Necessary investigation not undertaken - vascular registrar and Auckland District Health Board (now Te Whatu Ora Te Toka Tumai) found in breach of the Code

21HDC00223

Former Auckland DHB (now Te Whatu Ora Te Toka Tumai) and a vascular registrar have been found in breach of the Code of Health & Disability Services Consumer's Rights (the Code) after a woman presented to Auckland Hospital in April 2016 with leg pain and swelling and was discharged twice with a diagnosis of sciatica.

The woman, who had a privately performed sclerotherapy procedure in March, returned to hospital for a third time in the same 24-hour period and was found to have a retroperitoneal bleed and deep vein thrombosis. She required major surgery, care in the Cardiovascular Intensive Care Unit, and a lengthy rehabilitation.

Health and Disability Commissioner Morag McDowell found that at the time of the second presentation, given the ongoing severe pain without a clear diagnosis, a further ultrasound or CT scan should have been arranged.

Ms McDowell concluded: "I find the vascular registrar breached Right 4(1) of the Code which states every consumer has the right to have services provided with reasonable care and skill. I find the breach not in relation to a failure to diagnose the woman's condition, but in failing to undertake further investigations in the context of her presentation."

Ms McDowell also found Te Whatu Ora breached Right 4(1) of the Code for failing to provide the woman with care of an appropriate standard, including that the documentation of the medical reviews from her first two presentations to the APU were inconsistently recorded, and the failure to have set out clearly its expectations for referrals between specialties, which did not support a safe clinical journey for the woman.

She also criticised documentation by the vascular registrar and a general medicine registrar.

Ms McDowell made a number of recommendations, including:

- That Te Whatu Ora and both registrars each provide a written apology to the woman;
- That Te Whatu Ora confirm to HDC that its current orientation includes clear guidance about who is to document internal referrals made by telephone, or face-to-face, and where this information is to be recorded; and

- That Te Whatu Ora use the case (in an anonymised form) as the basis for training its new registrars in medical and vascular services, focusing on the importance of robust communication around intra-hospital referrals.

Since the complaint, a number of changes have been made by Te Whatu Ora and the registrars.

- Te Whatu Ora undertook to address a number of systems and processes related to its referral processes, SMO escalation, and diagnosis-based specialty referral guidelines.
- The vascular registrar stated that his handling of similar cases in the time since has been heavily informed by learnings from this case, and the knowledge he has built around the management of chronic venous disease. He also advised that he has improved his record-keeping significantly.
- The general medicine registrar said that he has discussed his assessment, management, and the subsequent outcome of the case at great length with clinicians from a range of specialties. He believes that this engagement has given him greater insight and informed changes to the way he practises.

8 May 2023

Editor's notes

The full report of this case will be available on HDC's website. 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 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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