HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Health NZ Southern and registrar breach man's rights for failures in care

21HDC02293

A man's rights under the Code of Health and Disability Services Consumers' Rights were breached by Health New Zealand|Te Whatu Ora Southern and a registrar, the Deputy Health and Disability Commissioner has found in a decision released today. Sadly, the man died of a brain haemorrhage.

The man had an unwitnessed fall at his care home and was taken to Southland Hospital emergency department. A yellow envelope containing patient information was misplaced which meant that hospital staff who were treating the man were not aware that he was on anticoagulants.

The man had his initial observations taken by a registered nurse about six hours after his arrival at hospital. He was first seen by the registrar around nine hours after his arrival. The registrar noted it was usual practice for her to review the information in the yellow envelope but there wasn't one. The registrar did not order a CT scan because she was not aware he was on anticoagulants.

The man was kept under observation and was discharged back to the care home the next day. The man became increasingly ill and was taken back to Southland Hospital where a CT showed he had experienced an intracranial haemorrhage and he later died.

Deborah James said Health NZ breached the Code by not providing services with reasonable care and skill.

"Health NZ did not have a clear or well understood process in place for ambulance staff to hand over the yellow envelope when there were no available beds in ED, resulting in the man's yellow envelope being misplaced," she said.

She added that the man was not assessed for initial observations until around six hours after his arrival and that several clinicians had failed to identify he was on warfarin. These factors combined meant Health NZ did not provide the appropriate standard of care.

Ms James said that due to the man's age, fragility and because he had suffered a head injury, a CT scan should have been completed, regardless of whether or not he was on anticoagulants. She found that the registrar breached the Code by not providing reasonable care and skill in their management of the man's care by not ensuring a CT was completed or identifying that he was on anticoagulants.

Health NZ says it has since increased the number of nurses on at night shift and made sure there is always a medical imaging technologist on site to take scans. The registrar has also made a range of changes, which are outlined in the report.

Ms James has recommended both parties formally apologise to the man's family. She has recommended Health NZ standardise its process for yellow envelopes to cover when there are no beds available.

4 November 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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