22 July 2022

Final report to the Chief Executive regarding the circumstances of a patent leaving the Middlemore Hospital Emergency Department.

Confidential

This report expands on the interim report previously provided.

Information has been obtained from the Adverse Event review conducted by the Service Manager, Clinical Director, HOD, and the Clinical Quality Risk Manager all responsible for the Emergency Department (ED). In addition, I have spoken with the Clinical Director about his discussions with the family and his review of CCTV tapes, and with the Service Manager regarding interviews she performed with the Triage nurses on duty at the time of the presentation and the Associate Charge Nurse Manager (ACNM) on duty. I have reviewed the relevant Departmental metrics such as volume of patients in the Department.

CCTV footage has been reviewed by the Clinical Director to clarify aspects especially regarding establishing the timeline and any interaction with staff.

I am satisfied the following has been established:

Timeline:
At approximately 0045 hours, the ACNM began informing the ED waiting room that the waiting time for non-urgent cases would be some hours. This message was generic in nature to all in the waiting room and not on a case-by-case basis.

The ACNM advised that if people felt reasonably well, it was recommended that they went home and saw their GP in the morning, or an Emergency Q (EQ) voucher could be offered. Patients were also advised there was a 24-hour countdown supermarket at the airport where over-the-counter analgesia could be purchased. The ACNM also advised those in the waiting room they were welcome to stay, but a lack of beds for comfort was noted.

It is likely the patient entered the waiting room part-way through this announcement as CCTV footage confirms the patient entering the ED at approximately 0100 hours, 15 June 2022. This was into the waiting room in the Main Building as the Triage Tent had closed. (Closure of the Tent was normal practice at approximately 2300 hours).

The patient entered the ED waiting room on [redacted] own as [redacted] was parking the car. [redacted] was not registered at the front desk and did not go through Triage.

Soon after [redacted] arrival in the waiting room, the patient was joined by [redacted]. The patient then spoke to the ACNM; this interaction was brief. CCTV reveals the [redacted] was seated and not part of this conversation. The patient is reported by the ACNM as saying [redacted]; however, it is important to note the patient [redacted]

The ACNM reports [redacted] informed the patient that [redacted] were welcome to wait and be assessed or alternatively they should return if any concerns arose.

This interaction was clearly not "triage" in a clinical sense, but, in many respects, a brief repetition of the message the ACNM had delivered to the waiting room. The patient was not offered an Emergency Q voucher (and all staff report they would not offer EQ for headache)

The patient is then observed on CCTV speaking to [redacted], and they are seen to leave the Department at approximately 0130 hours.

The patient returned to the Department by ambulance at 0525 hours in a critical condition. Assessment and care following this arrival was timely and appropriate.

State of the Department:
At 0100 hours there were 46 patients in the Waiting room and the Department itself was abnormally busy with a total of 195 patients in the ED.

Medical staffing was normal as per rosters (in fact at least one doctor above normal).

Nursing Staffing was below normal as per rosters by a total of three nurses. There were 32 nurses (including the Nursing Unit Manager) and one Charge Nurse on duty. There were two nursing shortfalls - one each in the monitored area and waiting room (from 0100) - and one Charge Nurse vacancy compared to normal roster numbers.

Summary:
I am satisfied the patient was not triaged. I am also satisfied the patient was not declined care or instructed to leave the Department. However, there was opportunities to potentially avoid the patient leaving.

The fundamental issue was the excessive demand for assessment and care in the ED; that, in turn, led to excessive waiting time in the Department. However, the lack of Triage assessment meant there was no opportunity to clinically assess the patient's symptoms and obtain "vital signs" and therefore assign an appropriate triage status.

Nursing staffing was below the rostered total, but the overwhelming problem remained excessive patient load. Therefore, even if staffing had been at 100% of the nursing roster I believe this would still not have adequately met the excessive demand in the Department that night.

This case highlights a tragic outcome. I do not know if it is possible to determine with any degree of certainty if the outcome would have been different had the patient been triaged and remained in the Department (see "Further Recommendations" below). To be clear, there is absolutely no criticism of any decision or action made or taken by the patient or [redacted]

Improvements:
Communications about waiting times and the possible alternatives, including going home, should be explicitly directed to those patients that have been via Triage, had appropriate

Recordings taken, and been told their Triage category means their waiting time is likely to be excessive.

Messaging about waiting times need to be understood by all those potentially affected. This includes in language understood by each patient, otherwise there is increased clinical risk of a patient leaving when the clinical intention is they should remain.

The overarching improvement necessary is to eliminate excessive demand over and above Departmental capacity. This will of course require a pan-system approach to resourcing in the District to improve patient access to care both in community and secondary settings across the 24 hours of each day. This is also a need to address workforce and for a consideration of the ideal physical design of the Middlemore Emergency Department.

Further Recommendations:

1. [redacted]

2. I recommend the hospital consider an independent review by an Emergency Department expert to determine if any further improvements are indicated

Andrew Connolly
Acting CMO
22 July 2022