Recognition of deteriorating patient post-surgery (10HDC00419, 10 June 2013)

Public hospital ~ District Health Board ~ Orthopaedic surgery ~ Postoperative monitoring and assessment ~ Co-morbidities ~ Communication between staff ~ Deterioration ~ Documentation ~ Standard of care ~ Rights 4(1), 4(4), 4(5)

A 75-year-old man was assessed as being fit to undergo elective surgery to replace his right knee joint. However, he was advised that, because of his serious co-morbidities, there was a significant risk he could die during surgery or post-operatively. The surgery proceeded without incident and the man was well in the immediate postoperative period. However, by the afternoon of the second postoperative day, the man's urine output and blood pressure began to decrease. This was recorded in the notes by the nursing team but was not communicated to the orthopaedic team.

In the early hours of the third postoperative day, the nursing team had concerns about the man's decreased urine output and decided not to remove his catheter. However, that information was not noted by the nursing team or the orthopaedic team on the next shift and the man's catheter was removed. At that time, a nurse also incorrectly recorded that the man had passed a total of 935mls of urine since 1am, instead of 435mls. Throughout the third postoperative day, the man's blood pressure remained low and he did not pass any further urine. Bladder scans were carried out at 2:30pm and 11pm, and the man was given saline at 8pm. However no further action was taken to address these concerns.

The night shift doctor and nurse do not recall being alerted to any concerns about the man at handover on the evening of the third postoperative day. Nothing was recorded in the notes about the man's urine output during that evening shift. On the morning of the fourth postoperative day, it was noted that the man had not passed urine since the removal of his catheter the previous morning and attempts were made to treat his deteriorating condition. However, the man died in the early hours of the fifth postoperative day, following a cardiac and respiratory arrest.

On the third postoperative day, when the man's urine output decreased and his blood pressure dropped, he should have been referred for specialist medical review. A combination of poor documentation and poor communication led to the failure by both the orthopaedic team and the nursing team to fully recognise the man's deteriorating condition. In addition, critical information about the man that was available to both teams was not adequately accessed and used.

The failures of the orthopaedic and nursing teams were service failures and are directly attributable to the DHB. The DHB breached Right 4(1) for failing to provide the man with services with reasonable care and skill, and Right 4(5) for poor communication, inadequate documentation, and the widespread failure by the nursing team to consistently comply with relevant procedures.

The orthopaedic team's failure to communicate to the nursing team that particular attention needed to be given to the man in the postoperative period given his co-morbidities, resulted in a lost opportunity to ensure the man was monitored closely, and increased the risk of harm to the man. Accordingly, the DHB also breached Right 4(4).