

**Care of patient with deteriorating vascular condition  
(07HDC14839, 18 June 2008)**

*Surgical registrar ~ Vascular surgeon ~ Public hospital ~ District health board ~ Deterioration ~ Family communication ~ Warfarin ~ Consultant review ~ Documentation ~ Rights 4(1), 4(2) 4(3), 4(5)*

A woman complained about the care provided to her father at a public hospital (the DHB). The man was not reviewed in person either by the consultant surgeon or the specialist vascular surgeon for over 90 hours following his admission. He was monitored by a surgical registrar. By the time he was reviewed by a vascular surgeon, his condition had deteriorated and, despite surgery, he died.

It was held that, in many respects, the man received a good standard of care. He suffered from a number of serious illnesses that made his care complex and challenging.

However, the surgical registrar's failure to document his review did not meet professional standards, and may well have jeopardised the subsequent care provided to the man as it deprived other clinical staff of important information. It is an important professional responsibility to keep clear, accurate, and contemporaneous patient records. This was a serious omission and a breach of Right 4(2). The registrar should have contacted the responsible consultant following his review of the man, who was suffering from a vascular surgery emergency that required the support and advice of a consultant surgeon. By not doing so, he failed to co-operate with other clinicians to ensure quality and continuity of services, and therefore breached Right 4(5).

It was also held that the DHB did not fulfil its duty of care in relation to this patient. The hospital's cover arrangements for vascular surgery did not work properly, and the man did not receive services in a manner consistent with his needs. Medical staff did not work together effectively to ensure quality and continuity of services. Accordingly, the DHB breached Rights 4(1), 4(3) and 4(5).