Woman's rights to appropriate care for diabetes breached by Health NZ Te Tai Tokerau

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A woman's rights to receive an appropriate standard of care were breached over a two month period, which included several admissions to Kaitaia Hospital, said Deputy Commissioner Rose Wall in a report published today.

The woman's rights under the Code of Health and Disability Services Consumers' Rights (the Code) were breached by Health New Zealand Te Tai Tokerau (previously Te Whatu Ora) for care by multiple staff.

The woman suffered from multiple complications from Type 2 diabetes. On several occasions she presented, or was admitted, to Kaitaia Hospital for treatment. Following a deterioration in her symptoms, and subsequent hospital admission, she underwent a toe amputation, followed by a below-knee amputation and further surgery. Sadly, she died from a bacterial infection in her right groin.

Ms Wall Found Health NZ Te Tai Tokerau breached the Code for failing to provide services to the woman with reasonable care and skill.

"Health NZ Te Te Tokerau was the group provider with overall responsibility for ensuring that the woman received timely intervention to try to avert the profound difficulties she ultimately experienced," Ms Wall said.

During the woman's two-week hospital admission, the clinicians failed to assess and consider the cause of her ulcers adequately, Ms Wall said.

In addition, she was seen on multiple occasions over two months and despite a clear need, was not referred to the vascular service or the diabetes clinic. "In my view this was a failing of multiple staff over the course of her care," Ms Wall said.

Ms Wall also made an adverse comment about the registered nurse at the medical centre who assessed the woman's foot and incorrectly classified the extent of disease present. This led to an inappropriate referral to the community podiatry service, rather than the diabetes clinic.

Ms Wall acknowledged, however, that the nurse was working within a system where guidance and terminology were confusing, which enhanced the likelihood of an error.

In relation to the community podiatrist who returned the referral to the system administrator, Ms Wall made an educational comment. The community podiatrist correctly identified that the referral should go to the diabetes clinic but did not provide adequate clarity in her explanation for her referral rejection. Ms Wall acknowledged issues with the referral system that did not have a default requirement to leave a note of explanation.

In addition to the investigation into the care provided to the woman, Ms Wall also investigated whether the Primary Health Organisation contracted by Northland District Health Board to deliver community podiatry services in Northland (PHO 1) provided an appropriate standard of care to multiple consumers from July 2017 to June 2020.

Considering the overall community podiatry services in Northland, Ms Wall made an adverse comment about PHO1.

"I am critical that PHO 1 did not provide an adequate community podiatry referral system and processes, which affected multiple consumers," Ms Wall concluded.

While noting that PHO 1 was removed from the Companies Register in March 2022 and no longer has legal status, Ms Wall wrote to Manatū Hauora|Ministry of Health and the Health NZ National Office highlighting her concerns.

Since the events, a number of changes have been made by Health NZ, with further recommendations outlined by Ms Wall in her report.

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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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