Case 5: Nicki

Case for discussion

Nicki is a 65-year-old woman with chronic obstructive pulmonary disease (COPD). She has had a cough and breathlessness for several years and needs antibiotics periodically. She is a smoker. She requests a GP consultation for breathlessness.

In a video consultation, the GP trainee notes that Nicki is a little breathless at rest, but the image is not very clear. He diagnoses a flare-up of COPD. He prescribes inhalers and advises Nicki to call back next week if not better. The following week, Nicki submits a consultation request saying she has not improved. In a same-day telephone consultation, the duty GP diagnoses bacterial super-infection and prescribes antibiotics. But a week later, Nicki is no better.

What would happen now in your practice? Focus on access and triage issues, not Nikki's clinical management.

Consider what would happen if…

A. **An administrator picks up the request.** What options are open to them? Consider, for example, allocating a routine telephone call-back from a GP or nurse practitioner, asking Nikki to supply additional information; passing the request to Nikki's usual GP.
B. **The duty triage clinician picks up the request.** What options might they consider? For example, a prescription for antibiotics, a same-day call-back from the duty doctor, a face-to-face appointment within 48 hours.

The safety incident

Nicki did not respond to inhalers or antibiotics. She continued to receive telephone and video consultations without further investigation. Her smartphone was fairly basic, so the image seen by the doctor was always indistinct, even when a video consultation was done. Her symptoms continued to worsen, and after another month she called an ambulance. In the Emergency Department, she was diagnosed with severe heart failure and died soon afterwards.

*In this tragic case, the **system was oriented to managing the known condition** (COPD), and the patient's worsening breathlessness was assumed to be due to this condition. There were **no clear criteria** for bringing in a patient who is not improving, and there may have been **capacity constraints** (e.g. limited slots for in-person appointments). The video consultation added almost nothing to an ordinary telephone call because the **visual quality was poor**.*

Checklist for practice discussion

Are all staff groups aware of the criteria for bringing a patient in for a face-to-face review (e.g. no improvement despite 2 remote contacts)?	☐
Are all staff aware of the limitations of remote assessment of patients with potentially life-threatening symptoms (in this case, breathlessness)?	☐
How might you reduce the tendency of staff to assume that a patient's symptoms are due to a known condition rather than a new problem?	☐
What safety-netting advice is given to patients with breathlessness or other 'red flag' symptoms? Is this advice always understood and acted on?	☐

Learning outcomes

On completion of this exercise, we hope that staff in your practice will be better able to:

1. Identify clinical conditions and trajectories for which an in-person assessment is typically required. Be aware of practice criteria for this option.
2. Provide comprehensive safety-netting advice to patients who may deteriorate, adapting this to different conditions, contexts and patient features.
3. Be open to the emergence of new problems in patients with existing ones.