Informed consent and postoperative care of a patient undergoing neurosurgery (09HDC01565, 5 September 2012)

District health board ~ Public hospital ~ Neurosurgeon ~ Neurosurgical trainee ~ Registered nurse ~ Informed consent ~ Postoperative care ~ Chiari malformation ~ Posterior fossa decompression ~ Right 4(1)

A 21-year-old man was diagnosed with a structural defect in the bottom part of his brain (a Chiari malformation). He was admitted to a public hospital for elective surgery to relieve pressure on the brain (a posterior fossa decompression). A trainee neurosurgeon met with the patient to discuss the proposed surgery and obtain his consent. The patient was concerned that there were more risks with the surgery than he had realised, and he was consequently uncertain about whether to proceed. Later that day, the patient met with the consultant neurosurgeon whose care he was under, and after discussing his concerns further, the patient decided to go ahead with the surgery. The patient was not told that the surgery would be performed by two trainee neurosurgeons under the direct supervision of the consultant.

The surgery was performed the following morning. After 1½ hours in the recovery ward, the patient was transferred to a special care unit for the postoperative care of neurosurgical patients. The patient's neurological observations were checked hourly for the first 12 hours postoperatively, and then two-hourly. However, his respiratory rate was not recorded after 5pm on the day of surgery. There were no issues identified with the quality of the surgery and initially his recovery appeared to progress as expected.

At approximately 7am the next morning, the nurse who had been looking after the patient overnight left the unit to give handover. She reported no concerns. Following handover, the nurse who had just come on duty entered the unit. The curtains around the patient's bed space were drawn, and the nurse did not initially sight him. At approximately 7.30am, the nurse drew back the curtains and found the patient unresponsive. He was not able to be resuscitated. The pathologist was not able to anatomically ascertain the cause of death. The post-mortem report referred to the possibility of a "functional loss of breathing control while asleep".

The DHB carried out a Root Cause Analysis, which identified several concerns, some of which were associated with the unit's routine practices. A number of changes were made by the DHB as a result of what happened.

It was held that the patient was not provided with services of an appropriate standard. There were deficiencies in the service provided by the DHB, as well as individual members of staff. Sub-optimal processes and practices in the neurosurgical unit meant services were not provided by the DHB with reasonable care and skill. Concerns included: a conflict between the postoperative monitoring instructions documented for this patient and a generic ward protocol; a failure to check and/or document the patient's respiratory rate; that close observation of the patient ceased at the time of the nursing handover rather than following medical review; and that morning handover was held in another room. Collectively, these factors resulted in sub-optimal care being provided to the patient. This was a breach of Right 4(1) of the Code.

In these particular circumstances, the patient should have been informed as to who would be performing his surgery. In addition, there were some deficiencies in the care provided by individuals. However, in the circumstances it was found that individual breach findings were not warranted.