

Care of woman with abdominal pain
17HDC00419, 28 March 2019

District health board ~ General surgery registrar ~ Perforated bowel ~ Handover policy ~ Documentation ~ Early Warning Score System ~ Right 4(1)

A woman presented with severe stomach pain and was seen over two days by two different general practitioners. She was admitted to hospital where she underwent surgery for a perforated bowel. The woman did not recover from the surgery, and passed away the following day. This investigation focused on the care provided by the district health board (DHB).

Findings

Although individual staff hold some degree of responsibility for the inadequate care outlined in the report, overall the deficiencies identified indicate a pattern of poor care across services, for which the DHB is ultimately responsible. Of most concern are the staffing levels; the failure to follow both the handover policy and the Early Warning Score System policy, which should be a fundamental part of clinical care; the poor documentation, which did not convey the woman's potential to deteriorate; and the lapses in communication between the services. These factors hindered the coordination and delivery of care. Accordingly, the DHB failed to provide services with reasonable care and skill, and was found to have breached Right 4(1).

Adverse comment was made regarding the care provided by a general surgery registrar. When the registrar received the woman's CT scan result during the night, she should have communicated this to the on-call consultant directly, rather than wait until morning to discuss the proposed treatment plan. The registrar was reminded of the importance of effective communication, including her responsibility to ensure that she always consults with her senior colleagues when considering a treatment plan for a patient with abnormal results, regardless of the time of day or night.

Recommendations

It was recommended that the DHB audit clinical records of patient transfer between its Emergency Department and Acute Assessment Unit (AAU) to ascertain whether the ISBAR tool has been utilised in full; audit clinical records to ascertain compliance with the Early Warning Score System policy in the Emergency Department and AAU; provide evidence that surgical junior doctors are being informed at orientation that the on-call consultant is to be called at any time for support or advice regarding a patient of concern; provide documentation to show the implementation of a dedicated surgical night registrar; and provide a written apology to the family.