Continuity of services
17HDC00893, 14 June 2019

District health board ~ Surgery ~ Complications ~ Delay ~ Rights 4(1), 4(5)

A 78-year-old man was admitted to a public hospital having sustained a laceration to his right lower leg and other wounds and abrasions following a fall. His regular medications included dabigatran (an anticoagulant).The man had surgery to clean and close his wounds under the orthopaedics team. He was discharged from hospital and seen by district nurses at home.

Two weeks after the surgery the man was readmitted to the public hospital under the orthopaedics team, with cellulitis and a haematoma in his calf. His dabigatran was withheld pending anticipated further surgery, and he then received Clexane injections. The man did not have a clearly documented VTE risk assessment during his admission.

The man was identified as requiring debridement and skin grafting early in his admission, but there was no clearly documented plan setting out whether the orthopaedics team or the plastic surgery team would be undertaking these procedures. Accordingly, there was a delay in undertaking surgery.

Sadly, the man became non-responsive during surgery, and he died. He was found to have had a large right middle cerebral artery infarction.

Findings
The man did not receive quality and continuity of services because of the failures in communication and a lack of clear planning between the orthopaedics and plastic surgery teams. Accordingly, it was held that the district health board breached Right 4(5). These communication and planning failures led to a delay in undertaking surgery. In these circumstances, it was also found that the DHB breached Right 4(1) for failing to provide services with reasonable care and skill.

The Commissioner was critical that the orthopaedics team did not initiate Clexane treatment earlier, and considered that it would have been useful for the documentation of the decision-making in relation to the man's anticoagulation to have been more explicit.

Recommendations
It was recommended that the DHB (a) update its policy on clinical documentation; (b) consider implementing policies outlining when a patient should become a plastic surgery patient and when to undertake patient transfers between teams via the teams' consultants; (c) reiterate to its plastic surgery and orthopaedics staff the need to document communication pathways accurately; (d) provide an update to HDC on the efficacy of its venous thromboembolism (VTE) prevention pathway; and (e) provide a written apology to the man's family.