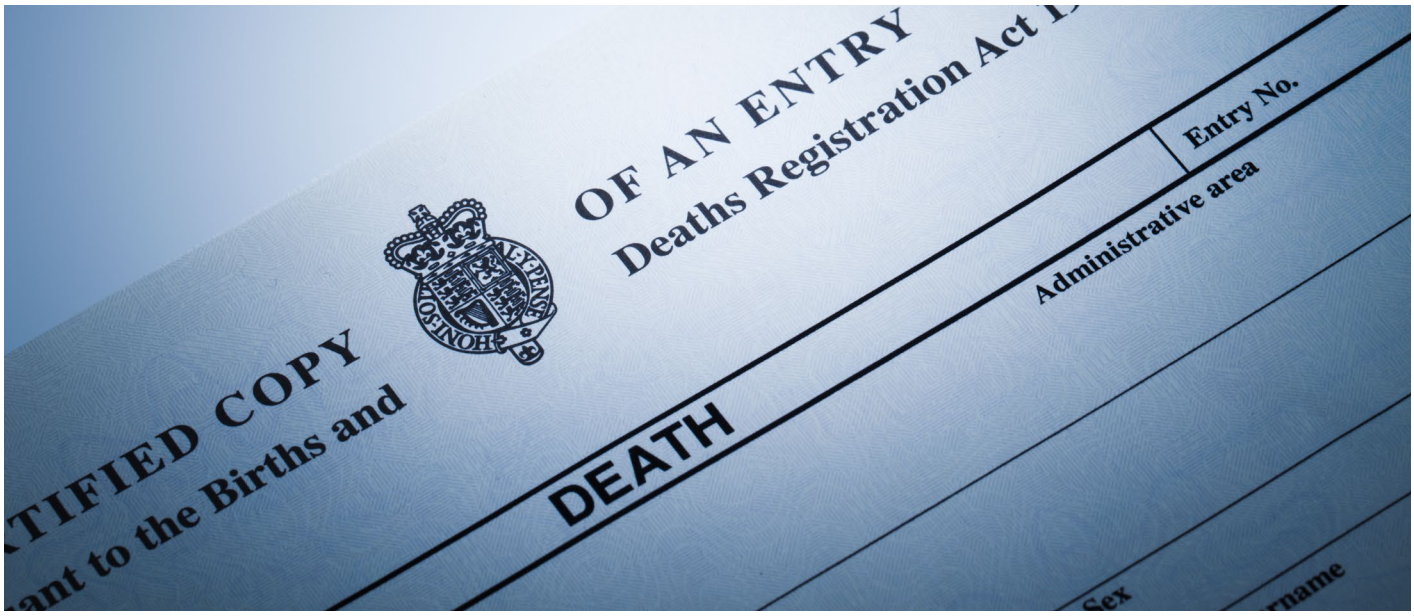
Coroner finds poor handover systems between hospitals contributed to patient's death



Key messages from the case

This coronial decision illustrates the importance of:

- taking a detailed clinical history and considering possible differential diagnoses
- making detailed notes to facilitate handover of care and alert other care providers to potential issues, particularly in complex care situations.
- consultants providing direct supervision and support of junior medical staff involved in dealing with emergency clinical situations of which they may have no experience.

The coroner reserved most of his criticism for inadequate systems for handover and transfer of care that left relatively inexperienced and junior staff struggling to navigate a complex system, and contributed to the patient's death.

Details of the decision

Mr P had a history of well-controlled epilepsy, and a more recent diagnosis of atrial fibrillation (AF). When out drinking with a friend, he briefly visited the bathroom and had an unwitnessed collapse. He woke on the bathroom floor moments later with no recollection of the event, but wondered if he hit his head. He appeared uninjured and walked home with his friend.

The next morning, Mr P felt unwell and attended a local GP, who found Mr P to have an irregular heart rate and low blood pressure. Mr P was referred to the Emergency Department of the local hospital where it was thought the syncopal episode was the result of his rapid AF and he was admitted to Coronary Care Unit (CCU) for rate control and anticoagulation. In the multiple points of patient handover between departments and healthcare professionals, the possibility of head trauma appears to have been missed or not clearly communicated.

The next day Dr O, a physician trainee, discovered the possible head trauma associated with the syncopal epsidode. Dr O requested a CT brain scan, which revealed an acute left frontotemporal subdural haematoma. She requested an intern call the neurological registrar of a nearby tertiary hospital to arrange a transfer and cease all anticoagulation.

There were procedural delays in transferring the patient to the tertiary hospital. By the time the patient was transferred his prospects of recovery were poor. Despite a craniotomy and evacuation of the subdural haematoma, the patient died the following day.

Communication and handover

On Mr P's initial admission to the Emergency Department, the attending CMO did not discover that Mr P had fallen, bumped his head and found himself on the floor. His initial impression was that the syncope was a cardiac issue related to his history of AF, with a differential diagnosis that the syncope may have been related to his epilepsy. The attending CMO had not followed this up or made a note about it in the patient's record, contrary to his usual practice, due to the pressure of time. The coroner considered the CMO's failure to document his possible differential diagnosis meant an opportunity was lost to investigate a possible neurological cause. Despite this, the coroner found that in all circumstances, referral of the CMO to the medical regulator was not warranted.

The coroner was also critical of handover processes within and between the hospitals. Within the CCU, transfer of care between physicians was not documented and the transfer was not formally accepted, contrary to the applicable policy directive on clinical handover, although this did not impact on the care provided.

When Mr P was eventually transferred to the tertiary hospital, there was incomplete documentation of the medication Mr P had been given. The coroner recommended policies be amended to ensure that medication prescribed and administered be clearly documented and this be transferred with the patient.

Supervision of junior medical staff

Another issue the coroner commented on was the lack of supervision and support for the junior medical staff in the time critical transfer, where they had not previously encountered a neurosurgical emergency. The coroner concluded that junior medical staff can clearly benefit from the experience of consultants, particularly in dealing with emergency clinical situations of which they may have no experience. He recommended that in all time critical inter-facility transfers, consultants should provide direct supervision and support (by phone or in person) to junior medical staff involved in the transfer process.

Systems failures

The coroner concluded that the main issue contributing to Mr P's death was the inefficient systems leading to a delay in transferring Mr P to the tertiary hospital. The transfer protocols used inconsistent and confusing terminology, making it unclear who actually had responsibility or authority to make decisions, or how to escalate issues when necessary.

Outcome

The coroner was not critical of care provided by individual practitioners. However he noted the miscommunication about the patient's history and initial failure to appreciate the urgency of the patient's clinical situation.

His recommendations focused on system issues that led to the delay in transferring the patient to the tertiary hospital.

Key lessons

Complex and confusing systems can create unnecessary risks to patient safety – so it is important for healthcare organisations to consider systems and processes to ensure these are as simple and easy to navigate as possible – and that staff are trained in how to follow them.

Even in an emergency, take time to take a careful patient history, consider differential diagnoses and document these carefully to ensure effective handover of care.

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