Complications following insertion of suprapubic urinary catheter (07HDC15291, 17 October 2008)

Public hospital ~ District health board ~ Surgical registrar ~ Tetraplegic ~ Suprapubic catheter ~ Responsibility of on-call consultant ~ Rights 4(1), 4(5)

A woman complained about the care provided to her husband by a public hospital. The man, who had tetraplegia, had a permanent suprapubic urinary catheter, which he managed with the assistance of community nursing staff.

On one occasion, when the catheter required changing, the man's nursing staff were unable to replace it. He presented at a public hospital's Emergency Department, and attempts were made to introduce a suprapubic catheter, but this proved difficult. Eventually, the on-call surgical registrar inserted the catheter, and the man was admitted to hospital to be observed. Two days later, his condition rapidly deteriorated. He was subsequently admitted to intensive care, but he died later that day.

It was held that it was inappropriate to make continued attempts to introduce the suprapubic catheter once initial attempts had failed. It was also unsatisfactory that the surgical registrar continued with the attempts to introduce the suprapubic catheter despite having no previous experience of performing the procedure for a patient with tetraplegia. While individual members of staff must consider their own practice in light of this case, the clinical team as a whole let the man down. In these circumstances, the public hospital breached Right 4(1).

When urology specialist advice was required, it could not be obtained from a registrar, and the on-call urologist was operating off-site in a private facility. The request for advice and the response were relayed through a third party. Specialist advice was required, but for all practical purposes it was unavailable, with no urology registrar on duty, and the on-call urology consultant operating in another hospital. The registrar's absence was known to the public hospital, and the public hospital condoned the practice that resulted in the consultant's absence. It was held that the clinicians did not work together effectively to provide good quality care. Accordingly, the public hospital breached Right 4(5).