Submission No 84

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Name: Name suppressed

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Submission for the Inquiry into the operation and management of the Northern Beaches Hospital

Submitted 19 July 2019 by

Terms of Reference

This submission relates to the following term of reference:

That Portfolio Committee No. 2 – Health inquire into and report on the operation and management of the Northern Beaches Hospital

(d) standards of service provision and care at the hospital,

Case of negligent diagnosis in the Emergency Department

This is a submission by for the parliamentary enquiry. This submission addresses a lack of standard of service and duty of care.

Date:

Around 11:00pm Sunday, 3 February 2019

Patient:

Presented to Emergency with:

Chest pains, patient thought it may be a sever reflux episode or gallbladder attack given recent investigations and wanted to ensure it wasn't a heart attack.

Negligent diagnosis:

Diagnosed with a blocked artery and told by a Dr that she would need to be transferred via ambulance to Royal North Shore to have a stent put in her heart. This caused a panic attack.

Outcome:

had a panic attack whilst being given the news that she would need emergency heart surgery. She called her husband and mother to advise of the news. Shortly after a different Dr approached and told that they had an update on her condition and that she would be transferred to a ward. There was confusion as to what would cause such a dramatic change in procedure and it took several lines of questioning before it became clear that a mistake had been made. Apparently, blood results had been mixed up with those of another patient and that caused a misdiagnosis, panic attack and subsequent confusion in treatment which led to very low blood pressure for the following 4 or 5 hours. Several days later was diagnosed with an inflamed gallbladder and gall stones and remained in hospital to have her gallbladder removed around 6pm on Wednesday, 6 February 2019.

Detail of event:

Admission background

of Brookvale, 39-year-old mother of two, entered the Emergency Department on Sunday night around 11pm accompanied by her mother. She presented to the Emergency department with chest pains and was seen to immediately, she did not have to wait. The staff were caring and kind. She was hooked up to a machine and shortly after a friendly young female Dr came to question her. related that she had chest pains, tightness in her chest, and a burning sensation under her ribs. She had recently had 3 other of these episodes the most recent around 3 days earlier. She was concerned as she had seen a Gallbladder surgeon who had said she was not a typical case and that she should only return to him after if an episode happened again, he recommended going to Emergency to establish if it was indeed her heart. Given that she had been in pain since January with a burning sensation in her lower abdomen and this was the fourth attack she decided to go to Emergency as recommended.

advised the female Dr she had regular low blood pressure.

Drs gave intravenous medication for heart burn and some pain medication. They took bloods.

Result of blood tests and negligent diagnosis

After several hours around 3:00am a different friendly young male Dr came and calmly sat next to where he unfortunately had to relate that they now knew the cause of her pain. They had been in contact with the Cardiologist Consultant via telephone and they had concluded that blood tests had shown she had a blocked artery and that she would need to be transferred to RNSH soon by ambulance. She would require a stent in her heart, and this would happen tomorrow. In the meantime, they would administer blood thinners. She was not to worry as she was in a hospital and there were Drs everywhere to care for her. She never saw this Dr again.

began to tremble and shake, and she became aware she was having a panic attack. She couldn't really speak. She was shocked. She rang her husband and mother to tell them of the diagnosis.

As soon as she had hung up the phone to her mother the young female Dr returned to inform that they had an update. They were going to transfer her to a ward and give her a patch to lower her blood pressure. At this point questioned why she wasn't being treated for her heart and going to RNSH by ambulance and the Dr said that there had been a change. questioned why this was no longer urgent and the Dr said that they wanted to observe her. Again, questioned what had caused this change in urgency and at this the Dr said that the blood results were not showing it was urgent. Again, she questioned if a mistake had been made. The Dr simply said that some of the results now showed it may not be her heart. was confused as to how such a dramatic change could happen. continued questioning until the Dr finally confirmed that her blood results had been mixed up with those of another patient!

At this point reasoned that if the bloods were not hers then she did not want to have the patch as she has chronic low blood pressure and if the issue was NOT the heart then she did not want anything to lower her blood pressure further. The Dr insisted she needed the patch as a precautionary measure. reiterated that she did not want it. Regardless the Dr returned with the patch and put it on. asked if she could take it off the Dr said let's see what happens. At this fell asleep. She was then woken up around 4:30am by the Dr as her blood pressure had dropped, as had predicted, so they took the patch off and transferred her to a ward.

Transfer to ward

Once in the ward the poor nurse who had had no explanation as to why had low blood pressure had to call Drs for advice. explained what had happened and again reasoned and asked that if there was a drug in her system would it help if she drank a large amount of water to expel it. The Nurse went away to call a Dr who advised she should flush her intravenously. Then every 30 minutes the diligent nurse returned to take blood pressure with an electronic pressure taker which never read properly. again requested that they stop inflating the electronic blood pressure reader and just use the manual one.

After sunrise then saw the cardiologist in her ward who advised her, he had been woken up with her case. He had now reviewed the situation and felt that her heart had no issues and that they would refer me to the Gastroenterologist Dr .

Actual diagnosis and surgery

From here on the hospital staff were very kind and caring and all proper care was taken. Ultrasounds showed an inflamed gallbladder and gallstones and a clear solution was to have the gallbladder removed. This was going to be booked in asap.

Observation by patient:

As a result of the negligent diagnosis in the Emergency Department was alarmed and highly alert, despite being in pain, and observed that the greatest challenge for all staff was communication and. Lack of timely communication and overdependence on computer systems actually delayed decision making and communication to the patient. It appeared that information even if it had been lodged on a computer system in one area was not available to another. Often the patient was left in limbo with an unofficial update and then had to wait hours to be reassured officially.

Comments and concerns based on this case:

- How could blood tests get mixed up and a Consultant be called to review these? And then how can you be sure that the subsequent results were indeed those of the patient?
- The patient communication once the error had been made could have been much easier to digest if the Dr simply stated a mistake had been made rather than attempt to lessen the impact by using words like “we have an update” when really they should have calmed the patient with ”we have a made a mistake” – whoever wouldn’t be pleased that they don’t need heart surgery?
- Ultrasound results took over 6 hours to be available on the Tuesday, 5 February.
- Additionally, and of lesser importance, although it could have delayed procedures by a day, it seemed staff delivering meals weren’t aware in time of sudden changes. For example, was advised she needed an ultrasound on Monday afternoon and was told to be nil by mouth, this did not occur in the end and then no dinner remained. Then on Tuesday morning she was offered breakfast 30 minutes before she was to be taken to the ultrasound.
- Finally post op at around 6am on Thursday, 7 February 2019, after an operation ending around 8pm Wednesday, 6 February 2019, she was requested to pack up her bags and get ready to go to the discharge lounge. She had not walked alone post op yet and had terrible shoulder pain and the nurse only stayed with her at her own request whilst she had a shower, (another very lovely nurse had recommended she ensure someone was with her the first time she walked post op), the nurse trying to discharge her said they urgently required the bed. Finally, when the junior Dr came to see how she was he ensured that she was not rushed out.