

Management of laparoscopic hernia repair (13HDC00478, 1 May 2015)

*General surgeon ~ Public hospital ~ District health board ~ Hernia ~ Patient history
Documentation ~ Handover ~ Postoperative decline ~ Discharge ~ Rights 4(1), 4(2)*

A woman in her late twenties experienced discharge from the site of an incisional hernia that had developed after a Caesarean section, and the woman's GP referred her to a regional public hospital.

The woman saw a consultant general surgeon at a surgical outpatient clinic. The surgeon considered that the hernia should be repaired. The resulting clinic letter made reference to the woman having a hernia as an infant, but did not refer to the woman's full clinical history, which included her being born with a condition requiring significant abdominal surgery. The woman underwent laparoscopic abdominal wall hernia repair with mesh surgery under the care of the surgeon, who experienced some difficulty with adhesions during the surgery. The difficulty was not reflected in the surgeon's operation report, the operation note, or in the progress notes.

The following day, a usual Friday morning ward round did not go ahead because it was a public holiday weekend. A second general surgeon was the surgeon on call over the holiday weekend, and was responsible for the woman's care during that time. The woman's postoperative progress declined over the holiday weekend. The second surgeon was initially suspicious of infection and ordered an urgent CT scan. The scan could not go ahead as the hospital's CT scanner was not working, and an urgent ultrasound was performed instead, which revealed a collection of fluid superficial to the hernia repair. The second surgeon then considered diagnoses of wound haematoma, postoperative ileus, atelectasis, and chest infection.

Later that weekend the second surgeon requested that the woman be transferred to the HDU/ICU for monitoring. She responded well to intravenous antibiotics and fluids in the ICU, and was transferred back to the ward the next morning. The woman went back under the care of the first surgeon. Despite the woman's complaints of abdominal pain overnight, a low grade temperature, difficulty mobilising, and faecal ooze from her wound, the surgeon discharged her home. She had a painful taxi trip, and said that bowel fluid came out of her wound.

The woman was readmitted to hospital three days later under the surgeon's care owing to abdominal pain and discharge. A CT scan showed that the woman had developed a fistula. She was taken to theatre for repair of the fistula by the first surgeon. A third general surgeon assisted. A further CT scan was performed, which identified multiple intra-abdominal collections.

Over the weekend of her second admission the third surgeon reviewed the woman, and provided care for her persistent fluid collections.

The first surgeon's pre-operative review of the woman was substandard, as he did not review her full relevant clinical history. It was also not appropriate for the surgeon to discharge the woman following her first admission when she had an appearance of bowel fluid from her wound. It was held that the first surgeon failed to provide services with reasonable care and skill and breached Right 4(1). The first surgeon also

failed in his obligations to keep clear and accurate clinical records and breached Right 4(2).

The second and third surgeons' postoperative care was deemed reasonable in the circumstances and, consequently, neither was found in breach of the Code.

The district health board was criticised because the system that was in place at the public hospital for handing over care on a weekend had not been carried over to public holidays. The woman's handover on Friday was affected, and was a contributing factor in suboptimal co-operation and continuity of services.