Surgical Registrars / Crown Health Enterprise

Report on Opinion - Case 97HDC7172

Complaint

The Accident Rehabilitation and Compensation Insurance Corporation ("ARCIC") Medical Misadventure Unit complained to the Commissioner concerning the standard of care a consumer received from a Crown Health Enterprise over a period of weeks from early August 1996 to late September 1996. The complaint is as follows:

- *In early August 1996, the consumer presented to an accident and medical centre with a swelling of the right buttock. The consumer was referred to hospital where the swelling was incised and drained. He was referred to the district nursing service for on-going wound care and dressing.*
- *Gauze used to dress the wound was not that which was recommended. This resulted in the consumer attending the hospital on two separate occasions for the surgical removal of retained wound packing.*

Investigation

The complaint was received by the Commissioner on 8 July 1997. After reviewing the consumer's clinical records, the Commissioner decided to widen the investigation to determine whether it was appropriate:

- *To discharge the consumer to district nursing care.*
- *To continue care on an outpatient basis following removal of gauze ten days later.*
- *To continue care on an outpatient basis following removal of gauze.*

An investigation was undertaken and information obtained from:

The Consumer
The second Surgical Registrar/Provider
The first Surgical Registrar/Provider
Customer services representative, the Crown Health Enterprise

The consumer's clinical records from the Crown Health Enterprise and a second Crown Health Enterprise were obtained and considered. The Commissioner also obtained documents from the ARCIC. ACC accepted the claim on the basis of medical error, due to a failure by a registered health professional(s) to observe a standard of care and skill that was reasonable in the circumstances.

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Outcome of Investigation

The consumer is paraplegic as a result of a motor vehicle accident in 1987. One year after this accident he fell out of his chair and sustained a right femoral fracture, resulting in the insertion of a femoral nail.

In early August 1996 the consumer presented to an accident and medical clinic with a 10cm x 5cm swelling of the right buttock which was mobile, fluctuate and well demarcated. The clinical impression was of infection and he was referred to hospital.

At the hospital the lump on the right buttock was incised and drained by the first surgical registrar. A Penrose drain was sutured in the wound and the surgical registrar prescribed a course of oral antibiotics. An appointment was made for five days time for removal of the drain and the consumer was also referred to the district nursing service for wound dressing.

After five days the consumer returned to the hospital's surgical outpatients clinic. Daily visits by district nursing continued. The first surgical registrar noted that the consumer felt well and the wound drainage had dramatically decreased. The Penrose drain was removed and the consumer was discharged from the clinic. No further instructions to district nursing services were made. The first surgical registrar's notes do not appear to have been copied to any other person.

Daily visits from district nursing services continued. Eight days after the initial presentation to the clinic the wound was probed and was approximately 2.5 inches deep with a large haemoserous ooze. The wound was irrigated with a syringe and catheter, and was lightly packed with 0.5 x 6 inch ribbon gauze. The next day the packing could not be found. The cavity was probed with sinus forceps. The notes record *"girlfriend changed dressing in am… no packing seen – we saw dressing removed… no packing present. For review in am – may need an x-ray to check if packing is in wound."*

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Outcome of Investigation, *continued*

The district nurse visited the consumer the following morning for review. The nurse contacted the hospital assessment ward to arrange an appointment for the consumer to be seen by the surgical team. The consumer attended the hospital at 1.15pm and was seen by the surgical registrar who was unable to find the lost packing in the wound. The consumer was asked to return to the hospital the following morning for further exploratory surgery. While nursing notes record the consumer's attendance at the hospital there is no record made by the surgical registrar.

Eleven days after the first presentation, the consumer returned to surgical outpatients clinic for removal of ribbon gauze which was performed by the second surgical registrar. The packing material was changed and the consumer was returned to district nursing care the same day. There were no instructions given for continued wound management and it is not clear whether the district nurses received any information directly from the second surgical registrar. The second surgical registrar advised the Commissioner that he understood that the consumer had a dislike of hospitals and did not want to remain at the hospital. The consumer preferred to maintain his independence at home. It was agreed that the consumer would return home with continued assistance from the district nursing service. The consumer advised that Commissioner that his understanding was that he would not receive a different standard of care by returning home and that the district nurses would contact the most appropriate person if any additional input was required. No further follow-up arrangements were made. In mid-September the notes record "*Packing missing? Sucked deep into wound*". Again, this was removed at the hospital. The district nursing Care Plan records that a McFarlane Roll was considered to be more appropriate in the light of the problems experienced. There is no record of the action taken at the hospital.

In late September there was a difficult removal of the McFarlane packing which had been inserted by the consumer's partner. The last quarter was firmly packed into the wound and when ultimately removed by working the packing loose a 2-3 cm plate of bone came away.

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Outcome of Investigation, *continued*

The consumer was taken by ambulance to the emergency department and then transferred to a second hospital the next day.

A report on the district nursing care given from early August 1996 to late September 1996 states:

> *"Although it has not been recorded in the nursing notes,* [the consumer] *was advised at the first district nurse visit that a general practitioner was a necessity if good ongoing medical supervision was to occur.* [He] *declined this advice…*[and] *continued to work although it was felt inadvisable for him to do so in view of his wound and as a result district nursing visits could only occur once a day…* [The consumer] *agreed that his friend* […] *(who stated she is a registered nurse) could redress his wound regularly, and this happened. This was supervised by a district nurse initially and deemed to be satisfactory."*

The consumer noted that he had recently moved to a new city and had asked the district nurses if they could recommend a doctor in his area. He was given a list of several local doctors but by the time the list was provided the infection had progressed to the stage where the consumer was admitted to hospital.

The day after the packing was removed the consumer was examined at the second hospital. The examining doctor noted:

> *"This case is somewhat difficult… two months ago* [the consumer] *developed a fluid collection over his right buttock. I understand this was drained without anaesthetic in the emergency department at* [the first] *hospital and subsequent to that time the wound has been cared for predominantly by the district nurses and then through the emergency department. It doesn't sound like he has been admitted under any team. At some stage a nurse has decided that the wound should be packed and apparently she has lost the packing. Attempts have been made to remove the packing but it may well be hooked around the proximal locking screw of the GK rod…*

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Outcome of Investigation, *continued*

I have explained to [the consumer] *that I believe this is going to require some prolonged hospitalisation. Initially we want x-rays of the femur to demonstrate the distal locking screw. The next step is to arrange a sinogram which hopefully we can get done today to demonstrate how far this pressure area communicates and if indeed it communicates and implies infection of the rod. Should that be the situation I think he will need removal of the rod and then management of the pressure area."*

The distal femoral screws and the rod were then removed at the second hospital the following day.

The consumer was transferred to another hospital five days later (early October 1996).

The first surgical registrar replied to the Commissioner in August 1998 that he would endeavour to obtain the relevant notes and reply. He was sent the relevant notes in late November 1998 by the Commissioner's investigation officer but despite a follow-up letter sent in early March 1999, the first surgical registrar did not comment on the consumer's case.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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Opinion: Breach, Crown Health Enterprise

In my opinion the Crown Health Enterprise breached Right 4(2), Right 4(3), Right 4(4) and Right 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Rights 4(2) and 4(5)

I have been unable to identify the person who surgically removed wound packing in mid-September 1996. The Crown Health Enterprise was unable to provide me any documentation regarding this procedure. In my opinion, in the absence of information identifying the individual responsible, the failure to document such a procedure must be borne by the Crown Health Enterprise. This failure is a breach of Right 4(2) of the Code.

There were a large number of health professionals involved in the consumer's care and no one particular health professional ultimately took responsibility for his care plan and ongoing treatment. These circumstances made it difficult to identify any one health professional as being the person who failed to provide services of a professional standard.

In my opinion it was inappropriate to care for the consumer's deteriorating wound on an outpatient basis without a clearly identifiable health professional taking direct responsibility for the consumer's management. The number of different caregivers involved in the consumer's case resulted in a lack of continuity of care. This contributed to the consumer's wound deteriorating, resulted in two separate removals of retained packing and finally the surgery in late September 1996 to remove retained packaging and the femoral nail.

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Opinion: Breach, Crown Health Enterprise, ***continued***

In my opinion there was also a lack of communication between the district nursing service and the surgical team regarding the consumer. Apart from the initial referral to the district nursing service, in early August 1996, there is no evidence that the surgical team advised the service of the surgical procedure performed, any changes in wound management or whether any follow-up arrangements had been made or were necessary. I have also seen no evidence that the nurses who referred the consumer to the first hospital on three separate occasions provided details of his care and management. It appears that the nurses did make telephone contact with the hospital. In my opinion this was insufficient. Whenever one health professional refers a consumer to another health professional, a written summary outlining the history, the presenting problem and the care already provided, must be completed. This is a generally accepted practice undertaken by other health professionals such as general practitioners and there is no reason why district nurses should not also communicate in this manner.

When a consumer is receiving care from more than one service for a single problem it is vital that those services communicate to ensure that the consumer receives quality care.

In my opinion there was a system failure rather than the fault of any particular individual. Consequently, it was the Crown Health Enterprise that did not provide care of an appropriate standard as required by Rights 4(2) and 4(5).

Rights 4(3) and 4(4)

In my opinion the Crown Health Enterprise also breached Right 4(3) and Right 4(4) of the Code.

In the two instances where the packing was lost, the gauze was used was an unacceptable type for the consumer's deep wound. As a result surgery was required to remove retained ribbon gauze in mid-August 1996 and again in mid-September 1996. It was not until then that McFarlane Roll was considered to be a more appropriate packing material for the consumer's needs.

In my opinion the CHE's treatment of the consumer's wound, in particular the inappropriate gauze used, was inconsistent with the consumer's needs, did not minimise potential harm and was inappropriate in the circumstances.

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Report on Opinion - Case 97HDC7172, continued

Opinion: No Breach, The second Surgical Registrar

In my opinion the second surgical registrar did not breach the Code of Health and Disability Services Consumers' Rights in respect of discharging the consumer home. The options were discussed with the consumer who elected to return home.

Opinion: Breach, The second Surgical Registrar

In my opinion the second surgical registrar breached Right 4(3) and Right 4(5) of the Code of Rights.

Right 4(3)

The second surgical registrar was aware that the consumer did not wish to remain in hospital after the removal of packing in mid-August 1996. There is no evidence that the second surgical registrar made any arrangements for the consumer to be reviewed by the surgical team in the outpatients clinic. The consumer was entitled to elect to return home following his surgery. However given that he is paraplegic and given the site and size of the wound, the second surgical registrar should have arranged for the consumer to be seen in the outpatients department for follow-up assessment.

Right 4(5)

I have seen no evidence that the second surgical registrar discussed the consumer's ongoing nursing requirements with the district nursing service following the removal of packing in mid-August 1996. The consumer was a paraplegic and reliant on district nursing services for ongoing wound management. In my opinion it was necessary that a multi-disciplined approach be taken and this did not occur. In my opinion there was no continuity of care provided to the consumer.

In my opinion the second surgical registrar also breached Right 4(5) by not making any arrangements for the consumer to be reviewed by the surgical team. I acknowledge that the consumer had chosen to return home after the procedure performed in mid-August 1996. However, if the consumer had remained in hospital, even overnight, he would probably have been seen by the surgical team. The consumer had previously attended a surgical outpatients appointment arranged by the first surgical registrar and there is no evidence that he was unlikely to attend if required again. In order to ensure that the consumer received continuity of care, the second surgical registrar should have arranged for the consumer to be seen as an outpatient.

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Report on Opinion - Case 97HDC7172, continued

Opinion: No Breach, The first Surgical Registrar

In my opinion the first surgical registrar did not breach the Code of Health and Disability Services Consumers' Rights.

The first surgical registrar saw the consumer on two occasions; the second being a follow-up appointment. There is no evidence that the first surgical registrar's decision to discharge the consumer home was inappropriate.

Actions

The Crown Health Enterprise
I recommend the CHE takes the following actions:

- Apologises to the consumer for its failure to treat him appropriately. The apology is to be sent to my office and I will forward it to the consumer.
- Reviews its policy regarding managing its care in a co-ordinated way and undertakes education of clinical staff to ensure a team approach is taken with clinical staff being required to influence other providers to ensure co-ordination of care.
- Reviews its record keeping processes to ensure all contacts with consumers are recorded. Further, the Crown Health Enterprise is to review its processes to ensure that copies of relevant information, such as operation notes, are copied to other providers to ensure continuity of care.

The second surgical registrar
I recommend the second surgical registrar apologise to the consumer for breaching the Code of Rights. The apology is to be sent to my office and I will forward it to the consumer.

Other Actions

A copy of this opinion is to be sent to the Medical Council of New Zealand, the Medical Misadventure Unit, the Health Funding Authority and the Crown Company Monitoring Advisory Unit.