

**Assessment, monitoring and documentation of a postoperative spinal surgery patient's deteriorating neurological status
(10HDC00158, 14 November 2012)**

Orthopaedic spinal surgeon ~ Registered nurse ~ Private surgical hospital ~ Assessment ~ Documentation ~ Communication ~ Standard of care ~ Cauda Equina Syndrome ~ Rights 4(1), 4(2), 4(5)

A 69-year-old woman underwent elective surgery at a private hospital to decompress a two-level lumbar spinal stenosis. The surgery was performed by an orthopaedic surgeon specialising in spinal surgery. That evening, the surgeon and his anaesthetist reviewed the woman.

The registered nurse assigned to the woman's care from 11.15pm recorded that the woman had lost sensation and movement in her feet at midnight. She continued to monitor the woman two hourly, noting the varying degrees of this deficit, but did not report her observations to the duty manager or surgeon.

At about 7.15am the next morning, the surgeon and his anaesthetist reviewed the woman, noting her loss of movement and sensation in her ankles and feet. The surgeon did not document his findings or provide further instructions to the nursing staff about ongoing monitoring of the woman. The surgeon arranged for the woman to have an MRI scan, and this was performed at 9am.

There is disagreement about when a theatre was available for the surgeon to operate on the woman. The surgeon stated that as a theatre was only available at the hospital from 2pm, he decided to carry out his surgical list at another private hospital while waiting to return the woman to theatre. However, the theatre manager stated that the surgeon contacted her from the second hospital and she advised the surgeon that a non-orthopaedic theatre could be made available for the woman's surgery before midday. However, the surgeon declined this offer and booked a theatre for 2pm. The surgeon stated that operating between six hours and 48 hours after the onset of neurological impairment symptoms makes negligible difference to the outcome in such cases.

The surgeon was delayed at the second hospital and the woman's surgery, to evacuate a haematoma, took place at 3.28pm. Following the surgery, the woman was transferred to a public hospital for ongoing treatment for impaired neurological function. Two weeks later the woman was transferred to a spinal unit for rehabilitation.

The woman was discharged from the spinal unit one month later. She requires intermittent catheterisation and manual bowel evacuation. The woman also suffers ongoing neuropathic pain in her feet and perineum, and cannot sit for any length of time without experiencing pain.

It was held that by failing to report the changes in the woman's neurovascular status, the registered nurse who was responsible for monitoring the woman's status during the night failed to act appropriately to ensure she was provided with services of reasonable care and skill, and breached Right 4(1). In addition, by failing to record all assessments, undertake a critical evaluation of the observations or make a plan of

action, the registered nurse did not meet accepted professional standards or comply with the private hospital's policies regarding documentation, and therefore breached Right 4(2).

The surgeon was found to have breached Right 4(1) by not providing services with reasonable care and skill, Right 4(2) by failing to comply with professional standards in relation to clinical documentation, and Right 4(5) in relation to his failure to communicate effectively with the private hospital staff to ensure the quality and continuity of the services provided to the woman.

The private hospital had processes in place at the time of this woman's surgery to provide for a "return to theatre" should complications arise from surgery. The failures in communication between the surgeon and the hospital staff in relation to organising a "return to theatre" for the woman was not caused by the actions of the private hospital's staff. The private hospital did not breach the Code.