Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Failures in care of older man after emergency surgery

21HDC00696

In a report issued today, Aged Care Commissioner Carolyn Cooper found Tairāwhiti District Health Board (now Te Whatu Ora Tairāwhiti) and a registered nurse breached the Code of Health and Disability Services Consumers' Rights (the Code) for their care of an older man.

The man was admitted to Gisborne Hospital for emergency surgery. He was then transferred to the Intensive Care Unit in a stable condition but passed away the following day from a cardiopulmonary arrest from atrial fibrillation.

Ms Cooper found Te Whatu Ora breached Right 4 of the Code – the right to an appropriate standard of care | Tautikanga – for failing to provide services with reasonable care and skill.

"Te Whatu Ora had an organisational responsibility to provide a reasonable standard of care to its patients," Ms Cooper said. "I consider that a combination of inadequate staffing and support affected the care provided to this man."

The breach covered failings involving staffing levels, inadequate supervision and support provided to medical staff, a lack of training for medical staff on the Prescribing Policy and inadequate communication with the man's whānau.

Ms Cooper said she was aware of the pressure hospitals were under nationally. However, she said, "healthcare consumers had the right to expect hospitals to be sufficiently resourced with the appropriate mix of skilled and experienced staff to provide safe and competent care."

Ms Cooper also found a registered nurse breached Right 4 of the Code for shortcomings in care. The nurse did not appropriately escalate the man's care or monitor his blood pressure and did not use the Early Warning Score (EWS) appropriately. In addition, the nurse's documentation was not up to the standard required by the Nursing Council of New Zealand.

Ms Cooper made an adverse comment about the junior doctor, relating to escalation of care, medical review, and verbal prescription. However, she acknowledged the numerous mitigating factors involved.

Ms Cooper expressed her sincere condolences to the man's whānau for their loss.

Since the events Te Whatu Ora has made significant changes. Taking into account these changes, Ms Cooper made a number of further recommendations, outlined in the report.

13 May 2024

Editors 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 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%.

Read our latest Annual Report 2023

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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