Southern District Health Board

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC01234)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report relates to the failure to return a patient's tonsils following surgery at a public hospital.

2. On admission, the day-surgery nurse documented on the Preoperative Checklist (MR12) form the woman's request to have her tonsils returned, and highlighted the request. The woman's request was also noted by a trainee anaesthetic technician who was under the supervision of a registered anaesthetic technician.

3. The hospital's process is that during "time out", the circulating nurse holds up the Consent Form for the surgeon to read, and each member of the team is asked whether there are any issues that need to be addressed. No issues were raised during "time out" regarding the return of the tonsils, and there was no space on the Consent Form to record a patient's wishes regarding the return of tissue.

4. The surgery took place without incident, and the woman was transferred to the recovery area. When she asked about the return of her tonsils, the tissue could not be found, despite a thorough search.

Findings

5. Right 7(9) of the Code provides that every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances that are removed or obtained in the course of a healthcare procedure. The Deputy Commissioner acknowledged the significant personal and cultural importance of the matter for the woman, and considered that her wishes should have been respected. Accordingly, the Deputy Commissioner found that Southern District Health Board (DHB) breached Right 7(9) of the Code.

6. The woman's request to have her body parts returned was a patient-specific concern that should have been communicated to the circulating nurse, and also identified during theatre "time out" as part of the surgical safety checklist process. The surgical team's failure to communicate and cooperate effectively that day was found to have been a breach of Right 4(5) of the Code.

Recommendations

7. The Deputy Commissioner recommended that Southern DHB:

   a) Revise its policy concerning patient requests for the return of body parts, to reduce the reliance on staff to pass on the information.

   b) Review its admission process to ensure that patients who wish to have body parts returned have that request brought to the attention of the surgeon prior to surgery.

   c) Undertake an audit of the use of Southern DHB's surgical safety checklist at the hospital.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her at Southern DHB. The following issue was identified for investigation:

- *Whether Southern DHB provided Ms A with an appropriate standard of care in 2019, including the return of body parts.*

9. This opinion is the decision of Deputy Commissioner Meenal Duggal, and is made in accordance with the power delegated to her by the Commissioner.

10. The following parties were directly involved in the investigation:

Ms A	Consumer/complainant
Southern DHB	Provider
RN B	Provider/registered nurse
RN C	Provider/registered nurse
RN D	Provider/registered nurse
RN E	Provider/registered nurse
Dr F	Provider/surgeon
Dr G	Provider/anaesthetist

11. Also mentioned in this report:

Ms H	Trainee anaesthetic technician
Ms I	Anaesthetic technician

Information gathered during investigation

Background

12. In 2019, Ms A, then aged in her twenties, was admitted to hospital for a routine tonsillectomy (removal of her tonsils). Ms A has Māori heritage, and requested that her tonsils be returned to her after they were removed from her body. This report considers the failure of Southern DHB to return Ms A's tonsils to her following her surgery, despite her documented wish to have them returned.

Expected process for return of body parts

13. Southern DHB stated that where a patient has requested the return of body parts, the expected process is as follows:

- The day-stay nurse has a discussion with the patient around Taonga Pounamu and return of body parts, to include what is expected if the tissue is required to be sent to the laboratory.

- The request to return the body part(s) is documented on the Preoperative Checklist (MR12 form) by the day-stay nurse.

- In the preoperative bay, a verbal handover is given by the day-stay nurse to the operating theatre staff member (this could be the anaesthetic technician or a theatre nurse) regarding the patient's wishes to have his or her specific body part(s) retained.

- Upon entering the operating room, the anaesthetic technician/theatre nurse informs the circulating nurse of the patient's wishes.

- At the "time out", the circulating nurse includes the request for return of the body part(s) with other relevant information provided to the team.

- At the conclusion of the operation, the circulating nurse places the particular body part(s) in a specimen jar and labels the jar and form for return to the patient.

- The body part(s) is/are sent to the laboratory to be prepared for safe return to the patient.

- The body part(s) is/are then sent to the relevant ward for the patient, or kept in the laboratory with instructions for the patient to collect.

Surgery

Sign-in

14. Ms A told HDC that the admitting nurse asked her whether she had any spiritual or cultural requests. Ms A said that she requested that her tonsils be returned to her after they had been removed from her body, and the nurse assured her that this was not a problem, and told her that the tonsils might get sent to histology first, but would be returned to her eventually.

15. Registered Nurse (RN) E stated that she was the day-surgery nurse on the day of the surgery. She said that as part of the process of admitting Ms A, she had a full discussion with Ms A regarding Taonga Pounamu and the return of her tonsil tissue. RN E stated that this included a discussion around the safe handling of the tissue and what to expect if the tissue needed to go to the laboratory. RN E said that she documented on the Preoperative Checklist (MR12) form the request to return the tonsils, and highlighted the request.

16. RN C stated that she was the scrub nurse in the operating theatre for Ms A's surgery. RN C said that the scrub nurse is not present for "sign-in" (the process when the patient is admitted).

17. RN C stated:

> "There is no specific part of the Pre-Operative Checklist form [MR12] or the Consent Form where the [Circulating] Nurse can note cultural consideration or return of body part — If this is an issue, I would expect that it would be noted in the 'Further comments' section."

18. At the time, Ms H, a trainee anaesthetic technician, was being supervised by a registered anaesthetic technician, Ms I. Ms H stated that she remembers introducing herself to Ms A and completing the Preoperative Checklist in the holding bay. Ms H recollects that Ms A wanted her tonsils to be returned, and that the information was highlighted in yellow on the MR12 form. Ms H stated that Ms A's patient notes and MR12 form were in the theatre during the operation.

Circulating nurse

19. RN B was the circulating nurse on the day of the surgery. She stated that at the time of the incident she had recently returned to Southern DHB to work as a registered nurse in the perioperative team, and was still within her three-month orientation period. She said that her orientation was mentorship only, with no specialist competency sign-off or direction to key perioperative policies. Southern DHB stated that previously RN B had been employed in the Perioperative Department of another hospital, and had prior knowledge of Ear Nose and Throat (ENT) procedures, so a mentorship was thought to be appropriate.

20. RN B said that on the day of the surgery, there were four operating theatres working at the hospital. She stated: "My recollection was that staffing levels were low across most theatres." She said that she and RN C, a newly orientated nurse, were the nursing staff in theatre four. RN B stated that as this was an ENT list with fast turnaround, her expectation would be that the theatre would have a minimum of three nurses, one of whom needed to be a senior nurse, because she and RN C were relatively new staff members. RN B said that RN C had told her that she had doubts about her confidence, and required reassurance relating to her development within the team. However, Southern DHB stated that RN C indicated that this was not the case.

21. RN B said that she raised her concerns about the staffing with her supervisors "on the day". Southern DHB stated that neither the co-ordinator in theatre nor the Associate Charge Manager can recall any concerns being raised with them.

22. Southern DHB said that at that time it had staff vacancies, and on the day of Ms A's surgery there was staff sickness. The DHB said that given the straightforward nature of the list, and that there was an anaesthetic technician and a trainee technician in theatre, "staffing in that theatre on the day was acceptable".

23. RN B recalls that Ms H and her supervisor, Ms I, completed pre-theatre checks by approximately 4.15pm. RN B stated:

> "I cannot recall if I was the second team member to check the identity and procedure, this can occur in the waiting bay or in OT before the anaesthetic occurs. At this time I was also out of the theatre in the set-up area assisting [RN C] [to] set up her surgical trolley and completing the surgical count."

Anaesthetic

24. Consultant anaesthetist Dr G told HDC that he anaesthetised Ms A. He said that he did not conduct her pre-assessment, and there was no mention on the pre-assessment form that she wanted her tonsils to be returned. He said that had he been aware of her wishes, he

would have made a note on the form. He does not recall any discussion in theatre about the return of the tonsils.

25. RN B said that she had a ten-minute break, and when she returned to the operating theatre, Ms A had been brought in and anaesthetised. RN B stated that after completing the pre-surgical count in the set-up area, she entered the operating theatre to ensure that it was set up for the procedure, and RN C also entered the theatre.

26. RN C stated that when she entered the operating theatre, Ms A was already anaesthetised, and the anaesthetic technician, circulating nurse, and surgeon were present. The draping for the sterile field had been done, and the "time-out" procedure had been conducted. Ms I does not recall these events, but agrees that she was in the operating theatre, as her writing is on the "operation data form".

Time out

27. RN B stated that "time out" would have been initiated by the surgeon, Dr F, when all the team was present. She said that the procedure was that the surgeon would read from the Consent Form. She has no recollection of the return of tonsils being discussed during "time out". She said that when return of body parts was discussed, her normal process was to record the request on the specimen form. However, as she had not been made aware that the tonsils were to be returned, she did not complete a specimen form.

28. RN C stated that the process is that the circulating nurse holds up the Consent Form for the surgeon to read, and each member of the team is asked whether there are any issues that need to be addressed. During Ms A's "time-out" procedure, no issues were raised regarding the return of her tonsils.

29. Dr F stated that he does not recall Ms A's case, so he is unable to say whether he read the Preoperative Checklist prior to the surgery. In response to the provisional opinion, he said that the surgeon is shown only the Consent Form, and generally does not view the Preoperative Checklist prior to the surgery.

30. With regard to whether he was aware of Ms A's request to have her tonsils returned, he stated that they always "do the Preoperative Checklist before surgery", and normally during the preoperative "time out" it would be flagged that the patient wanted the tonsils returned. Dr F stated: "If I was aware that she wanted tissue returned I would have certainly checked with the nurses that that occurred. I can only assume that I wasn't made aware of that."

31. Southern DHB told HDC:

> "The expectation would be that throughout the pathway as staff were made aware of the patient's wishes it would be documented and highlighted on the document they were using."

32. However, the only documentation relating to the return of Ms A's tonsils is on the Preoperative Checklist, where "Requests return of Tonsils" is recorded under the "further comments" section.

Recovery

33. RN B stated that the surgery took place without incident, and she supported the anaesthetic team during extubation, and transferred Ms A to the recovery area. RN B said that because they were short staffed, she was asked to remain in the recovery area with Ms A until a recovery nurse was available. RN B remained with Ms A until approximately 6pm, when her shift ended.

34. RN E stated that at around 7.45pm, Ms A felt well enough to get up and get dressed, and asked where her tonsils were. RN E said that she looked under Ms A's pillow for a specimen jar, expecting to find them there, but when she could not see them she carefully stripped the bed searching for a container. She then contacted RN D, who was in the operating theatre, to tell him that the tonsils were missing.

35. RN D stated that he was working in the perioperative theatre unit as the senior nurse in charge that day. He said that when he arrived in the recovery area, he noticed that Ms A was crying and being consoled by a support person. RN E showed him Ms A's MR12 Preoperative Check sheet, and they both noted that Ms A's request that her tonsil tissue be returned was marked with yellow highlighter to make the request stand out. RN D stated: "[Ms A] was very upset (tearful) wanting to know why her tonsils were not given to her." He said that he told Ms A that he would check in the theatre area to see whether tonsil tissue had been left in the specimen container, check the theatre where the procedure took place, and go to the laboratory to see whether the tissue was on a histology shelf for fixing before being returned to her. However, nothing was found during the search for the tissue.

36. RN D said that he returned to the day-stay unit and informed Ms A that the tonsils could not be found, and suggested that they might have been discarded by the theatre staff. He advised Ms A that it was not possible to check the rubbish for the tonsils, as it would be difficult to identify any tissue found, and would pose potential injury for staff. He asked RN E to complete a Safety First form to identify the incident, and contacted the duty manager to advise her of the incident.

37. RN E stated that Ms A said that she knew that it was not the fault of RN D or RN E, and accepted that there was no way to say that any tissue found was actually hers. Ms A said that ending up with someone else's tonsils would be as bad as not having her own.

38. At 8.35pm, Ms A was discharged.

Subsequent events

39. RN E stated that she did not complete a Safety First form that night, because she did not finish work until 9pm and was on early shift the next day, and no physical injury had occurred. She said that the following day, she spoke to her Clinical Nurse Manager and was

told that as the incident happened in the operating theatre, they would handle any incident forms, and she was not required to do one.

40. Five days after the surgery, RN C completed a "Provision of Care Event" (Safety First) form. The form states that there was miscommunication between theatre staff, and under "Resolution and Outcomes" the form notes: "As a recommendation for improvement, that there be better communication and clear documentation by the staff involved."

Southern DHB policies

41. The "sign-in" section of the surgical safety checklist does not refer to any request for return of body parts. Similarly, there is no reference to any request to return body parts under the "time-out" section.

42. The Southern DHB policy, "Tikaka Best Practice — Removal of Body Parts" (District) (4 September 2017) states as a guiding principle:

> "Regardless of how minor the part/tissue or substance (e.g. nail clippings, hair, and blood) is perceived to be by staff, the following process will be followed. All discussions will be non-directive and follow an informed process."

43. The policy states that staff will document all discussions and decisions in the clinical notes, using the appropriate documentation, and that all body parts/tissue/substances will be returned when requested (if this does not involve a high risk to safety).

44. The "Return and Disposal of Body Parts and Bodily Substances" policy (1 September 2017) states that where practical, decisions relating to the return of body parts will be made with the individual prior to the clinical procedure being undertaken, as part of the informed consent process. When the decision to return the body parts is made, a Laboratory Request form must be completed. When this is to occur as part of a surgical procedure, the form must be visible in the front of the patient's healthcare record, and handed over to operating theatre staff by the attending healthcare professional. The request for the return of body parts should also be documented in the healthcare record.

Southern DHB — further information

45. Southern DHB stated that there is now a new process in the operating theatre suite, where each rubbish bag is labelled with the date, theatre number, and case number to easily identify the bag from each patient in the event that something has been disposed of inadvertently.

46. Southern DHB said that it is "looking at introducing a second checklist which will include a routine check for all patients to determine if they wish to have body parts returned to them".

47. Southern DHB has made further reference to Taonga Pounamu, return of body parts, in the Orientation Manual.

48. A senior corporate executive stated:

> "Please could you pass on my apologies to [Ms A] again for this incident. As you can see we have made some improvements to our processes to minimise the risk of this happening to other patients."

Responses to provisional opinion

49. Responses were received from Southern DHB, RN C, and Dr F, and have been incorporated into the "information gathered" section of the report where relevant.

50. Dr F stated that when the incident occurred, he was doing a locum at Southern DHB. He works full time at another DHB, where the surgical consent form contains a question asking patients whether they want tissue to be returned. He noted that the Southern DHB form does not have such a question, nor does the Preoperative Checklist. He said that the Preoperative Checklist was "more a checklist for the theatre nurses".

51. Dr F stated that on the day of surgery he always speaks to the patient in the preoperative waiting area, but generally this is not documented. He said that if Ms A had informed him that she wanted her tonsils to be returned, he would not have forgotten this so soon before her surgery.

52. Dr F stated that to avoid such a failure in future, on the day of surgery he will ask the patient himself whether he or she would like tissue to be returned, "as one cannot always rely on other team members".

53. Southern DHB stated that it is close to introducing a new consent form, which includes a section on the return of tissue.

54. Ms A stated that she does not recall speaking to Dr F in the preoperative waiting area. She said that she is glad to hear that changes have been made as a result of her experiences, but she remains disappointed that she had to lose her tonsils for these changes to be made.

Opinion: Southern District Health Board — breach

Introduction

55. Ms A was admitted as a day-stay patient for what was expected to be a routine tonsillectomy. She made it clear at "sign-in" that she wished to have her tonsils returned to her after they had been removed from her body. RN E documented the request to return the tonsils on the Preoperative Checklist (MR12) form, and highlighted the request. However, the tonsils were discarded after the surgery.

Process undertaken

56. RN E appropriately discussed Taonga Pounamu and return of body parts with Ms A, documented the request on the MR12 form, and highlighted the information. Ms A was also seen by the trainee anaesthetic technician, Ms H (supervised by Ms I), who noted the information regarding return of the tonsils on the MR12 form.

57. The next step of the process was that Ms H or Ms I should have informed the circulating nurse, RN B, about the patient's wishes. However, that did not occur. Neither Ms H nor Ms I took steps either to inform RN B or to raise the matter of the return of the tonsils during "time out".

58. RN B said that she and RN C, who were both new staff, were the only nurses working in that operating theatre, and as RN C required reassurance, she (RN B) went to assist RN C to set up her surgical trolley and complete the surgical count. RN B said that she was never told about Ms A's wish to have her tonsils returned. As a result, during "time out" she was not in a position to inform the team about Ms A's wishes. I am critical that the operating theatre was staffed by two nurses who were relatively new in their roles and, as a consequence, RN B was assisting RN C and did not receive handover of the necessary information.

59. In my view, Ms A's request to have her tonsils returned was a matter that needed to be raised during the theatre "time out", as part of the Surgical Safety Checklist process. The Checklist requires members of the surgical team to identify "any patient specific concerns". I consider that Ms A's request was a "patient-specific concern" that should have been identified at that stage.

60. Southern DHB needed to have in place a more effective system to ensure that Ms A's request to have her body parts returned was brought to the attention of the relevant staff. RN C stated that the process was that during "time out", the circulating nurse would hold up the Consent Form for the surgeon to read. Dr F does not recall whether he read the Preoperative Checklist prior to the surgery. He said: "If I was aware that she wanted tissue returned I would have certainly checked with the nurses that that occurred. I can only assume that I wasn't made aware of that." In response to the provisional opinion, he stated that he did not read the Preoperative Checklist, and it was "more a checklist for the theatre nurses".

61. There is no evidence that Ms A's request was flagged to the surgical team or any other staff. Ms H (and possibly Ms I) appear to have been the only members of the team present in the operating theatre who were aware of the request, and I am critical that neither of them spoke up during "time out". I consider that this reflects an unsatisfactory culture at the DHB at the time. This was a missed opportunity to ensure that Ms A's request to have her tonsils returned was communicated to the other clinicians in the operating theatre. Without such communication, what should have occurred did not.

62. As this Office has stated previously, "[c]ommunication of information to the right person at the right time is critical to safe care".[1] DHBs must have clear, robust processes that support the timely communication of relevant information. Southern DHB did not have in place an effective system to ensure that all members of the clinical team were alerted to significant information regarding Ms A. The process relied on the anaesthetic technician or day-stay nurse telling the circulating nurse, who then would raise the matter with the surgeon, or alternatively the surgeon having noticed the annotation on the MR12 form.

63. Right 7(9) of the Code provides that every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances that are removed or obtained in the course of a healthcare procedure. This was clearly a significant personal and cultural matter for Ms A, and it goes without saying that her wishes should have been respected and, accordingly, there was a breach of Right 7(9) of the Code.

64. In my view, Ms A's request to have her body parts returned was a matter that needed to be communicated to RN B and also raised during theatre "time out" as part of the surgical safety checklist process, as a patient-specific concern that should have been identified at that stage. In these circumstances, I consider that there was a failure in effective communication and cooperation by the surgical team that day, and accordingly a breach of Right 4(5) of the Code.

Opinion: Dr F — other comment

65. There is no evidence that Dr F met Ms A prior to the surgery; however, in response to the provisional opinion he said that he would have spoken to her in the preoperative waiting area. He said that generally such meetings are not documented, but that if Ms A had told him that she wanted her tonsils to be returned, he would not have forgotten that. In contrast, Ms A does not recall having spoken to Dr F. Given the lack of records, I am unable to make a finding as to whether Dr F spoke to Ms A prior to the surgery.

66. Despite this, I remain of the view that it is reasonable for a patient to expect that the information provided to a nurse would be passed on to the relevant clinicians. In my view, Dr F needed to read Ms A's notes to the extent necessary to satisfy himself that he had all of the information that he, as the operating surgeon, needed to know.

67. Dr F was unable to recall whether he read the Preoperative Checklist prior to the surgery. In response to the provisional opinion, he said that the surgeon is shown only the Consent Form, and generally does not view the Preoperative Checklist prior to the surgery. He stated that his experience has been that one of the theatre nurses would inform him in theatre if the patient had requested that tissue be returned.

[1] Opinion 09HDC01505, page 23. Opinion 11HDC00531, page 29.

68. Dr F initiated "time out" once all the team was present. RN C stated that the process "during time-out" was that the circulating nurse held up the Consent Form for the surgeon to read.

69. In my view, it is evident that Dr F did not read the Preoperative Checklist, as he did not note the reference to Ms A's request to have her tonsils returned, despite the information being highlighted. I acknowledge that Dr F was a locum, and the practice at his DHB was that such information is recorded on the Consent Form rather than the Preoperative Checklist.

70. As noted above, I have found that there was a breakdown in communication within the surgical team.

Recommendations

71. I recommend that Southern DHB provide Ms A with a written apology for its breaches of the Code. The apology is to be sent to HDC within three weeks of the date of issue of this report, for forwarding.

72. I recommend that within three months of the date of this report, Southern DHB:

a) Revise its policy where a patient has requested return of body parts, to reduce the reliance on staff passing the information from one to another, and provide HDC with a copy of its revised policy.

b) Review its admission process to ensure that patients who wish to have body parts returned have that request brought to the attention of the surgeon prior to surgery.

c) Undertake an audit of the use of Southern DHB's surgical safety checklist at the hospital, and report back to HDC.

Follow-up actions

73. A copy of this report with details identifying the parties removed, except Southern DHB, will be sent to the Royal Australasian College of Surgeons, the Central Technical Advisory Service, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.