Summary report in English



Ukom



NÅR HELHETEN GLIPPER – MANGLENDE KONTINUITET I PREOPERATIVE FORLØP

Summary report in English

Publisert 16. juni 2026

ISBN 978-82-8465-047-0

About this report

This chapter is an English summary of a more comprehensive report published in Norwegian by the Norwegian Healthcare Investigation Board (Ukom). Ukom is an independent national body that investigates serious adverse events and risk areas in the Norwegian health and care services, with the aim of producing learning for the sector through identifying systemic factors that shape patient safety. Ukom does not assess individual culpability, makes no findings of blame, and has no authority to issue sanctions or take regulatory action. That role sits with the Norwegian Board of Health Supervision (Statens helsetilsyn), which operates separately.

Background

The investigation was prompted by two serious adverse events at a Norwegian hospital in 2024. Both involved older patients undergoing planned surgery within a cancer pathway. One patient died; the other sustained a serious and lasting injury. Rather than focus on the operating theatre, Ukom examined the whole preoperative pathway, from referral through the decision to operate until the day of surgery. The investigation found that, in both cases, opportunities to recognise risk had existed earlier, and that deterioration could have been identified at several points if the system had supported the clinicians involved to do so.

The patient stories

Bjørn

Bjørn was in his mid-70s. He had multiple myeloma and ankylosing spondylitis, with a pronounced forward curvature of the upper spine (kyphosis) that meant he could not lie flat. After cancer of the renal pelvis was confirmed, a multidisciplinary team (MDT) meeting recommended robot-assisted

removal of the kidney and ureter at the university hospital. His preoperative assessment was cancelled when he and his accompanying daughter fell ill, was not rescheduled, and he was admitted two days before surgery without it. The lead surgeon first saw him already intubated on the operating table, and became concerned about the severity of his spinal deformity. The operation went ahead in technically difficult conditions, and Bjørn sustained a vertebral fracture caused by his positioning on the table, leaving him with significant and lasting loss of function.

Ingrid

Ingrid was in her mid-80s, active and living alone. She was diagnosed with aggressive (triple-negative) breast cancer with axillary node spread. An MDT recommended a modified neoadjuvant regimen – chemotherapy and immunotherapy before surgery – adapted to her age. At the start of treatment, she already had moderate hyponatraemia. Over the following weeks she deteriorated steadily: breathless, weak and unsteady, with falling blood sodium levels and weight loss. Her own descriptions to clinicians remained reassuring, even as her GP, home care service, family and friends observed a marked decline. After her fourth treatment cycle she was admitted to her local hospital with grade 3 pneumonitis, a serious immunotherapy side effect, and stayed there for three weeks on high-dose steroids. Surgery at the university hospital was brought forward, and she was discharged home on a tapering steroid regime to wait for the operation. Her preoperative assessment was cancelled because she felt too unwell to travel; she was admitted the day before surgery, with no blood tests taken and a previously recorded weight measurement reused. She was operated on the following day, developed acute renal failure, and died eight days later.

Findings

Ukom grouped its findings under five themes.

Assessment of patients' health before and during treatment

Decisions to operate were taken on a narrow information base. Neither patient had a structured frailty assessment, although clinical guidance recommends screening in these age groups before cancer treatment. Information from relatives – often a critical source for older patients who may overstate their function – was not systematically sought or documented, even though Ingrid's family, GP and home care staff registered a steady decline. Shared decision-making was effectively absent: both patients were told the MDT recommendation by telephone, with no documented discussion of alternatives or their own goals. A genuine concern not to discriminate on grounds of age appeared to push assessments away from explicit consideration of frailty, so that vulnerability carried less weight than it should have. MDT recommendations were made without a complete picture of overall condition, and were rarely revisited as new information emerged.

Responsibility and information flow in complex care pathways

In Ingrid's pathway, a university hospital held formal responsibility for her cancer treatment, while weekly treatment was delivered at a local outpatient clinic. Her acute deterioration was managed at her local hospital. Several clinicians had noticed concerns, but each assumed another team was acting on them. When her cancer team handed her over to the surgical team, no one took clear ownership of her continuing recovery or steroid tapering. Relevant information existed in the electronic record, but was fragmented across separate hospital versions of the same system, each requiring a separate login. Clinicians were also reluctant to open records held by other hospitals, uncertain whether this was permitted and fearful of being seen to "snoop". Information that was technically accessible was therefore, in practice, not used.

Preoperative routines

Preoperative routines are intended to act as safety barriers: independent checkpoints that confirm a patient is fit for the planned operation. In neither case did they function as such. Preoperative

assessments were missed without any system flagging the absence. Admission notes were written by junior doctors, in one case by a colleague borrowed from another ward and asked to take "a quick admission" of a patient she did not know. Old measurements were carried forward; the weight in Ingrid's admission note was around ten kilograms higher than what her home care service had recorded shortly before. At each stage, staff assumed the patient had already been cleared earlier in the pathway. By the time both patients reached the operating theatre, the threshold for stopping was very high.

Improvement measures and their unintended effects

Two well-intentioned improvement initiatives contributed to what happened. The first was a move away from routine blood tests, aligned with national efforts against overuse of diagnostic testing. On the ward it had become unclear who was responsible for ordering tests when clinical judgement called for them, and Ingrid was not tested on admission.

The second was a focus on reducing operation cancellations, being a national quality indicator. Cancelling at preoperative assessment did not count; cancelling once the patient was admitted did. The asymmetry made it harder to stop late, even when concerns emerged. Both initiatives worked well for most patients, but each narrowed the room for clinical judgement for the individuals who needed it most.

Geography and division of functions

Distance and the division of functions between hospitals were not only practical issues but structural ones. Because Ingrid lived far from the university hospital that held responsibility for her cancer treatment, her serious complications were managed at a local hospital without an oncology department, while the team that knew her treatment plan was not routinely informed and received no discharge summary. Informants said that, had she lived locally, she would probably have been admitted directly to the cancer department and called back for outpatient review. Geography did not cause harm on its own, however, combined with weak information sharing and unclear responsibility, it meant that no single team held a continuous picture of her condition.

Recommendations

Ukom makes five recommendations. They describe a direction and level of ambition rather than prescribing specific measures.

1. Holistic and systematic assessment. Hospitals should enable healthcare personnel to make holistic and systematic assessments of patients' health before and during treatment – including structured frailty screening, input from relatives, shared decision-making in which the patient's own goals form part of the basis for choice, and prehabilitation where indicated.

2. Preoperative routines that work as safety barriers. Hospitals should design preoperative routines so that clinicians can detect changes in a patient's condition and adjust the plan. Patients who have not completed planned preoperative assessment should be identified by the system so a complete review can take place before surgery.

3. Shared understanding of when to access patient records. Hospitals should ensure clinicians share a common understanding of when accessing health records, including records held by other hospitals, is necessary and lawful, so available information is in fact used.

4. Clear responsibility across sites. Hospitals and regional health authorities must ensure clear allocation of responsibility in pathways involving more than one site, including the continuing role of the hospital that initiates treatment.

5. Improvement measures that support clinical judgement. Improvement measures must support, rather than undermine, healthcare personnel's responsibility to exercise clinical judgement – for example, in deciding when investigations and tests are needed.

Statens undersøkelseskommisjon
for helse-og omsorgstjenesten

Postboks 225 Skøyen
0213 Oslo
E-post: post@ukom.no
Org nr: 921018924