Delay in provision of services to patient with vascular problems (09HDC01146, 28 April 2011)

District health board ~ Public hospital ~ General surgeon ~ Surgical registrar ~ Vascular surgeon ~ Ischaemia ~ Amputation ~ Transfer ~ Rights 4(1), 4(5)

A woman complained about the care provided to her 79-year-old father by a public hospital. The man was referred to the emergency department with acute pain in his left leg and a cold, blue, left foot. He was diagnosed with impending ischaemia and admitted to hospital.

The man was initially under the care of a general surgeon, and there was a delay of ten days before he was seen by a general surgeon with an interest in vascular surgery ("the operating surgeon"). The general surgeon relied on inaccurate information provided by the registrar about when the operating surgeon would return from leave.

A week later the man underwent surgery for an aneurysm behind his left knee. Following the surgery, the operating surgeon again went on leave but failed to hand over care to the on-call consultant. The man suffered complications but the significance of his symptoms was not appreciated by the registrar. After several days the man was referred to a vascular surgeon at another district health board, but his leg could not be saved and he required an above-knee amputation.

It was held that the first general surgeon breached Right 4(1) for failing to seek specialist advice within a reasonable time. The operating surgeon breached Right 4(5) for failing to adequately hand over care. The registrar breached Right 4(1) for failing to verify the information he provided to the first general surgeon about the absence of the operating surgeon, keep adequate records, or adequately assess the patient.

The district health board was found to have adequate systems in place and was not found in breach of the Code. The district health board took reasonable steps to enable the three providers to provide safe services, and was not vicariously liable for their breaches. However, adverse comment was made about the failures of nursing and junior medical staff to report their concerns to the on-call consultant as the man's condition deteriorated, and the need to develop a culture in which the asking of questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team.