Nurses recorded postoperative deterioration without seeking medical review (00HDC04656, 24 October 2003)

Nurses ~ General surgeon ~ Private hospital ~ Patient monitoring ~ Follow-up care ~ Record-keeping ~ Hospital protocols ~ Rights 4(1), 4(2)

A 58-year-old woman died six days after a laparoscopic cholecystectomy at a private hospital. The day after her operation her blood pressure and pulse were normal, but she was noted to be very short of breath and had a productive cough. Her oxygen saturation on room air was 88%. The nursing notes that night record a drop in oxygen saturations and blood pressure and a low temperature. She felt clammy and was in a cold sweat. She subsequently "warmed" and seemed settled but remained hypotensive and tachycardic. The next day she was coughing, vomiting, short of breath and complaining of abdominal pain. She was assessed and transferred to Intensive Care but deteriorated and died. The Coroner determined that she died from a duodenal perforation giving rise to an abdominal wall abscess and septicaemia.

The Commissioner held that the general surgeon breached Right 4(1) because he did not adequately manage the patient postoperatively. He failed to follow up the patient's progress or arrange for an appropriate delegate to do so, and did not attend the patient as soon as significant changes in her condition were reported to him.

The nursing staff also breached Right 4(1) in failing to recognise the significance of the deterioration in the patient's observations and advise the surgeon. Nurses are more than simple recorders of observations — observations should be interpreted and acted upon. The nursing staff failed to think critically about the patient's ongoing abnormal symptoms and seek timely medical review. Instead, they simply recorded a continued and significant deviation from the expected course of recovery until the patient was in a parlous state.

Concerns were also expressed about the standard of record-keeping. Observation times were not well documented, and not all entries included a signature. If additions or amendments to notes are required, the time, date, and signature of the writer must be included. Although the hospital's policy was reasonable, the consistent failure of staff to accurately record significant events, the time of such events, and the personnel involved, indicated that the policy was not satisfactorily complied with. By failing to ensure that staff implemented the policy, the hospital breached Right 4(2) of the Code.