Case 7: Abeni

Case for discussion

Abeni is a 6-week-old girl, born at term in a community obstetric unit. Her parents contact the practice concerned about a possible feeding problem.

How would this request be managed in your practice? Think about possible routes for this child and who would assess this request further. Focus on access and triage issues, **not Abeni's clinical management.**

Consider what might happen if….

A. **Abeni's father submits an online triage form; a GP registrar telephones back** the same day and discusses the case with her supervisor. What information might be sought to inform next steps? While "feeding problems" are common, how might less common but more serious conditions be suspected?
B. **After another week, Abeni's father phones the practice and says she's no better**. She has a health visitor appointment next week for a routine baby check. In your practice, would an alert be triggered—or would the parents just be told to keep the routine appointment?
C. **Abeni is assessed by video consultation**, but the image is poor quality and Abeni's parents have some trouble angling the camera to get the infant in view. What (if anything) might the visual information add over a telephone call? What disadvantages might a video assessment have?
D. **The practice protocol flags** that Abeni is very young and has never been seen face-to-face. In your practice, what pathway would be followed? Who would assess Abeni, when and how? Consider if this case would be managed by doctors in training or novice staff.

The safety incident

Abeni was assessed repeatedly over the telephone and once by video. A diagnosis of “feeding problem” was recorded on her record. The child’s dark skin colour and a poor-quality video image meant that cyanosis was not easily apparent to the reviewing clinician. She was not seen face-to-face until a formal 8-week baby check, when she was found to have signs consistent with congenital cyanotic heart disease (“blue baby”) and was admitted acutely to hospital.

*This case highlights both **patient features** (young age, darker skin colour) and **technology features** (poor image quality) that can make remote assessment by video unsafe (hence, the threshold for bringing the patient in for a face-to-face assessment should be lower if they are present).*

*The case also illustrates the crucial importance of attending to **the clinical trajectory** (Abeni had not improved and may have been deteriorating) and to **parental concern** when assessing a child without a face-to-face examination.*

Checklist for practice discussion

What features of this case (consider patient factors and technology factors) should have alerted you to the need for an in-person review? Would such a review have been triggered in your practice?	☐
What protocols do you have for offering an in-person contact for babies and children? Do you have informal ‘rules of thumb’ for such decisions?	☐
How do you support GP registrars who undertake remote consultations?	☐
What systems are in place to identify rare but serious illnesses when patients seek care for an apparently mundane condition?	☐

Learning outcomes

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

1. Identify features that make remote assessment riskier and more difficult.
2. Decide when remote encounters for babies and children are potentially inappropriate.
3. Support doctors in training and others with limited remote consultation experience.