Dislodgement of T-tube during postoperative period (07HDC19531, 30 March 2010)

General surgeons ~ District health board ~ Public hospital ~ Gallstones ~ Cholecystectomy ~ T-tube ~ Postoperative management ~ Communication ~ Rights 4(1), 4(2), 4(5)

An 85-year-old man underwent a cholecystectomy. The surgeon intended that a tube in the bile duct (called a T-tube) be left in place for a month after surgery. However, on the evening prior to the man's discharge home, it was discovered that the tube had accidentally become dislodged. The nurse caring for the man asked another surgeon for advice, as he was in the ward reviewing another patient, although not on call. This surgeon advised the nurse to cover the hole from which the tube had been dislodged, and then attempted unsuccessfully to contact the man's surgeon through the hospital switchboard. He advised the nurse to inform the surgical team caring for the man. The nurse noted in the progress notes that the tube had been dislodged, but neither the operating surgeon nor his surgical team noticed this, and the man was discharged home the following day.

Over the next few days at home, the man's condition deteriorated. He was readmitted to hospital with abdominal pain. His surgical wound had also broken down, and he was generally unwell. Treatment was commenced for a wound infection and possible bowel obstruction. Eventually, the man was taken back to theatre for a further operation. Unfortunately, his condition did not improve, and he died a few days later.

It was held that the first surgeon failed to provide an appropriate standard of postoperative care in the following respects: (1) the instructions regarding the management of the T-tube were inadequate. There was no specific management plan or guidance to the hospital staff or the community nurses on discharge; (2) the medical reviews were inadequate and failed to identify the emerging wound dehiscence and dislodgement of the T-tube for nine days; and (3) his documentation was deficient. The surgeon did not manage the man's postoperative care appropriately and breached Rights 4(1) and 4(2).

It was also held that the man did not receive the "co-operation among providers to ensure quality and continuity of services" to which he was entitled. The second surgeon's communication failure amounted to a breach of Right 4(5).

The care of patients should never be jeopardised because of dysfunctional working relationships and communication difficulties. The unsatisfactory care and communication at the hospital supports a finding that the DHB breached Rights 4(1) and 4(5).