to the correct physician is time-consuming. The other options were to sign off on the result for a patient for whom they did not have responsibility, or to leave the result unsigned.

25. Dr C noted that in Mrs A's case, both the urine result and the chemistry results were not reported officially until many hours after her discharge, and therefore the "viewing and accepting" could not have occurred as part of her real-time care. Dr C said that they would likely sign off the results the next day when they returned for another clinical shift.

26. Dr C told HDC that they had been instructed not to sign off results for patients for whom they did not provide care. However, to follow this instruction, it would be necessary to reassign patients to the correct physician, which would take hours of non-clinical time because of the way the system is built. Dr C said that instead, while reviewing the results, Dr C decides whether they are within acceptable limits and, if near normal, Dr C signs them off, even if the signing doctor is not the doctor responsible for the patient. If the result is abnormal and needs to be actioned, Dr C takes the time to reassign to the correct physician where possible. However, Dr C noted that sometimes it is impossible to identify the physician who is clinically responsible for the test.

Recollections of care provided to Mrs A

27. SHO Dr D provided the majority of the care Mrs A received. Dr D told HDC that she remembers both Mrs A and her daughter, but her memory is vague given the passage of time.

28. Dr C has no recollection of providing care to Mrs A on Day 1, or any recollection of the events described in the clinical records or the complaint.

29. Dr E told HDC that any involvement in providing care to Mrs A is highly unlikely, as Mrs A arrived after the handover at 3pm (discussed below), and Dr E would not have seen any new patients after the handover.

30. Dr F has no recollection of having a conversation with Dr D about Mrs A, and has reviewed the clinical notes and reflected on the events of Day 1.

[10] HDC requested an explanation from TDHB in relation to the laboratory test ordering. TDHB told HDC that Dr C would provide a response.

Handover at 3pm

31. At 3pm, the morning SMO hands over patients to the afternoon SMO. It is not clear whether Mrs A's case was discussed during the handover, and to whom handover was provided.

32. TDHB told HDC that it is unlikely that Mrs A's case was included in the 3pm handover because she arrived during the handover at 3.03pm.

33. Dr E told HDC that if an SHO attempts to present a new patient after handover, Dr E's usual practice is to direct the SHO to the two afternoon consultants, and after 3pm Dr E resolves only outstanding issues with existing patients.

34. Dr D's recollection of the handover is vague. Initially, she told HDC that she discussed Mrs A with Dr E, and that later they handed over to Dr C. However, after further reflection, Dr D told HDC that Dr E did hand over to Dr F, and that Dr C was not present.

35. Dr C is certain that neither Dr E nor Dr D provided a formal handover about Mrs A at the end of Dr E's shift.

Mrs A's presentation

Initial review

36. At 3.03pm on Day 1, Mrs A was triaged as category three (the maximum clinically appropriate time within which medical assessment and treatment should commence is 30 minutes[11]). TDHB told HDC that usual practice is for house officers to discuss their patients with the SMO in charge at the time, which at that time (3.03pm) was Dr C.

37. At 3.10pm, Mrs A's observations were taken, and showed high blood pressure and low oxygen levels.[12] It is unclear what time Mrs A was seen by Dr D. Dr D told HDC that she took a detailed history, performed a thorough physical examination, and requested investigations (blood and urine tests, CT,[13] and ECG[14]). Dr D did not document any details of Mrs A's history or examination in the progress notes, but did include this information in the discharge summary.

38. Dr C told HDC that usual practice when a patient arrives is for the triage or treating nurses to ask one of the doctors for verbal permission to order tests, but regardless of who they ask, all tests are ordered in the name of the consultant in charge at the time.

[11] New Zealand EDs use the Australasian triage scale, which has five triage categories. For each triage category there is a specified maximum clinically appropriate time within which medical assessment and treatment should commence.

[12] Oxygen saturation 92%, temperature 36.4°C, respiration rate 20 breaths per minute, blood pressure 225/89mmHg.

[13] Computerised tomography (a scan that shows soft tissues, blood vessels, and bones in various parts of the body).

[14] Electrocardiograph (a recording of the electrical activity of the heart to look for abnormalities).

39. Blood and biochemistry tests[15] for Mrs A were taken at approximately 3.10pm,[16] which Dr D documented[17] as showing a normal white blood cell count and normal C-reactive protein.[18]

40. It is documented that the blood test results were reported at 3.28pm, and that Dr D accepted the results. It is recorded that the biochemistry report was produced at 12.38am on Day 2, and that Dr C viewed and accepted the results.[19] However, Dr D entered the biochemistry results into the discharge summary (ie, prior to Mrs A's discharge).

41. As outlined above, Dr C told HDC that it is likely that they signed off these results on Day 2 (the day following Mrs A's presentation).[20]

Discussion of initial review with consultant

42. Dr C told HDC that usual practice in the ED is to discuss a patient at length, early on in their presentation, and formulate a care plan. Dr C said that if the supervising consultant finishes their shift before the patient is discharged, the care plan and the patient are reviewed with the SHO and, if there are outstanding issues or an unclear disposition,[21] the care is handed over to the new supervising consultant.

43. Dr D did not document which consultant she spoke to about Mrs A's presentation, examination, and care plan after her examination.[22] The following recollections were obtained by HDC:

- Initially, Dr D recalled that she presented Mrs A to Dr E.
- Dr E disputes this and has no recollection of providing care to Mrs A, and denies any involvement in her care.

[15] Tests used to assess the function of major body organs such as the liver, kidneys, and heart.
[16] The records document that these tests were ordered by Dr C. However, as noted above, Dr C has explained that this is because the computer system automatically recorded Mrs A's consultant as the consultant who was in charge that day.
[17] In the discharge summary.
[18] A substance produced by the liver in response to inflammation.
[19] The time and date on which the results were viewed and accepted by Dr C is not recorded.
[20] Dr C noted to HDC that Mrs A's renal function was at her baseline, and in fact it was much better than it had been on several earlier chemistry panels done in the six months prior to her presentation. Dr C said that their usual practice was to sign off on the results rather than take the time to reassign them to the correct physician.
[21] Whether to admit or discharge the patient.
[22] TDHB told HDC that all RMOs (resident medical officers, which includes SMOs) are instructed to document the ED consultant with whom they have discussed a patient's presentation, examination, and care plan. TDHB referred to the RMO Handbook, which states: "Documentation 1: As per any consultation with a patient in the organisation, this must be documented. It is expected that all patients being discharged from the ED will receive an electronic Discharge Summary Document (EDS) if discharged by an ED doctor, or an electronic Consult Note if discharged by a doctor from another specialty service. There is a multi-page paper ED Clinical record which contains triage information, nursing notes, occasionally medical notes, a drug chart and an observation chart. The majority of the Emergency Medicine clinical notes are being written in the EDS, electronic Admission Note or electronic Consult Note."

- Dr C does not recall being involved in Mrs A's care that day, and therefore considers that they, Dr C, did not receive a presentation of Mrs A. Dr C explained to HDC that, if prior to becoming involved in a patient's care, they know that the patient has already been presented to an SMO thoroughly, it is not Dr C's standard practice to ask an SHO to re-present completely unless the patient has deteriorated markedly or the SMO is made aware of clinical deterioration.

Bedside ultrasound scan (USS)

44. Dr D performed a bedside USS with one of the three consultants present. Dr D did not document which consultant performed the USS with her[23] or what time it was performed. Dr D recalled that both she and Mrs A told the consultant that Mrs A had only one functioning kidney.

45. Mrs A's daughter, Mrs B, told HDC that the consultant who performed the USS told them that Mrs A had an inflamed appendix, not a kidney stone. Mrs B recalls that the consultant pushed the ultrasound probe deeply into her mother's abdomen, which exacerbated her pain. Mrs B also recalls the consultant handing the probe to Dr D and telling her to "have a go".

46. Dr D documented in the discharge summary that the bedside USS showed that Mrs A's right kidney "appeared to have a large cyst".

47. As noted above, it is unclear which consultant was involved in the USS.

- Dr D told HDC that Dr E performed the USS with her.
- Mrs B gave HDC a description of the physical characteristics of the consultant who performed the USS.
- In response to the provisional opinion, Mrs B told HDC that after learning that Dr E, Dr C, and Dr F had all disputed that they had been involved in performing the ultrasound scan, she had attended the ED (in 2022) and looked at the photographs of the ED doctors that were displayed there. She identified Dr C as the consultant who performed the USS.[24]
- Dr E told HDC that any involvement with Mrs A's USS is highly unlikely because Mrs A was admitted at 3.03pm and Mrs A's ultrasound would have taken place after 3pm, and Dr E would not have seen any new patients after the 3pm handover. Dr E has different physical characteristics to those described by Mrs B.
- Dr C also told HDC that any involvement in Mrs A's USS is extremely unlikely.
- It has not been suggested that Dr F was involved in the USS.

48. Dr E told HDC that if involved, a bilateral bedside USS examination would have been insisted on, and if for any reason the left kidney could not be seen, the concern that Mrs A might have only one functional kidney would have been emphasised. Dr E also stated that it was

[23] TDHB told HDC that Dr D should have documented the name of the consultant who assisted.
[24] This identification of Dr C took place approximately three years after the events.

always emphasised to all of the SHOs that any elderly patient with abdominal pain must be reviewed by the SMO, especially if discharge is being considered.

49. Dr C told HDC that when performing a bedside USS, their routine practice is to document that the USS took place and to document any findings. When supervising junior members of staff, Dr C expects them to complete the clinical record, but will often direct what to write based on the findings, and tells them to note the assistance of the SMO. Dr C said that there is no such record in Mrs A's notes, and believes this suggests that any involvement of Dr C in Mrs A's USS is extremely unlikely.

Care and investigations — 4.30–7.30pm

50. At 4.15pm, Mrs A's oxygen saturation had reduced to 71%[25] (which is lower than normal) and her Early Warning Score (EWS)[26] was calculated as six.[27] At 4.18pm, Mrs A's oxygen saturation levels were checked again and had increased to 97%. It was documented in the progress notes at 4.30pm that the nurse informed Dr D of these results. At 4.31pm, an ECG showed no issues.

51. At 5pm, Mrs A was moved to a higher acuity area, and it is documented that paracetamol was commenced and her EWS was calculated as five.[28]

52. Dr D administered morphine to Mrs A, but the time of administration is not documented.

53. At 5.15pm, a urine test was taken, and the results showed higher than normal levels of protein and glucose, and also red blood cells (erythrocytes) and white blood cells (leukocytes) in the urine, indicating a urinary tract infection. Dr D did not document any information regarding Mrs A's urinalysis in the progress notes, but did record the abnormal results in the discharge summary.

54. It is documented that Dr C viewed and accepted the urine results. Dr C told HDC that (as above with the biochemistry results), the urine results were officially reported many hours after Mrs A was discharged, which meant that they were not viewed and signed off officially as part of her real-time care. Dr C noted that the results showed mixed organisms, which indicated that there was not a clinical urinary tract infection based on that culture, and it would be their usual practice to sign off on the results rather than take the time to attempt

[25] Normal vital signs for a healthy adult are: oxygen saturation near 100%; temperature around 37°C; respiratory rate between 12 and 20 breaths per minute; heart rate 60–100 beats per minute; and blood pressure 90/60–120/80mmHg.

[26] A system for scoring a patient's vital signs for the purpose of identifying acute clinical deterioration while in hospital. The vital sign parameters measured are respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, and level of consciousness.

[27] An EWS of 6–7 required a house officer review within 60 minutes, and vital signs to be checked every 60 minutes.

[28] An EWS of 5 required management of pain, fever, or distress, and to increase the frequency of vital signs to two hourly.

to reassign them to the correct physician (which in any event may have been impossible to do for Mrs A).

55. At 5.39pm, Mrs A underwent a CT scan of her abdomen and pelvis. The records show that the referring clinician for the CT scan was Dr E. However, Dr E's shift had finished at 5pm, and Dr E does not recall being involved in Mrs A's care. In addition, TDHB advised that at 3pm the administration staff should switch over to the new consultant in charge (Dr C), but unfortunately this does not always happen at precisely 3pm.

56. At 6.24pm, Dr D prescribed intravenous (IV) antibiotics.[29] Dr C denied any involvement in the decision to treat Mrs A with IV antibiotics.

57. At 6.25pm, RN G documented that Mrs A's oxygen saturation had decreased to 93% and she remained hypertensive,[30] her respiration rate[31] was elevated at 22 breaths per minute, and her heart rate and temperature were within normal ranges.

58. RN G calculated Mrs A's EWS as nine,[32] and it was documented that she "awaits CT results and further plan". RN G noted that she had spoken to Dr D after completing the EWS and would continue to monitor Mrs A.

59. Dr C is certain that no alert was received from either Dr D or any nursing staff about Mrs A's abnormal vital signs, elevated EWS, or the urine results showing possible infection.

60. At 7.01pm, the CT scan findings were reported, and noted a 3.4mm stone causing right-sided swelling and enlargement of the ureter.[33] The scan also showed that Mrs A's left kidney was smaller than normal, with urine retention in the upper urinary tract and scarring. Dr D documented this in the discharge summary.

61. TDHB told HDC that the CT report was viewed at 7.10pm, and that Dr D accepted the report at 7.37pm. Dr C told HDC that they, Dr C, probably never saw the official CT report, noting that it was accepted by Dr D and ordered under Dr E's name.

Discussions regarding Mrs A's discharge — 7.30pm

62. RN I documented in Mrs A's ED records that at 7.30pm Dr D reviewed Mrs A for discharge, and that Mrs A's intravenous cannula[34] was removed and she was awaiting discharge documentation, and that she was to follow up with her GP regarding her increased blood pressure.

[29] Ceftriaxone.
[30] Mrs A's blood pressure was documented as 226/98mmHg.
[31] The normal respiration rate for an adult at rest is 12 to 20 breaths per minute. A respiration rate under 12 or over 25 breaths per minute while resting is considered abnormal.
[32] An EWS of 8–9 required a registrar, who may delegate to a house officer, to review within 20 minutes and inform the Duty Nurse Manager and increase the frequency of vital signs to every 30 minutes.
[33] The tube that carries urine from the kidney to the bladder.
[34] A thin tube inserted into a vein to administer medication.

63. RN I told TDHB that she recalls speaking to Dr D about Mrs A's EWS score and telling Dr D that she was concerned about Mrs A being discharged. TDHB told HDC that RN I stated that Dr D told her that she "would discuss [Mrs A] with the ED consultant (unknown)", and that "the consultant was happy for the patient to go home and that [Mrs A] was for follow up with her GP regarding hypertension".[35]

64. Dr D told HDC that she discharged Mrs A, but she would not have made that decision independently, and would have sought senior input. Dr D stated that she is not certain which consultant she sought input from prior to Mrs A's discharge, or what details she provided to the consultant.

65. However, Dr D also told HDC that she recalls that she saw Dr C about to leave the handover location and, before Dr C left, she said that Mrs A was about to go, and she presented Mrs A's case.

66. Dr D told HDC that due to the passage of time, she cannot remember what she said to Dr C, but she thinks that she would have mentioned that Mrs A had only one kidney, as it was such an important piece of information. However, Dr D also said that she cannot clearly recall telling Dr C that Mrs A had only one kidney, and therefore she accepts the possibility that she may not have not highlighted this.

67. Dr C does not recall a discussion with Dr D about discharging Mrs A, but "cannot say that [Dr D] did not discuss the case at all with [Dr C] prior to the patient's discharge". Dr C stated that based on their knowledge of Dr D's regular practice, Dr C is quite sure that she would have discussed Mrs A's discharge with Dr C or a senior clinician, but the discussion was probably very brief and included only a verbal report in regard to the CT scan results.

68. The only way Dr C could imagine approving the discharge of Mrs A was if, at the time just prior to discharge, Dr D gave a brief report of the CT scan results without providing any of the background history of a solitary functioning kidney, abnormal urine results, abnormal vital signs, or other details of her care in the ED. Dr C is certain of not being told that Mrs A suffered from renal failure or had only one functioning kidney.

69. Dr C stated that it would be against their standard practice to approve discharge of any patient with both a kidney stone and a solitary functioning kidney, or any sign of urinary infection, history of low oxygenation, or grossly elevated blood pressure, without personally reviewing the patient and involving the urology service in the patient's care. Dr C has never knowingly discharged a patient with a kidney stone of any size on the side of a solitary functioning kidney.

70. Dr F cannot recall having a conversation with Dr D about Mrs A.

[35] It is unclear from the evidence whether Dr D said that she *would* discuss with a consultant or whether she *had* discussed with a consultant.

Discharge summary — 7.45pm

71. Dr D did not admit Mrs A, and instead she was discharged at 7.45pm. Dr C was the consultant documented in the discharge summary, and the provisional diagnosis was noted as a right kidney stone, with evidence of a blockage. It was also recorded that Mrs A's left kidney was smaller than normal[36] with scarring, and that there was no evidence of diverticulitis[37] or appendicitis.[38]

72. Dr D documented in the "clinical management" section of the discharge summary: "[S]een by ED SHO, discussed with ED SMO on-call."[39]

73. The discharge summary also documented that at the time of discharge, Mrs A's vital signs had normalised[40] except for her blood pressure, which was still high (180/85mmHg).

74. Mrs A was discharged with analgesia and an anti-nausea drug, and advised to increase her fluid intake to approximately two litres and return to the ED if the pain "became too strong" or if any new symptoms or concerns arose.

Consent

75. Mrs B told HDC that no one sought consent from Mrs A for the procedures she underwent. TDHB told HDC that a patient arriving at the ED gives implied consent for treatment, and that if someone wishes to remove this consent by telling them to stop, they comply. TDHB also told HDC that if there is some type of invasive procedure, there is a more formal process for consent that includes a written form, but in Mrs A's case, no invasive procedures were performed on Day 1.

Subsequent events

76. Three days later, Mrs A re-presented to ED after seeking an opinion from her general practitioner (GP). She was seen by Dr C at this presentation.

77. Dr C told HDC that when Mrs A presented to ED on Day 4, Dr C did not recognise her, or her history, and Mrs A's family did not recognise Dr C. Mrs B was asked whether Mrs A saw the same SMO as at the previous presentation, and she believes it was another doctor, although she is uncertain.

[36] Renal atrophy.
[37] Inflamed or infected pouches in the lining of the digestive system.
[38] An inflamed appendix.
[39] TDHB did not operate an on-call SMO on Day 1.
[40] Oxygen saturation 97%, heart rate 68 beats per minute, respiratory rate 20, temperature 36.4°C.

78. Mrs A was admitted under the urology service and taken to theatre for stenting.[41] Mrs A developed severe metabolic acidosis.[42] Dialysis[43] was discussed, but it was decided that it was not suitable. Mrs A deteriorated, and she was made comfortable.

79. Sadly, Mrs A passed away as a result of acute kidney failure and obstruction of a single functioning right kidney.

Dr D

80. Dr D qualified overseas and was awarded a general scope of practice in New Zealand in 2017. She had completed eight rotations[44] and had had two and a half months of ED experience at the time of these events.

81. Dr D told HDC that her introduction to the ED was "minimal/next to none", and she was given an orientation of the department that included the location of the toilets, the staff room, and the emergency exits. Dr D said that there were weekly teaching sessions for all ED house officers and registrars, and she had two routine meetings with her supervisors.

82. TDHB told HDC that at the beginning of their rotation, all ED RMOs receive a comprehensive induction[45] that includes an in-depth orientation to ED medicine. TDHB said that on several occasions throughout the induction process it is made clear that house officers are to discuss all patient cases with an ED SMO.

83. TDHB stated that house officers and registrars attend teaching sessions every week with ED SMOs. The sessions cover ultrasound skills, simulations/scenarios, and multidisciplinary mortality and morbidity review sessions, and that Dr D attended 75% of the junior medical staff teaching sessions. She also occasionally attended registrar training sessions, which was above the expected requirements of a house officer.

84. TDHB stated that ED SMOs work alongside the junior medical staff 24 hours a day,[46] 365 days a year, allowing junior medical staff to receive a significant amount of "on the floor" training from the SMOs and, if patient numbers and acuity allow, a short 3pm teaching session "on the floor" takes place each day.

Supervision of Dr D

85. TDHB told HDC that throughout Dr D's rotation in the ED, she met with the two directors of the ED regularly for support, and to address areas of concern and areas needing

[41] Insertion of a tube to restore flow through a blocked passage.
[42] A condition in which there is too much acid in the body fluids.
[43] A procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly.
[44] In general medicine, geriatric medicine, orthopaedics, general surgery, urgent care, psychiatry, obstetrics and gynaecology, paediatrics, and emergency medicine.
[45] All RMOs receive a welcome email attaching policies; a document outlining the ten most important ED patient presentations; information on how to "present" a patient to the ED SMO; and an orientation manual (which outlines how the ED functions; clinical and non-clinical information; and expectations).
[46] The consultant shifts in ED are: 7am–5pm, 8.30am–11.30am, 12pm–10pm, 3pm–1am, 11pm–9am.

improvement. Dr D was provided with feedback, and the ED SMOs were notified of the need to supervise Dr D more closely during clinical shifts.

86. TDHB told HDC that concerns about Dr D's ability to practise independently in an environment with less close supervision than in an ED (where SMO presence exists 24 hours a day) was reported to the Medical Council of New Zealand, to ensure both patient safety and to support Dr D's future wellbeing, career, and training. This occurred after Mrs A's care, but prior to the DHB's knowledge of Dr D's involvement in Mrs A's care.

ED meetings

87. TDHB told HDC that it did not conduct a formal review, but there were many meetings to review this case. TDHB provided an extract from meeting minutes on 7 May 2020, in which a reminder was given to update the whiteboard in the ED (used to record the supervising consultant for patients).

External opinion obtained by Dr D

88. During the investigation, Dr D obtained an external opinion on the care that was provided to Mrs A, from emergency medicine physician Dr H. Dr H agreed with the HDC expert advisor that Mrs A should not have been discharged from the ED on Day 1. In Dr H's opinion:

- An early admission decision could have been made for Mrs A, with or without the CT scan revealing a stone, due to her red flags, but that whether these or the EWS were presented to the SMOs, and whether other red flags were elicited at USS or at the time of discharge, is unclear.
- This was not a failure by a single individual SMO or RMO, but rather the system that was occurring in the ED. She noted the steps the DHB has taken to address systems errors, including nursing empowerment to bring higher EWS to the attention of an SMO, improving SMO documentation to ensure that the SMO responsible is identified correctly, IT solutions, and a review of ultrasound practice.
- With respect to Dr D, the expectation of knowledge around individual presentations would be limited due to her experience. In Dr H's experience, house officers can struggle to identify severity of illness in patients. It was Dr D's responsibility to elicit key information from Mrs A, but Dr H assumed that she had not appreciated the significant consequences of the condition in Mrs A, which required admission.
- (Agreeing with the HDC advisor) the communication between an SMO and SHO requires shared clinical responsibility. However, she considered that any failure of a junior doctor is ultimately the responsibility of the supervising SMO in an ED. Dr H stated: "This does not remove all responsibility from the junior doctor but rather the responsibility of a conversation to occur to ensure safe decision making in a busy and stressful environment."
- The documentation of the SMO discussion and decision to discharge is the responsibility of the house officer. Dr D had written that she had discussed with an ED SMO but not the

details of her discussion or who she discussed them with, which was a deviation in the expected level for a house officer/SHO.

- She did not identify issues with the training provided to Dr D.

Further information

89. Dr D told HDC that she is very sad about the outcome of the case, and she wishes she had done better by being more assertive, focused, and alert to potential danger.

90. TDHB stated that it is deeply sorry about Mrs A's death, and provided its condolences. It stated that work is being undertaken in the hospital to improve patient care to prevent a similar occurrence in the future.

Responses to provisional report

Mrs B

91. Mrs B was given an opportunity to respond to the provisional opinion, and her response has been incorporated where relevant.

Dr D

92. Dr D was given an opportunity to respond to relevant sections of the provisional opinion, and her comments have been incorporated where relevant. Dr D accepted that she ought to have kept better records, and should have appreciated that Mrs A ought to have been admitted. She deeply regrets these failings.

93. Dr D accepted the recommendations and wishes to apologise to Mrs A's family, and wants to learn further from these terrible circumstances.

Dr C

94. Dr C was given an opportunity to respond to relevant sections of the provisional opinion, and had no comment to make.

TDHB

95. TDHB was given an opportunity to respond to the provisional opinion, and advised that it accepted the provisional findings. Its comments have been incorporated into the report where relevant. It stated:

> "Taranaki DHB sincerely apologises for the identified shortfalls in [Mrs A's] care and the distress this has caused to her family. Taranaki DHB will action the recommendations that you have proposed, in addition to the initiative already undertaken."

96. TDHB stated that during the shift overlap between 3pm and 7pm, TDHB also required the additional SMO (float) to help with the workload, which is too great for a single SMO. The SMO capacity at the time of the events in question was below that recommended by the Australasian College for Emergency Medicine (ACEM) for staffing of an ED of its size. TDHB advised that a change in the staffing model of SMOs took effect five months ago, and TDHB now meet the standards set by ACEM (outlined below under "Changes made").

Consideration of issues

97. On Day 1, Dr D did not document (and is vague in her recollection) the consultant who had overall responsibility for Mrs A, the consultant to whom she presented Mrs A, or the consultant who undertook the bedside USS. In addition, none of the three consultants recall being involved in Mrs A's care. Recollections of events were obtained approximately a year after the incident took place, and they are vague, and at times contradictory.

98. As a result of inaccurate or absent information in the ED system in this case, it is unclear what involvement the consultants had in Mrs A's care. Dr C told HDC that becoming the consultant in charge at 3pm did not necessarily indicate involvement in Mrs A's care (see paragraphs 22–26). It is unclear what involvement Dr E had in Mrs A's care, in particular in providing a bedside USS for Mrs A. There is no evidence of Dr F's involvement in Mrs A's care (namely, Dr F has not been identified by Dr D as being involved, and Dr F's name does not appear on documentation), despite Dr F being present in the ED.

99. Mrs B recalled the physical characteristics of one of the consultants involved in Mrs A's care. The physical description did not match any of the consultants working at the time. Approximately three years after the events, Mrs B identified Dr C as the consultant who conducted the USS. However, Dr C said that when Mrs A re-presented to ED on Day 4, Dr C did not recognise her, and Mrs A's family did not recognise Dr C. Mrs B was asked whether Mrs A saw the same SMO as at the previous presentation, and she believes it was another doctor, although she is uncertain.

100. Mrs A presented to the ED during the usual handover time at 3pm, and because of conflicting evidence and lack of documentation, I cannot establish whether Mrs A was included in the handover, what time handover occurred, or who Dr E handed over to (Dr C or Dr F). The usual practice at the ED was to discuss a patient at length early on in their presentation, and formulate a care plan. However, owing to a lack of documentation, it is unclear whether a care plan was formulated with any of the consultants, and, if so, which consultant.

101. From the information gathered during the investigation, I cannot make a factual finding as to which consultants were involved in Mrs A's care. The lack of recollection of having been involved in Mrs A's care, by all three consultants, raises concerns about whether there was a consistent supervising consultant for Dr D when she was providing care to Mrs A.

Opinion: Taranaki District Health Board (now Te Whatu Ora Taranaki) — breach

Introduction

102. At the time of events, district health boards were responsible for the operation of the clinical services they provided. They had an organisational duty to provide an appropriate standard of care to consumers of their services.

103. During Mrs A's admission to ED it was identified that she had one functioning kidney (her right kidney) that was being obstructed by a kidney stone, and that she had abnormal vital signs and a significant urinary tract infection. Mrs A was discharged five hours later, but re-presented three days later. Sadly, she passed away owing to acute kidney failure and obstruction of her single functioning kidney.

104. I consider that the failures in this case were the result of both an individual error in clinical decision-making, and an inadequate system within the ED, for which TDHB had responsibility.

105. Poor documentation within the ED has made it difficult to assess the care provided to Mrs A, and, in particular, to attribute individual responsibility. HDC sought recollections from the individual clinicians involved, but their statements were provided a year after the events took place, and, as evident from the above information, the recollections were vague. The statements and documentation have been reviewed and considered carefully to make the findings below. It is highly concerning that TDHB was unable to identify with certainty which consultant had overall responsibility for the care provided to Mrs A.

106. To assist my consideration of the care provided, I obtained independent clinical advice from an emergency medicine specialist, Dr Gary Payinda, which I refer to below. I have also considered the opinion obtained by Dr D from Dr H.

Consultant allocation in ED

107. At the time of events, consultant cover in the ED was 24 hours per day in four shifts. The three shifts relevant to Mrs A's care were 7am to 5pm, 12pm to 10pm, and 3pm to 1am.

108. Usual practice in the ED was, and is, that one consultant is the "consultant in charge". When a patient is admitted to ED, the computer system assigns the patient to the consultant in charge, and that consultant's name appears on the patient's medical record. However, the consultant in charge may not be the consultant responsible for the patient ("the supervising consultant"). There could be up to three consultants present in the ED at certain times of the day, and the identity of the supervising consultant is not reflected in the ED's computer system. TDHB told HDC that it was the SHO's responsibility to document the consultant to whom they presented a patient.

109. My independent advisor, Dr Payinda, stated that it is concerning that none of the three consultants working at the time can clearly delineate the start and end of their responsibility

for Mrs A's oversight, nor point to any documentation (either clinical notes, or ED whiteboard, or paperwork documentation) of their involvement in her care. Dr Payinda advised that supervisory responsibility must be clear to the RMO, the SMO, and, ultimately, to the patient. He stated that consultant responsibility is assumed, and it cannot be avoided or ignored, but it can be delegated to others (and documented clearly) when appropriate. Dr Payinda said that at some EDs, this is accomplished by an electronic whiteboard that documents the supervising consultant for every patient.

110. At the time of events, the TDHB ED did not have a system that clearly identified or allocated a supervising consultant for each patient, which resulted in Mrs A falling through the cracks.

Handover and clear delineation of duty

111. Handover from the morning SMO to the afternoon SMO in the ED usually takes place at 3pm. TDHB told HDC that it is unlikely that Mrs A's case was included in the 3pm handover because she arrived at 3.03pm, during the handover. As outlined in paragraph 34, Dr D's memory regarding who received the handover from Dr E is unclear. Her initial recollection was that Dr C received the handover after 3pm, then after further consideration she said that it was Dr F.

112. Owing to insufficient documentation and recollections, I cannot establish whether Mrs A was included in the handover; what time handover occurred (possibly later than the usual time of 3pm); or to whom Dr E handed over care. I acknowledge that it is possible that Mrs A was not included in the 3pm handover. It is documented that her blood and biochemistry tests were taken at 3.10pm. It is possible that Dr D was not part of the handover on Day 1 if she was taking Mrs A's blood. However, in response to the provisional opinion, TDHB noted that it is highly unlikely that Dr D would have been taking Mrs A's blood, as most likely this would have been drawn by the triage nurse or clinical initiatives nurse.

113. Dr C told HDC that usual practice in the ED is to discuss a patient at length early on in their presentation, and formulate a care plan. However, as Mrs A presented during the handover, it is unclear whether a care plan was formulated with any of the consultants.

114. Dr Payinda advised that he has the impression that the hours of the afternoon shift overlap — between 3pm and 7pm — were a time of indistinct and unclear delineations of duty, and that this was dangerous. He explained that responsibility for RMO supervision goes along with being an emergency medicine consultant, and that management and oversight of a hectic ED is part of consultant training.

115. I agree that between 3pm and 7pm the unclear delineation of SMO duty created a dangerous situation in the ED. While there were processes for having a single consultant in charge for different shifts and handover, Mrs A's case highlights the unclear delineation of which consultant took responsibility for a patient from which time, who provided the handover, and the process for patients who arrived at or around the usual time of handovers.

Discharge discussion

116. At 7.33pm, when Mrs A was discharged, Dr C and Dr F were present in the ED. Dr D did not document which consultant she spoke to or what was discussed before discharging Mrs A. The discharge summary records that Dr D completed the discharge summary for Dr C; however, as outlined above, Dr C has advised that this was because of being automatically assigned as the consultant in charge for the shift, but that it did not necessarily entail involvement.

117. Dr D told HDC that she is uncertain about which consultant she sought input from before she discharged Mrs A, or what details she provided. Dr D recalls presenting Mrs A's case to Dr C, and thinks that she would have said that Mrs A had only one kidney. However, she cannot recall this detail clearly, and accepts the possibility that she may not have provided this information.

118. Dr C told HDC that based on their knowledge of Dr D's regular practice, Dr C is quite sure that she would have discussed the discharge with them or another senior clinician. Dr C stated that the only way the approval of Mrs A's discharge can be imagined is if, just prior to discharge, Dr D gave a brief report of the CT scan results and did not mention Mrs A's solitary functioning kidney, abnormal urine results, abnormal vital signs, or other details of the ED course. Dr C is certain of not being told that Mrs A suffered from renal failure or had only one functioning kidney.

119. Dr F denied any involvement in Mrs A's care, and cannot recall any conversation with Dr D about Mrs A. There is no evidence to suggest that such a conversation occurred.

120. I have carefully considered all statements provided, together with the clinical record. I acknowledge that there are numerous scenarios of what could have happened.

121. Taking into account Dr C's comments that Dr D would not have discharged a patient without first discussing it with a consultant, and Dr D's recollection that she did discuss Mrs A's discharge with a consultant, in my opinion it is more likely than not that Dr D spoke to either Dr C or Dr F before discharging Mrs A. However, I am unable to make a finding as to which consultant Dr D spoke to, and what was discussed (ie, whether Dr D informed the consultant that Mrs A had a solitary functioning kidney).

122. Dr Payinda advised that Mrs A was a sick patient with a significant urinary tract infection, an obstructing kidney stone, and a solitary functioning kidney. He stated that Mrs A had vital sign abnormalities, comorbidities, and CT and laboratory findings that further mandated a need for admission. He advised that under no reasonable circumstances should Mrs A have been discharged home from the ED, and that this was a severe departure from the standard of care.

123. Dr Payinda also advised that it is the supervising consultant's role (according to TDHB's own policy) to review the care provided by all ED house officers. He stated that the consultant has a supervisory role over the emergency department and the emergency medicine house officers working within it, and that if a patient is discharged, the ED senior clinician must

agree with the discharge plan. Dr Payinda said that if the senior clinician has concerns about the plan, they must ask sufficient questions to be satisfied that the right decision is being made. Dr Payinda advised that in this case, it appears that this did not happen.

124. I accept this advice. I agree that Mrs A should not have been discharged from the ED, and consider that this was a severe departure from the standard of care.

125. While I cannot make a finding of fact regarding which consultant Dr D spoke to before discharge, I am critical of the consultant care provided. In the absence of an individual senior clinician being identified, TDHB must take responsibility for the failures of the individual.

Conclusion

126. TDHB's ED did not have clear systems in place to ensure that everyone (SHO, consultant, and the patient) knew which consultant was responsible for each ED patient, and I consider that TDHB had overall responsibility for these system failures.

127. On Day 1, TDHB's systems failed Mrs A, and she was discharged home when she should not have been.

128. In summary, I consider that on Day 1, TDHB failed to provide services to Mrs A with reasonable care and skill, as follows:

- Mrs A was discharged from the ED when she should have been admitted to hospital for further investigation.
- The ED systems did not provide clear identification and delineation of which consultant had oversight of Mrs A.
- The handover procedures were unclear.

129. Ultimately, TDHB was responsible for the care provided to Mrs A. Accordingly, I find that TDHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[47]

Laboratory and imaging requests — other comment

130. Usual practice in the ED was that all laboratory and imaging requests were made in the name of the consultant in charge (unless the SHO making the request changed the consultant). The consultant in charge was responsible for signing off or reassigning these requests to the supervising consultant. However, as explained by Dr C in paragraph 26, in reality this leads to consultants signing off laboratory and imaging results for patients they have not seen and without having the full clinical picture, and to difficulty identifying the supervising consultant.

131. Dr Payinda advised that the system of consultants checking laboratory results and signing them out when they have not been the consultant involved in the patient's care is a common

[47] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

system used in New Zealand EDs. He noted that often, the standard of care is for ED laboratory results to remain under "placeholder" names indefinitely, for unverified results to accrue, and for these results to be checked by any member of the ED team (SMOs, RMOs, nurse practitioners) at a later date, sometimes days later. He stated that many EDs will have backlogs of hundreds of such laboratory tests (and imaging studies) that are yet to be signed off.

132. Whilst I am concerned about the laboratory and imaging review process detailed above, I realise that this is common practice in EDs in New Zealand. This is another deficiency of the system, and results in an inability to identify the supervising consultant of a patient. Furthermore, the system for correcting the names of supervising consultants is inefficient. There is also an element of risk when results are reviewed by clinicians who have not had any involvement in a patient's care. I have addressed this in my recommendations.

Consent — other comment

133. Mrs B told HDC that no one sought consent from Mrs A for the procedures she underwent on Day 1. TDHB told HDC that a patient arriving at the ED gives implied consent for treatment, and that if someone wishes to remove this consent by telling them to stop, they comply. TDHB also told HDC that there is a more formal written process for consent for some types of invasive procedure, and that no invasive procedures were performed during Mrs A's care on Day 1.

134. Whilst I agree that Mrs A did not undergo any invasive procedures on Day 1, I remind TDHB of the importance of explaining procedures to patients to ensure that they feel comfortable and safe during their admission.

Empowering nurses — other comment

135. At 6.25pm, Mrs A's EWS had risen to nine, and RN G documented that she communicated this to Dr D. RN I also recalls speaking to Dr D about Mrs A's EWS and conveying her concerns about Mrs A being discharged, and Dr D telling her that she had discussed Mrs A with the ED consultant, and that the consultant was happy for the patient to go home and to follow up with her GP regarding hypertension.

136. It is apparent that RN I was concerned that Mrs A was being discharged, and spoke to Dr D about her concerns, but did not speak to an SMO. While I am not critical of RN I, and consider her actions reasonable, had she raised her concerns directly with an SMO, the course may have been altered. However, I acknowledge that at the time, RN I would reasonably have been reassured by Dr D's advice that she (Dr D) had discussed Mrs A with a consultant, who was happy with the discharge, and I note that the mandatory escalation pathway on the EWS chart did not require escalation to an SMO.

137. I therefore encourage Te Whatu Ora Taranaki to foster communication between nurses and SMOs, and to empower nurses to raise concerns when necessary.

138. In response to the provisional opinion, TDHB stated that it agreed with the need for nursing empowerment and made relevant changes to process (outlined below under "Changes made"). TDHB stated:

> "[The] ED has worked hard since this case occurred to foster a team approach and a work culture that empowers communication between nurses and SMOs. Regular team huddles are used to improve communication between members of the multidisciplinary team in ED and team building social events outside also work [to] help foster team culture."

SMOs — other comment

139. I have carefully considered the evidence of all the clinicians involved, and as I outline above at paragraphs 97–101, I cannot make a finding as to which consultant was the supervising consultant for Mrs A.

140. My independent advisor, Dr Payinda, stated that it is concerning that none of the three consultants working can clearly delineate the start and end of their responsibility for Mrs A's oversight, nor point to any documentation (either clinical notes, or ED whiteboard, or paperwork documentation) of their involvement in her care.

141. Dr Payinda advised that "[t]here should not be a situation where multiple doctors are involved with a patient's care, but each is pointing to the other and saying, essentially, that the other doctor is more responsible". He stated that supervisory responsibility must be clear to the RMO, the SMO, and, ultimately, to the patient.

142. It is evident that consultant input did occur at least once during Mrs A's presentation. Given this, it is disappointing that the consultants involved have deflected responsibility.

Opinion: Dr D — breach

143. As a healthcare provider, Dr D was required to provide services to Mrs A with reasonable care and skill, and in compliance with professional standards.

144. As an SHO, Dr D was the most junior member of the medical staff involved in Mrs A's care on Day 1. She qualified overseas and was awarded a general scope of practice in New Zealand in 2017. It is reasonable to conclude that she worked as a medical practitioner overseas prior to moving to New Zealand. She commenced her employment at TDHB in 2016 and, at the time of events, she had completed eight rotations before starting the emergency medicine rotation. By the time of these events she had had two and a half months of ED experience.

145. Notwithstanding that she was a junior doctor, I consider the criticisms made below to be within her scope and capabilities as an SHO with significant experience.

Escalation of care

146. On Day 1, Mrs A's concerning vital signs and EWS were escalated to Dr D on several occasions by nursing staff, but it appears that Dr D did not escalate or convey these to a consultant adequately.

147. At 4.30pm, Mrs A's EWS was calculated as six, and it is documented that a nurse informed Dr D. At 5.02pm, Mrs A's EWS was recalculated as five. At 6.25pm, Mrs A's EWS had risen to nine, and RN G documented that she communicated this to Dr D.

148. Prior to discharge, RN I recalls also speaking to Dr D about Mrs A's EWS and conveying her concerns about Mrs A being discharged. RN I recalled Dr D telling her that she had discussed Mrs A with the ED consultant, and that the consultant was happy for the patient to go home and that Mrs A was to follow up with her GP regarding hypertension.

149. Dr Payinda advised that Dr D's experience as a house officer was rather extensive, having completed eight house officer rotations, and that even without all those years of experience, she would be expected to recognise the severity of Mrs A's illness, and perform due diligence by reviewing the CT findings, urine findings, laboratory results, and vital signs.

150. Dr Payinda advised that the standard of care would have been for an emergency medicine house officer to convey the information of Mrs A's condition to her supervising consultant (as was a departmental requirement).

151. I agree with this advice. In my opinion, Dr D did not recognise the severity of Mrs A's illness, and it appears that Dr D did not escalate the concerns raised by RN I appropriately (discussed below).

Discharge of Mrs A

152. Dr D discharged Mrs A from ED at 7.45pm and, at that time, only two consultants were present — Dr C and Dr F. Dr D told HDC that she would not have made the decision to discharge Mrs A independently, and she would have sought senior input.

153. Dr D is uncertain which consultant she sought input from, or what details she provided. She recalls presenting Mrs A's case to Dr C, but she cannot remember what she said. She cannot clearly recall telling Dr C that Mrs A had only one functioning kidney. However, she thinks that she would have mentioned it, as it was such an important piece of information, but she accepts the possibility that she may not have.

154. Dr C does not recall such a conversation or being involved in Mrs A's care, but based on Dr C's knowledge of Dr D's regular practice, Dr C is quite sure that she would have discussed the discharge with Dr C or another senior clinician. Dr C stated that the only way the approval of Mrs A's discharge could be imagined was if, just prior to discharge, Dr D gave a brief report of the CT scan results and did not mention Mrs A's solitary functioning kidney, abnormal urine results, abnormal vital signs, or other details of the ED course. Dr C is certain of not being told that Mrs A suffered from renal failure or had only one functioning kidney.

155. Dr F cannot recall any conversation with Dr D about Mrs A, and denies any involvement in Mrs A's care.

156. I have carefully considered all statements provided, together with the clinical records. I acknowledge that there are numerous scenarios of what could have happened (including that the discharge conversation occurred with Dr C, or Dr F).

157. Taking into account Dr C's comments that Dr D would not have discharged a patient without first discussing it with a consultant, in my opinion it is more likely than not that Dr D spoke to either Dr C or Dr F before discharging Mrs A.

158. However, there is no record of a discussion with a consultant, and the information Dr D conveyed is not documented, and Dr D cannot recall specific information. While in my view Dr D did speak to one of the two consultants before discharging Mrs A, there is insufficient evidence to make a finding of what was communicated.

159. My independent clinical advisor, Dr Payinda, advised that under no reasonable circumstances should Mrs A have been discharged home from the ED, and that it was a severe departure from the standard of care. Dr Payinda stated that the standard of care would have been for an emergency medicine house officer, at Dr D's level, to recognise the precariousness of Mrs A's condition (especially in light of the clear CT and laboratory findings), convey that information to her supervising consultant (as was a departmental requirement), and refer the patient for admission.

160. Dr Payinda stated that whether or not Dr D informed Dr C about the presence of a solitary functioning kidney is immaterial. Dr Payinda explained that Mrs A was sick enough to require intravenous antibiotics and admission even if she had two healthy kidneys. Specifically, she had a concerning history, vital sign abnormalities, pain, serious comorbidities, and blood, urine, and CT imaging findings of great concern.

161. I agree with this advice. It is evident that Dr D was aware that Mrs A had a solitary functioning kidney and an obstructing kidney stone, vital sign abnormalities, an EWS of nine, and comorbidities, and Dr D was aware of the CT and laboratory findings. She had the information she needed, but failed to recognise the seriousness of Mrs A's condition when she should have, and refer Mrs A for admission. Dr D was an experienced SHO, being in her ninth rotation and with overseas experience, and in my opinion she should have recognised that Mrs A required admission.

162. While she was a junior staff member of the medical team, and ultimately it was not her decision to discharge, she was the holder of the necessary information and was required to convey that information to her senior adequately to ensure the safety of the patient.

Documentation

163. Dr D did not document in the progress notes her reviews of Mrs A, or Mrs A's test results, ultrasound or CT findings, and urinalysis, or the time at which she administered morphine

to Mrs A. However, aside from the time of the morphine administration, this information was documented in the discharge summary.

164. Dr D did not document which consultant she presented Mrs A to initially, which consultant assisted with the bedside USS, or which consultant she discussed Mrs A's discharge with.

165. The Medical Council of New Zealand's statement on "Maintenance and Retention of Patient Records" (2008)[48] states: "[You] must keep clear and accurate patient records that report relevant clinical findings, decisions made, information given to patients, [and] any drugs or other treatment prescribed."

166. Dr Payinda advised that Dr D's lack of appropriate documentation in this case was a moderate departure from the standard of care.

167. I accept this advice. The lack of documentation in this case obscured the identity of the consultant with whom Dr D discussed Mrs A prior to her discharge, and what information was conveyed to the consultant. I remind Dr D of the importance of clear, comprehensive, and contemporaneous documentation.

Conclusion

168. The actions and omissions of Dr D on Day 1 contributed to Mrs A being discharged from the ED inappropriately. While Dr D was a junior doctor at the time of events, I note her significant prior experience, and, as noted above, I consider that my criticisms of her care were well within her capabilities as a senior house officer.

169. Dr D's failure to recognise the seriousness of Mrs A's condition when she should have been capable of doing so, and her failure to admit Mrs A, amount to a failure to provide services to Mrs A with reasonable care and skill. Accordingly, I find that Dr D breached Right 4(1) of the Code.

170. In addition, I am critical of Dr D's inadequate record-keeping, and find that Dr D breached Right 4(2) of the Code.[49]

Communication — adverse comment

171. It is more likely than not that Dr D did communicate with a consultant, but as Dr D herself has indicated, she may not have communicated all relevant information sufficiently clearly for the consultant to make a sound clinical decision. However, as noted above at paragraph 158, there is insufficient evidence to make a finding of what was actually communicated because Dr D failed to document this discussion. I acknowledge that the communication between Dr D and the unknown consultant was a shared responsibility as, while Dr D needed

[48] This statement was updated in 2020: https://www.mcnz.org.nz/assets/standards/0c24a75f7b/Maintenance-patient-records.pdf.

[49] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

to convey information to the consultant adequately, the consultant also needed to elicit enough information from Dr D to be satisfied that it was safe to discharge Mrs A.

172. I remind Dr D of the importance of clear communication and of reporting sufficient information about the patient to enable sound clinical decisions.

Opinion: Dr C — other comment

173. As a healthcare provider, Dr C was required to provide services to Mrs A with reasonable care and skill, and in compliance with professional standards.

174. I have carefully considered the evidence of all the clinicians involved, and as I outline above at paragraphs 97–101, I cannot make a finding as to which consultant was the supervising consultant for Mrs A. Therefore, I have not found Dr C in breach of the Code.

Changes made

175. TDHB undertook the following:

a) Introduced the use of an electronic whiteboard to record the SMO with responsible authority, to eliminate confusion and ensure that one senior doctor is clearly focused on the patient's eventual disposition.

b) Reminded consultants to:

i. update the whiteboard with their name if it is not present when an RMO first presents a patient, to indicate who is the supervising consultant responsible for the care of that patient; and

ii. change the name at the time of handover when a consultant leaves their shift.

176. In response to the provisional opinion, TDHB advised that the full scope of the initiatives undertaken since Mrs A's case includes the following:

- Patient whiteboard: since 2020, TDHB has had the capability to identify the supervising SMO for each patient on an electronic whiteboard. TDHB also created a "hard stop" in the electronic medical record, so that no SMO is automatically assigned to a patient. The RMO must select the SMO who is overseeing the care of the patient.
- Identification of responsible SMO: An improvement solution was presented to IT to introduce a further "hard stop" into the electronic documentation, to require identification of the responsible SMO. This will prevent a patient's chart from being

closed until the responsible ED SMO is documented by name. It is anticipated that this improvement will be implemented this year.

- ED staffing: In January 2022, the SMO staffing model for the ED changed, resulting in the ED meeting the SMO staffing standards set by the Australasian College for Emergency Medicine (ACEM).
- Escalation by nurses: ED nursing staff have been directed by their nurse managers that any patient who has an EWS of six or greater will have their status escalated to the overseeing SMO.
  - The expectation is that the RMO would involve the supervising SMO in these cases, but if this is not seen by the nurse, the nurses are actively encouraged to go directly to the SMO.
  - The Department's SMOs have been made aware to expect this and concur with the protocol. This requirement has not been indicated on the EWS Chart, as this is a national form, but the protocol has been promulgated at team handovers and through emails to ED nurses from both the ED Clinical Nurse Educator and Clinical Nurse Manager.

Recommendations

177. Bearing in mind the changes already made by TDHB, I recommend that Te Whatu Ora Taranaki:

a) Provide a written apology to Mrs A's family for the deficiencies in care identified in this report. The apology should be sent to HDC within three weeks of the date of this report.

b) Develop a more formal system for consultant handover that includes clear guidelines on what time the handover consultant stops taking new patients, and on ensuring that any patients admitted during handover are allocated to a supervising consultant. Te Whatu Ora Taranaki is to provide evidence of this to HDC within three months of the date of this report.

c) Consider whether the "consultant in charge" model is appropriate for the ED, and investigate alternatives used in other EDs. Te Whatu Ora Taranaki is to provide HDC with evidence that this has been done, within six months of the date of this report.

d) Devise, with input from the SMOs, a new ordering system whereby SMOs are not reviewing test results of a patient for whom they have not been responsible, or transferring test results to another SMO. Te Whatu Ora Taranaki is to provide HDC with evidence that this has been done, within six months of the date of this report.

e) Provide training to all ED SHOs on the new guidelines/system for handover and laboratory or imaging ordering, and ensure that the guidelines are provided to new

members of staff at orientation. Te Whatu Ora Taranaki is to provide HDC with evidence that this has been done, within three months of the date of this report.

f) Send a memo to ED staff highlighting the importance of communication between nurses and SMOs, and emphasising the importance of nurses raising concerns when necessary, and provide HDC with evidence of this within three months of the date of this report.

178. I recommend that Dr D:

a) Provide a written apology to Mrs A's family. The apology should be sent to HDC, for forwarding to Mrs A's family, within three weeks of the date of this report.

b) Undertake further training on keeping clear and accurate patient records, in particular in relation to risk assessment, diagnosis, and formulation of a treatment plan, and provide evidence of this to HDC within six months of the date of this report.

c) Undertake the Medical Protection Society course "Mastering Professional Interactions", and provide HDC with evidence of enrolment in, and reflections on, the training, within six months of the date of this report.

179. I recommend that the Medical Council of New Zealand consider whether a competence review of Dr D is necessary on consideration of the information in this report.

Follow-up actions

180. Te Whatu Ora Taranaki will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for consideration of whether any further proceedings should be taken.

181. A copy of this report with details identifying the parties removed, except Taranaki District Health Board/Te Whatu Ora Taranaki and the expert who advised on this case, will be sent to the New Zealand Medical Council, and it will be advised of Dr D's name in covering correspondence.

182. A copy of this report with details identifying the parties removed, except Taranaki District Health Board/Te Whatu Ora Taranaki and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

183. The Director of Proceedings decided not to issue proceedings.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from Dr Gary Payinda, an emergency medicine specialist, pre-hospital and retrieval medicine specialist, and sonologist, dated 8 January 2021, and amended on 2 June 2021:

> "Thank you for the opportunity to review the responses on behalf of [Dr C], [Dr D], [Dr H] and the Taranaki DHB, and provide further expert advice on the complaint of [Mrs A] (Ref 19HDCO2396). I have reviewed these 22 documents and have placed your questions in boldface type below.
>
> I have been asked by your office to give my advice in the alternate, as several of the parties have proffered more than one possible explanation of events. I have tried to make it clear when I am discussing alternate scenarios. In some cases I have italicised for emphasis.
>
> **Expert advice requested**
>
> You will note that there are different versions of events in the information provided. Please review the enclosed policies, the responses of [Dr D], [Dr F], [Dr E] and [Dr C] and advise if the further information causes you to amend the conclusions drawn in your initial advice.
>
> Please also comment on:
>
> **1. The adequacy of the information provided to [Dr C] by [Dr D]. In particular, please provide your comments on both versions of events i.e. if [Dr D] did inform [Dr C] that [Mrs A] had one functioning kidney, or if [Dr D] did not inform [Dr C] that [Mrs A] only had one functioning kidney.**
>
> **a. What is the standard of care/accepted practice?**
>
> **b. If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate and severe) a departure do you consider this to be?**
>
> **c. How would it be viewed by your peers?**
>
> **d. Recommendations for improvement that may help to prevent a similar occurrence in the future.**
>
> [Dr D] writes regarding her recollection of aspects of the case 'A lot of it is vague in my memory, given the passage of time' and 'I initially thought we must have handed over to [Dr C], but, after putting things together, and reflecting more, I think [Dr C] was not there for the handover.'
>
> [Dr D] states she later discussed the case with [Dr C] prior to the patient's discharge. [Dr C] writes: 'I cannot say that [Dr D] did not discuss the case at all with me prior to the patient's discharge. Based on my knowledge of her regular practice, I am quite sure she would have discussed this discharge with me or another senior clinician. My guess is

that this discussion was very brief and only included a verbal report in regard to the CT scan results. As I have stated, I do not recall such a discussion, but I cannot say it did not happen.'

[Dr D] further states, 'I do not recall everything I had said. I would think I would have mentioned such an important piece of information as only one kidney, but I do not clearly recall doing so, and therefore I accept the possibility I could have not highlighted this. I am very sorry if this was the case.'

To sum, [Dr D] says she presented the case to [Dr C], [who] may or may have not discussed the case with [Dr D]. There is no documentation from [Dr C] regarding the case, nor any details regarding the presentation in [Dr D's] notes. The lack of appropriate documentation is, of itself, a moderate departure from the standard of care by the treating doctor, [Dr D], and would be viewed as such by my peers.

Given the absence of documentation, and the limitations of the doctors' recollection, it is difficult for me to determine the adequacy of information provided to [Dr C] by [Dr D] without speculation.

Regarding the second part of the question, as to whether the presence of a solitary kidney makes a significant difference to the ultimate decision to discharge vs admit, let me preface my response with a few facts on the management of urinary tract emergencies relevant to this case.

A sick patient with a urinary tract infection and an obstructing kidney stone is having a surgical emergency requiring admission and urologist review. A sick patient with a significant urinary tract infection and a single kidney is having a medical emergency and requires intravenous antibiotics and admission.

As my previous report stated, [Mrs A] was a sick patient with a significant urinary tract infection and an obstructing kidney stone and a solitary kidney. She also had vital sign abnormalities, comorbidities, CT and lab findings that further mandated a need for admission.

Under no reasonable circumstances should [Mrs A] have been discharged home from the emergency department. This is a severe departure from the standard of care, and would be viewed as such by my peers.

This departure applies to both emergency doctors mentioned in Question 1: [Dr D], the treating emergency medicine house officer, and her 'supervising consultant', whose identity cannot reliably be known due to deficiencies in documentation. The standard of care would have been for an emergency medicine house officer at [Dr D's] level to recognise the precariousness of [Mrs A's] condition (especially in light of the clear CT and lab findings), convey that information (as is a departmental requirement) to her supervising consultant and refer the patient for admission.

It is likewise the supervising consultant's role (per TDHB's own policy) to review the care provided by all ED house officers. The consultant has a supervisory role over the emergency department and the emergency medicine house officer working within it. If a patient gets discharged home, the ED senior clinician has to agree with the discharge plan. If they have concerns about the plan, they must ask enough questions to satisfy themselves that the right decision is being made. In this case, it appears this did not happen.

Neither [Dr D] nor her supervising consultant (whose identity is uncertain) have met the standard of care for the emergency management of [Mrs A], in allowing her unsafe discharge. Please see Question 2 for further discussion of this point.

To answer the second part of the question: whether or not [Dr D] did inform [Dr C] about the presence of a solitary kidney is immaterial. [Mrs A] was sick enough to require intravenous antibiotics and admission even if she had two healthy kidneys. Specifically, she had a concerning history, vital sign abnormalities, pain, serious comorbidities, and blood, urine, and CT imaging findings of great concern.

2. The adequacy of the information [Dr C] extracted from [Dr D] prior to [Mrs A's] discharge on [Day 1] if [Dr C's] account of events is accepted.

What is the standard of care/accepted practice?

If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate and severe) a departure do you consider this to be?

How would it be viewed by your peers?

Recommendations for improvement that may help to prevent a similar occurrence in the future.

[Dr C] writes 'I cannot say that [Dr D] did not discuss the case at all with me prior to the patient's discharge. Based on my knowledge of her regular practice, I am quite sure she would have discussed this discharge with me or another senior clinician. My guess is that this discussion was very brief and only included a verbal report in regard to the CT scan results. As I have stated, I do not recall such a discussion, but I cannot say it did not happen.'

And further, 'It would be totally against my standard practice to approve discharge of any patient with a kidney stone and a solitary functioning kidney, or any sign of urinary infection, or any history of low oxygenation or grossly elevated BP without reviewing the patient myself and involving the Urology service in their care. I have never knowingly discharged a patient with a kidney stone to whom I felt it was necessary to provide IV antibiotics in the ED. I have definitely never knowingly discharged a patient with a kidney stone of any size on the side of a solitary functioning kidney.'

'I think it is also very instructive that I was the physician who cared for [Mrs A] when she returned to our department in decompensated renal failure and moderate heart

failure on [Day 4]. At that time I did not recognize her or her history as a patient I had been consulted on just three days earlier. Her family did not recognize me. After hearing her history on that second visit I immediately consulted both the medical service and the Urology service.'

To summarise, [Dr C] says … either … a patient presentation from [Dr D was not received], or [one was received] and the presentation was inadequate.

I cannot further comment on the scenario if [Dr C] did not receive a patient presentation from [Dr D], except to say that most clinicians' statements in this case, including [Dr C's], suggest it would be an unlikely occurrence for [Dr D] to discharge a patient without discussing it with her SMO first. Who she may have discussed the case with is unknown.

But speaking to the second scenario, namely an inadequate presentation that did not cover important details such as a solitary kidney or vital sign abnormalities. Even if the house officer's presentation was inadequate, ie, lacking key clinical features, it is still the supervising consultant's responsibility to elicit enough data to make a decision about the appropriateness of a house officer's care. They need not know irrelevant details, but they do need to obtain enough data to decide that the patient's workup was adequate and that they're safe to be discharged home. Often in emergency medicine, this will take the shape of a verbal presentation, and a review of the relevant imaging.

This is an example of shared clinical responsibility: the house officer has a responsibility to be thorough, competent and provide good care, and the supervising SMO has a responsibility to be thorough, responsible, and provide good oversight. The SMO serves as a safety check on the house officer's workup as well as a vehicle for house officer education.

In this case, it appears that the supervising ED consultant (whose identity is uncertain) did not gather enough information to determine that [Mrs A's] discharge was safe and appropriate. This is a moderate departure from the standard of care and would be viewed as such by my peers. Because of limitations in TDHB record-keeping at the time, we do not know with certainty who this supervising consultant was.

Regarding the role of house officers, it should be explained that they have not yet had the minimum 5 years of further emergency medicine speciality training required to be an emergency medicine specialist. They are fully qualified doctors, just not full-trained emergency medicine specialists.

[Dr D's] experience as a house officer was actually rather extensive, having completed approximately 9 house officer runs. Even without all those years of experience, she would be expected to recognise the severity of [Mrs A's] illness, and perform due diligence by reviewing the CT findings, urine findings, lab results, and vital signs, among other things.

In a letter forwarded by [Dr C's] lawyer [Dr C] states, 'It is also not my standard practice to document in the chart on patients that are being managed by SHO level physicians unless I have taken over care of the patient personally or performed a procedure on the patient.'[Dr C's lawyer] further notes [that Dr C is] a very conservative clinician …

While I would agree that it is not expected for a supervising consultant to write a note after a patient care discussion with an RMO, it is reasonable to expect the ED to record the name of the supervising SMO for any patient receiving treatment. There was a failure of TDHB to maintain adequate documentation and ensure adequate supervision, a failure that seems to have been remedied per the later TDHB responses, with improvements to the whiteboard and other IT systems.

3. The adequacy of the care provided to [Mrs A] if [Dr C's] account of events is accepted.

What is the standard of care/accepted practice?

If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate and severe) a departure do you consider this to be?

How would it be viewed by your peers?

Recommendations for improvement that may help to prevent a similar occurrence in the future.

This is a challenging question to answer, because [Dr C's] own account of events allows for two divergent explanations of what may have occurred.

[Dr C] stated, 'Based on my knowledge of [Dr D's] regular practice, I am quite sure she would have discussed this discharge with me or another senior clinician. … The only way I can imagine approving the discharge of [Mrs A] on that day would be that, at the time just prior to her discharge, [Dr D] may have given me a brief report of the CT scan results without providing me any of the background history of a solitary functioning kidney, abnormal urine results, abnormal vital signs or other details of the ED course. Without this history, a brief verbal statement from [Dr D] stating that the CT scan had ruled out appendicitis and AAA and only showed a 3.4 mm stone in a patient with baseline renal function that was pain free and wanted to go home might have led to this inappropriate discharge.'

[Dr D] states 'I saw that [Dr C] was about to leave the "fish bowl" (the glass separated island in the middle of the ED department at TDHB …). [Dr C] was going to see a patient. I stopped typing, got up and caught [Dr C's] attention by saying something like: "[Dr C], just before you disappear, I need to let you know [Mrs A] is about to go ..." and presented the case.

I do not recall everything I had said. I would think I would have mentioned such an important piece of information as only one kidney, but I do not clearly recall doing so,

and therefore I accept the possibility I could have not highlighted this. I am very sorry if this was the case.'

[Dr D] then adds, 'I discharged [Mrs A]. I would not have made the decision to discharge [Mrs A] on my own. But at this point I cannot remember exactly what senior input I got on this, or who it was from.'

[Dr C's] account provides two distinct options for what might have occurred. The first is that [Dr C] had a cursory case presentation from [Dr D] that did not involve key details of her history and investigations. (See my response to question 2 for discussion.)

The second possibility [Dr C] provides is that [Dr C] knew nothing of the patient, and that [Dr D] did not discuss the case with [Dr C] nor involve [Dr C] in the patient's care. This would imply a failure by [Dr D] to seek appropriate senior consultation. That would constitute a severe departure from accepted practice, as viewed by me and the majority of my peers, for reasons discussed above. However, [Dr D] says, and other doctors consistently support, the idea that it would have been extremely likely for [Dr D] to have presented the case to an SMO. It seems plausible that [Dr D] sought SMO advice. However, there is no record of it.

Neither the clinicians nor TDHB is able to clearly identify who, if anyone, was supervising [Dr D's] care on [Day 1]. This is a systems failure of TDHB.

4. The appropriateness of the supervision [Dr D] received on [Day 1].

I acknowledge Taranaki's response that they are able to provide 24/7 SMO supervision of house officers. This is above what the vast majority of NZ emergency departments are able to provide. This is laudable from an RMO supervision and education standpoint. It certainly would contribute to a safer emergency department for patients than one supervised overnight by a house officer or registrar. I credit TDHB with being able to staff three specialist emergency medicine consultants the afternoon of [Mrs A's] care. I note that the patient census and staffing was near its average on the day in question.

[Dr D's] supervision on the afternoon of [Day 1] would at first blush appear robust: three overlapping shifts of well-trained consultants. However, there are some concerns raised as I read through the provided documents. My overall conclusion is that the supervision was mildly inadequate compared to accepted practice and that this would be agreed upon by most of my peers.

On her shift [Dr D] describes a handover where the evening physician taking over the ED was absent or late, missing the handover. This raised the need for either another handover, from [Dr E] to [Dr F] to [Dr C], or a delayed handover from [Dr E] to [Dr C], with a predictable loss of certainty about who was actually managing the supervision of a patient such as [Mrs A].

The fact that none of the three consultants working that day can clearly delineate the start and end of their responsibility for [Mrs A's] oversight, nor point to any

documentation (either clinical notes, or ED whiteboard/paperwork documentation) of their involvement in her care, is concerning. There should not be a situation where multiple doctors are involved with a patient's care, but each is pointing to the other and saying, essentially, that the other doctor is more responsible. Supervisory responsibility must be clear. One option is to have it start when the consultant-in-charge comes on shift, and it ends when the next consultant-in-charge comes on duty. During that time, the consultant-in-charge is ultimately responsible for the medical management of every patient within their emergency department, if not directly, then in a supervisory capacity. Every house officer presentation would go to them, or another clearly documented delegate. Departments will come up with their own strategy, but what matters is that the supervisory role is clear to the RMO, the SMO, and ultimately, to the patient.

Responsibility for RMO supervision goes along with being an emergency medicine consultant. The management and oversight of even a hectic ED is part of our training. Consultant responsibility is assumed. It cannot be avoided or ignored, but it can be delegated to others (in a clearly documented fashion) when appropriate. In some EDs this is accomplished by an electronic whiteboard documenting who is the supervising consultant for every patient.

In the TDHB emergency department during the period described, one gets the impression that the hours of afternoon shift overlap, between 1500 and 1700, were a time of indistinct and unclear delineations of duty.

This is something that is dangerous, but can be easily corrected. A transition from word-of-mouth transfers of care, to written/electronic documentation showing both the treating doctor, and the doctor-of-record for every patient, updateable in real-time, is achievable and recommended.

Per the later TDHB responses, it appears these accountability/supervision/ documentation problems were rectified.

5. The adequacy of the policies and information junior doctors are provided with at the start of their rotation in the Emergency Department.

I have examined the policies and information junior doctors are provided with at the start of their rotation. In my opinion they are adequate. [The] orientation materials seem particularly useful, if they are read and understood and abided by.

Specifically relevant in this case are the DEMT (Director of Emergency Medicine Training) materials clearly stating house officers are to discuss all patients they see with an ED SMO, with reiterations of this in the RMO Handbook. My only suggestion here would be to ensure that required and essential orientation topics are check listed, and that house officers are checked off one-by-one (and ultimately signed off) so there is a written record of their orientation. Likewise with attendance at teaching and

simulation. An auditable trail is necessary for ACEM accreditation, and a good idea for quality improvement purposes.

6. The adequacy of the induction and training of junior doctors to the Emergency Department.

[Dr D] states, 'The introduction to the ED department was minimal/next to none. I was shown where things were (staff room, toilets, emergency exits etc). During the 6 months there were weekly 1.5 h teaching sessions for all ED house officers and registrars, and I had 2 routine meetings with supervisors as a part of my ED run.'

[Dr D] had extensive experience at TDHB and was on what she describes as her 9th run. The DEMTs describe the orientation process in their letter. The provided policies describe a clear pathway for her to immediately and safely raise any concerns with her orientation, if she had any, or felt she required further assistance.

My opinion is that the induction and training of junior doctors to the TDHB Emergency Department meets New Zealand accepted practice.

7. Any recommendations for changes.

I note that the Taranaki District Health Board initially stated they have not considered making any further changes to the service it provides following this incident.

I would encourage them to have a method that in real-time documents every patient's treating doctor (in this case [Dr D]) as well as every patient's supervising SMO (which in this case is unclear and debated amongst the SMOs themselves.) Most electronic whiteboards allow this and may be worth looking into. This would create an auditable record of who was managing a patient's care at every moment in their patient journey.

(Per the later TDHB response, these changes were subsequently made, even before the receipt of HDC advice.)

Regarding documentation: TDHB's written policies and written resources make it very clear that house officers are to discuss all patients they see with an SMO. These discussions should be documented in the clinical note by the treating RMO.

I acknowledge [Dr C's] statement that excess documentation would 'drive our department to a standstill' and that [Dr C] doesn't 'routinely document in the charts of house officer's patients'. This is reasonable, and is indeed the standard of care.

I would clarify though, that when I refer to documentation, I don't exclusively refer to the SMO clinical note. I am also referring to the wider failure of ED documentation to record relevant detail: like who the supervising SMO actually was, or even who it was supposed to be. These are systems issues for TDHB. Per their later response, these issues are being addressed.

8. Any other matters you consider warrant comment.

Regarding house officer education, which was mentioned as an issue of concern to [Mrs A's] family. Trainee doctors must be trained upon patients. There is no way around that reality. No amount of simulation or practice with actors can take the place of amassing a body of knowledge and experience borne of examining and treating thousands upon thousands of patients. Patients coming to publicly funded hospitals should be informed of this fact, and expect training to be part of the hospital's mission, and their patient journey.

At that same time, they must be promised care and diligence in the supervision of doctors-in-training. Patients in public/teaching hospitals benefit from better care, not lesser care, because their doctors-in-training are getting the second opinions, supervision, and expertise of another more experienced clinician. The hospital system as a whole is far more progressive and reflective when it is actively engaged in teaching and training.

Proper supervision and teaching cannot be divorced from patient care. It cannot be the enemy of patient flow. Adequate supervision cannot 'bring a department to a standstill'.

It must be budgeted into the clinical time of an SMO, and into the patient-per-hour expectations of a house officer. If an ED clinician does not have time to provide adequate supervision, to document adequately, and to teach, then patient care will ultimately suffer, even if ED throughput transiently increases.

9. Recommendations for improvement that may help to prevent a similar occurrence in future.

Determining oversight and supervisory responsibility in healthcare can be difficult. Cases worldwide, from the Bawa-Garba case in the UK to the Libby Zion case in the USA all highlight the need for real-time documentation to take the place of 'recollection' as to who was managing a patient, or exactly who did what, when. Electronic whiteboards, e-prescribing and electronic ordering may help with this, with provider-specific time-stamps on all orders, notes, viewing of lab tests and imaging results. With patients being increasingly treated by teams of providers, the diffusion of accountability will likely continue unless seamless and efficient interventions are made to preserve an auditable record of care.

Per the latest response from TDHB, many of the recommendations described in this letter of advice have already been enacted.

Thank you for this opportunity to review this case. If you have any questions, feel free to contact me via email or phone.

Regards,

Gary Payinda MD MA FACEM FACEP DDU
original 08/01/21, amended 02/06/21"

Supplemental email dated 12 May 2022:

> "…
>
> Thank you for your email requesting my opinion 'on Taranaki DHB's system of consultants checking test results and signing them out when they have not been the consultant involved in the patient's care.
>
> I attach [Dr C's] response in which [Dr C] outlines how the system regarding results works. I would be most grateful if you would please respond by email and comment on the adequacy of this process and whether it meets accepted standards.'
>
> My opinion on TDHB's system of consultants checking lab test results and signing them out when they have not been the consultant involved in the patient's care is that a system such as this, where the ordering doctor is often unknown (often generically entered under the name of the Head of Department, or the Lead SMO on duty that day) is a common system in use in NZ emergency departments. Which is to say it is within the 'standard of care', at the present time in NZ EDs, regarding online ordering of tests.
>
> My opinion is that this system of 'anonymous online ordering' is likely to cause some errors, lacks accountability, and shifts risk from shortcomings in systemic data management/IT onto clinicians and patients.
>
> Emergency doctors often sign off lab test results many days after the tests have been performed. It is hoped that all critical/important results would have been checked in real-time on an ED patient while they are present in the ED or shortly thereafter. Yet many lab tests may remain unchecked until days later. This is a clinical risk.
>
> It is impossible to account for who actually ordered the test, because samples are often labelled under a generic name (often because the blood tests are drawn by triage nurses well in advance of any doctor seeing the patient; this allows for efficiency, because waiting for a doctor to first assign themselves to the patient would delay care, sometimes by hours).
>
> The obvious solution would be for a 'placeholder' name to be associated with the sample only initially. When a doctor clicks on the ED whiteboard and assumes care for an ED patient, then that 'placeholder' name would get changed over to their name. This should be an easy IT fix.
>
> Alas, this is not how IT within the DHBs work at present, and the standard of care is for ED labs to often remain under 'placeholder' names indefinitely, for unverified results to accrue, and for these results to be checked by any member of the ED team (SMOs, RMOs, NPs) at a later date, sometimes days later. Many EDs will have backlogs of hundreds of such lab tests (and imaging studies) that are not-yet-signed-off.

At the point of review by any member of the ED practitioner team, the practitioner signing them off must make a decision as to whether an abnormal lab [result] is likely to be clinically significant, and if so, to look up the patient's medical record in an attempt to figure out whether further action needs to be taken (and possibly contact the patient). This is time-consuming, inefficient, and risky, given that the doctor does not know the patient and is only familiar with the case from what information they can momentarily glean from the electronic medical record.

Another potential interim solution is to have 'sign-off' automatically occur whenever any clinician first views any lab result; this would reduce backlogs of 'un-reviewed' labs and ensure accountability and timeliness. At present, this is optional in some IT online-ordering systems, not required.

In summary, the description by [Dr C] of a system where [they are] instructed not to sign off on results for patients [they] did not care for, but [Dr C] does so all the time, is concerning. [Dr C] says [they have] to decide if abnormal lab results are relevant or not, sometimes days after the fact, while being uninvolved in the patient's care. This is a clinical reality for most ED doctors in regional hospitals. This is far from ideal, obviously.

But it is the standard of care in regional EDs at present, given the limitations of the laboratory, imaging, and IT systems. There are readily available solutions, but at present, they are often unimplemented."