Delay in orthopaedic surgery and inadequate post-operative care
14HDC01215, 17 August 2017

District health board ~ Orthopaedic surgeon ~ Orthopaedic surgery ~ Delay ~ Deterioration ~ Right 4(1)

A 78-year-old man was admitted to the emergency department at a public hospital on a Friday morning, following a fall at his home. On arrival, he was diagnosed with a displaced left neck of femur fracture. The man had a clinical history including a pre-existing problem of emphysema with alpha 1 antitrypsin deficiency (A1AD).

The man was admitted to the orthopaedic service that afternoon under the care of a consultant orthopaedic surgeon. The surgeon decided that an acute total hip joint replacement was appropriate. He anticipated that the man would have surgery later that morning. At 6pm, the surgeon finished his period on call. A second consultant orthopaedic surgeon then commenced his weekend call.

At 8am on Saturday, the second surgeon decided that it would be preferable to wait until Monday to perform the hip replacement. The first surgeon said that the decision to defer was in part because of the higher acuity of other patients awaiting surgery. The second surgeon did not dictate a note recording his decision to delay, however he stated that the medical and nursing staff present were aware of the decision, and that the first surgeon had dictated a note to the man's GP. The man's care was returned to the admitting first surgeon after the weekend. The second surgeon was not rostered on for Monday.

Late on Monday morning, and then again at 3pm, it was noted that the man was still awaiting theatre. In the early evening of the same day, the man was then told that surgery would not proceed that day. The man had his left total hip joint replacement surgery on Tuesday evening — four days post-admission. This was over double the optimal time frame (up to 48 hours) for such acute surgery.

On Wednesday morning, the man showed signs of deterioration. He did not make any sustained improvement, despite fluid resuscitation, and then deteriorated further.

The DHB utilises an observation chart scoring system to help identify adult patients at risk of deterioration. It also has a policy which states that senior medical officers (SMOs) should be contacted when a patient under their care deteriorates suddenly. The score for the man increased on the Wednesday afternoon and evening, and a nursing entry the following morning indicated that the score overnight had fluctuated. While the man experienced a period of improvement in his observations during the day on Thursday, he had deteriorated again by 7pm. Despite the man's deterioration, while an orthopaedic registrar and a medical registrar were contacted at different times, SMO assistance was not sought.

At 10.30pm, the man had increasing shortness of breath, ongoing hypotension, and poor urinary output. The man's care was escalated to intensive care staff and then later to the high dependency unit. He continued to receive treatment, but his

condition deteriorated over time. The man was placed on a palliative care pathway and, sadly, he died.

Findings summary
The man's case highlighted the following key deficiencies in the care provided by the DHB:

- A delay in undergoing total hip joint replacement surgery of over double the optimal time frame for such acute surgery.
- Inadequate postoperative care, particularly a failure to escalate to an SMO appropriately when the man deteriorated. This was contrary to DHB policy.

For the above reasons, it was found that the DHB did not provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

There was some criticism that the second surgeon did not himself document his rationale for the delay in surgery.

Recommendations
The Commissioner recommended that the DHB report to HDC on the effect of the key changes it had made to its services on acute orthopaedic waiting times and quality of patient care. Those changes included dedicated orthopaedic operating theatres, an acute escalation process, orthopaedic service subspecialising, and an integrated orthogeriatric service.

The Commissioner also recommended that the DHB conduct a scheduled audit of the standard of care provided to acute patients who have presented with a hip fracture, based on the Australian and New Zealand Guideline for Hip Fracture Care, and provide evidence of an up-to-date audit of staff compliance with the application of DHB policy, including the recognition of the deteriorating patient and the escalation of care to senior staff.

The Commissioner also recommended that the DHB provide a written apology to the man's family.