Surgical Registrars / Crown Health Enterprise

Report on Opinion - Case 98HDC13087

Complaint

The Commissioner received a complaint from the complainant about the services provided to her father, the consumer, by the staff at a public hospital. The complaint is as follows:

- *The consumer was left for an unreasonable length of time from his presentation at a public hospital at 9.00pm on a day in early March 1998, until he went for surgery at 3.00pm the following day.*
- *The consumer was asked to sign a consent form sometime during the evening of the day after the surgery or the early hours of the morning, two days after the surgery, when he was incapable of doing so.*

Investigation

The Commissioner received the complaint on 20 March 1998 and an investigation was undertaken. Information was obtained from:

The Complainant	The Daughter of the Consumer
The Consumer	
Provider/Surgical Registrar one	
Provider/Surgical Registrar two	
Provider/Surgical Registrar three	
Provider/Surgical Registrar four	
Manager of Theatre Services	
Director of Theatre Services, Auckland Healthcare	

The consumer's medical records were obtained from the Crown Health Enterprise ("CHE").

Information Gathered During Investigation

At 9.00pm on the day before his surgery, the consumer was referred from an accident and medical clinic to a public hospital emergency department with suspected appendicitis. He was referred to the acute assessment ward for overnight observation. At 10.15pm the consumer was examined in the acute assessment ward. The examining doctor made a provisional diagnosis of appendicitis or cholecystitis.

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Information Gathered During Investigation, *continued*

Surgical registrar three started duty at 11.00pm that night and operated in theatre until approximately 1.30am the following day. When he finished operating, surgical registrar three went to the acute assessment ward to assess the consumer. His notes state: "*appendicitis needs appendectomy, theatre booked."* Intravenous fluids were begun and the consumer was given 2mg morphine and placed on "nil per mouth" in preparation for theatre. The booking sheet for the consumer's operation booking was not retained in his medical notes in line with the CHE's usual practice. The observations of the consumer were recorded at 3.00am and 6.15am.

At 7.50am, the consumer was examined by surgical registrar two who agreed with the diagnosis. Surgical registrar two advised the Commissioner that:

> "*There were no signs of peritionitis. I instructed my house surgeon to ensure* [the consumer] *was ready for theatre.*
>
> *Having completed my ward round I proceeded to the operating theatre to perform* [the consumer's] *operation. I was informed at this time that the theatre staff were currently involved in an urgent case, but that* [the consumer] *was the next case scheduled.*

Surgical registrar two continued with his ward rounds and understood that he would be notified by the theatre staff when the consumer arrived in theatre.

The consumer remained in the acute assessment ward. His observations were recorded by acute assessment ward nursing staff at 10.00am and 2.30pm, the latter recorded temperature 37.7, blood pressure160/90 and pulse rate 60. It is recorded that the consumer received morphine for pain at 2.30pm.

The consumer does not appear to have been reassessed by the surgical staff following his consultation with surgical registrar two in the acute assessment ward at 7.50am. The Commissioner was advised by the director of theatre services that surgical staff are often seeing other patients. They rely on the nursing staff to inform them of any deterioration in a patient's condition.

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Information Gathered During Investigation, *continued*

Surgical registrar two further advised that:

> "*As I was not notified by the theatre staff that* [the consumer] *had come to theatre for his operation, I made further inquiries at approximately* [3.00pm] *and was informed that an additional urgent case had been commenced prior to* [the consumer].
>
> *At approximately* [4.00pm] *the theatre staff informed me that* [the consumer] *was able to proceed to his operation*."

The public hospital daily operations record confirms that three operations were performed on that day in early March 1998 before the consumer was taken to theatre.

The CHE advised the Commissioner that there was one acute theatre operating that day and for some time an anaesthetist was not available as he was required in the department of critical care medicine ("DCC").

The director of theatre services advised that there were times when a theatre is not in use because an anaesthetist is not available, or is required elsewhere. In this case the anaesthetist was in DCC. It is not common that an anaesthetist is required to perform a tracheotomy but it does happen on occasion.

The records indicate that the consumer arrived in theatre at approximately 3.00pm and was reassessed by surgical registrar four and surgical registrar two. Surgical registrar two recorded:

> "[Patient] *pt now has generalised peritonism maximal right s/b* [Surgical registrar four] *n* [normal] *appendix* incision *and convert to laparotomy if reqd.*"

The consumer's operation note, signed by surgical registrar four, indicates that the consumer had a gangrenous appendix with thin pus in the abdominal cavity.

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Information Gathered During Investigation, *continued*

The consumer's post-operative pain was controlled by patient controlled analgesia ("PCA") morphine pump. His notes indicate that he was reluctant to use the PCA and needed encouragement. The consumer had intravenous fluids but there is no reference to wound drainage.

The day after his surgery, the consumer remained reluctant to use the morphine PCA analgesia. Paracetamol was added to his pain control regime. Physiotherapy started at 9.50am and was repeated at 3.00pm. Notes made by the physiotherapist record her concern at the consumer not using the PCA to adequately relieve his pain. He therefore seemed reluctant to move or breathe deeply enough to prevent the development of pneumonia.

Later that same day at 10.00pm, fluid continued to drain from the consumer's wound drainage tubes, and *intravenous haemaccell* and *plasmoloyte* were given. His wound drainage continued to cause concern. At 2.25pm on the following day, the consumer was reassessed by surgical registrar two who suspected that the consumer might need to return to theatre because of this bleeding. *Antibiotics cefoxitin* and *flagyl* were started.

The consumer's post-operative PCA pump contained a concentration of *morphine* 2mg/ml. His medical records indicate that one syringe (60mg *morphine*) began on the day of his surgery was not changed until two days later at 5.10pm.

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Information Gathered During Investigation, *continued*

Two days after the surgery at 9.40pm, the consumer was again reviewed by surgical registrar two, who estimated his blood loss in the last 48 hours as approximately one and half litres and 110ml in the last two hours. Surgical registrar four was notified and decided to take the consumer back to theatre to find the cause of his bleeding. Surgical registrar one advised the Commissioner that he was responsible for obtaining the consumer's consent to the operation. He spoke with the consumer about the need for further surgery. The consumer seemed annoyed at having to return to theatre, but asked surgical registrar one questions about the surgery. In surgical registrar one's opinion, the consumer understood the importance of, and need for, the operation, and signed separate consent forms for surgery, analgesia and anaesthetic. His signature is legible and compares favourably with his signature for surgery signed two days earlier. Although the consumer's analgesia was controlled with morphine, he did not appear to be drowsy. Observations were recorded regularly while he was receiving the morphine. At each observation his "*arousability*" was described as alert or rousable to voice. A blood transfusion was begun and the consumer was taken to theatre at approximately 3.45am the following day. The surgery was performed by surgical registrar four assisted by surgical registrar three. They reported finding clots in the abdominal cavity, but no active bleeding points were found.

The PCA pump was discontinued four days later at 11.45am. The consumer's condition slowly improved and he was discharged on a day in mid-March 1998.

The director of theatre services advised the Commissioner that the circumstances surrounding the consumer's delay in going to theatre was discussed at the surgical mortality/morbidity monthly meeting where theatre processes are reviewed. The theatre process has now been reviewed and a number of changes implemented. These changes include:

- Proactive communication between operating surgeon and the theatre co-ordinator is now encouraged. This has been identified as an on-going training issue.
- There is liberalised access in the early hours of the morning for theatre time in cases such as the consumer's.
- Revaluation of how long cases like this can be left.

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Information Gathered During Investigation, *continued*

- The creation of a position of an anaesthetic co-ordinator which takes the responsibility for prioritising and ordering of cases. This is particularly important when situations of competing priority may arise. Currently, the director of theatre services is taking that role.
- The appointment of a clinical director for theatre who is developing systems and processes for efficient management of cases.
- The development of computerised booking system for better tracking of cases, to provide a permanent record, and to provide an efficient management tool.
- Follow-up review of the consumer's case by the theatre committee which included a general review of systems in place at that time.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

…

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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Opinion: Breach the CHE

In my opinion the CHE breached Right 4(3) and Right 4(5) of the Code as follows:

The consumer went to the emergency department and transferred to the acute assessment ward at 10.15pm for overnight observations. Following examination by three doctors he was booked for surgical treatment. The consumer was not taken to theatre until approximately 3.00pm the following day. In the meantime three other cases were taken ahead of him. The decision to proceed with two of these surgical cases was made by the theatre staff without consultation with surgical registrar two and without clinical reassessment of the consumer. Given the length of time the consumer waited, it would have been reasonable that surgical registrar two was consulted regarding his patient's condition before the decision was made to take other emergency surgical cases.

Sometime during the day the consumer's appendix ruptured. His observation remained mildly elevated and in the early afternoon he was given pain relief. There is no other documentation of the consumer's care. It would have been reasonable for the nursing staff to ask either surgical registrar two or the theatre staff when the consumer would go to theatre. If this occurred there is no record of it, and in my opinion the consumer was forgotten until surgical registrar two again called the theatre staff sometime about 3.00pm to be told another surgical case was in progress. This delay contributed to the consumer's deterioration in his condition and the rupture of his appendix.

There was acknowledgement there had been a breakdown in communication between the theatre management, acute assessment ward nursing staff, surgical registrar two and the consumer. Theatre management personnel have introduced a number of changes into the system so that this situation is unlikely to happen again.

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Opinion: No Breach surgical registrar four

In my opinion surgical registrar four did not breach Right 4(3) or Right 4(5) of the Code. Surgical registrar four performed the original surgery at 3.00pm the day after the consumer was admitted to the public hospital. He had not seen the consumer prior to performing the surgery and was not involved in his care prior to that time.

Opinion: No Breach surgical registrar three

In my opinion surgical registrar three did not breach Right 4(3) or Right 4(5) of the Code. Surgical registrar three examined the consumer in the early hours of the morning after the consumer was admitted to the public hospital. He agreed that the consumer required an appendectomy. In his judgement, the consumer was in no immediate danger. Furthermore, surgical registrar three understood it was hospital policy that unless the patient's condition was life threatening, the case could wait until the morning list. Surgical registrar three was the rostered surgical registrar and did not have further contact with the consumer until he was required to perform his second operation, three days after the consumer had been admitted to the public hospital.

Opinion: No Breach surgical registrar two

In my opinion surgical registrar two did not breach Right 4(3) and Right 4(5) of the Code. Surgical registrar two examined the consumer on the morning of his surgery. He ensured that the consumer was placed on the waiting list and relied on the theatre staff to inform him of the consumer's arrival in theatre. He checked with theatre periodically through the day, but was informed that two other emergency cases had been placed ahead of the consumer. Surgical registrar two was not notified of any deterioration in the consumer's condition by the nursing staff in the acute assessment ward. In my opinion it was reasonable for surgical registrar two to rely on nursing staff for this information. Furthermore, it was reasonable for surgical registrar two to be consulted about his patient's condition before the theatre staff took other cases ahead of the consumer.

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Opinion: No Breach surgical registrar one

In my opinion surgical registrar one did not breach Right 4(3) and Right 4(5) of the Code. Surgical registrar one was responsible for gaining consent from the consumer for his second operation. The consumer was on a PCA pump containing morphine. Although morphine can produce drowsiness in some circumstances, the amount of morphine the consumer was receiving was minimal. The consumer's observation confirms this. The consumer spoke with surgical registrar one and in my opinion was capable of understanding the need for surgery, and capable of signing his consent form.

Actions

I recommend that the CHE write a letter of apology to the consumer for their breach of the Code. This letter is to be forwarded to the Commissioner's office where it will be sent to the consumer.

As the CHE has introduced systems to ensure that incidents such as this are less likely to happen in the future I propose to take no further action in this matter.