Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Lack of communication between treating clinicians and failure to review clinical history prior to surgery
20HDC00176

The Health and Disability Commissioner has found Te Whatu Ora Nelson Marlborough, and a general surgeon, breached the Code of Health and Disability Services Consumers' Rights (the Code) in their care of a man in his sixties.

The man underwent an acute colonoscopy to investigate gastrointestinal bleeding. During the procedure he suffered a peri-respiratory arrest and had to be intubated. It was later discovered he had suffered a perforation to his colon, and he subsequently passed away.

Morag McDowell found Te Whatu Ora Nelson Marlborough (formerly Nelson Marlborough DHB) breached Right 4(5) of the Code which states consumers have the right to co-operation among providers, to ensure quality and continuity of services.

Her decision also found the surgeon breached Right 4(1) of the Code which gives consumers the right to have services provided with reasonable care and skill.

The patient had several co-morbidities including a prior pneumonectomy (lung removal) to treat lung cancer. This history was relevant in guiding clinical decision making. However, the surgeon was not fully aware of the patient's medical history at the time the colonoscopy was performed.

Ms McDowell concluded that Te Whatu Ora Nelson Marlborough did not communicate effectively to ensure the coordination of the man's care. In particular, there was no nurse-to-nurse handover from the ward to the endoscopy suite and the endoscopy team was unaware of the man's prior pneumonectomy until serious difficulties were encountered.

Oversights around communication and handover of care meant the endoscopy team were not able to consider the implications that the pneumonectomy might have on the sedation dose chosen and removed the opportunity for a different approach to the patient's sedation and procedure.

Ms McDowell says, "Where multiple clinicians and teams are involved in a patient's treatment, particularly a patient with significant co-morbidities, robust and open communication is the cornerstone of providing safe and effective care."

"While individual staff members hold some degree of responsibility for their failings, I consider that the deficiencies outlined indicate a service level communication breakdown at Te Whatu Ora Nelson Marlborough, for which it bears responsibility at an organisational level," Ms McDowell said.

Ms McDowell found the surgeon in breach of the Code for failing to review the man's clinical notes prior to the procedure.

"As this Office has stated previously, the onus is on the clinician to ask the relevant questions, examine the patient and keep proper records," said Ms McDowell.

Ms McDowell made a number of recommendations including for Te Whatu Ora Nelson Marlborough and the surgeon to provide written apologies to the patient's whānau.

However, she also acknowledged that significant and useful internal recommendations have already been undertaken by Te Whatu Ora and the surgeon as a result of their own review of these events. These changes include:

- Amending the booking process so that acute endoscopies are ordinarily performed by the general surgery service in the operating theatre.
- Providing an appropriate pathway for anaesthetist-led sedation for patients with multiple co-morbidities who have an urgent need for a colonoscopy.
- Reviewing the safety check list used prior to procedures and including a section to highlight relevant co-morbidities and patients' capacity to give informed consent.
- Implementing an "Introduction, Situation, Background, Assessment and Recommendation" (ISBAR) guided handover policy (for ward nurse to endoscopy nurse handover).
- Updating the "Transfer of Patients to and from Operating Theatre" policy to clarify that patients transferring from the ward to the endoscopy unit require a nurse escort.
- Reviewing and updating the "Serious Adverse Event Review" policy with a flow chart detailing staff responsibilities.

20 March 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendations.

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