Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Waitematā DHB found in breach of Code after a disabled man died when his dietary plan was not followed

21HDC02016

Waitematā District Health Board (DHB) (now Te Whatu Ora Waitematā) breached the Code of Health & Disability Services Consumer's Rights (the Code) in relation to the death of a significantly disabled patient whose dietary plan was not followed.

The patient was admitted to Waitakere Hospital with a chest and urine infection. He was an elderly man with intellectual disabilities and limited communicative capacity. He had resided in residential care for most of his life and required support with all aspects of daily living.

The man's usual caregivers provided information about the man's dietary plan, which outlined that he needed to be supervised appropriately and his food pureed due to his risk of choking and aspiration.

Following the man's transfer from the emergency department to the assessment and diagnostic unit, and two subsequent ward transfers, his dietary requirements and the level of care he required, were not handed over adequately between staff, or documented clearly. His dietary plan with the care facility was not adhered to and, tragically, he choked and passed away.

Deputy Health and Disability Commissioner, Rose Wall, found Waitematā DHB breached Right 4(1) of the Code which gives consumers the right to services provided with reasonable care and skill. She also found the DHB breached Right 4(3), which gives consumers the right to services provided in a manner consistent with his or her needs.

"Effective handover is vital to achieve high quality communication of clinical information and transfer of care, and to protect patient safety. I agree that quality handover practices between departments/wards is key, with the ramifications of inadequate communication tragically playing out on this occasion," Ms Wall said.

"Hospital staff did not give sufficient attention to a significantly disabled patient who was unwell in an unfamiliar environment, isolated from his usual caregivers and his familiar day-to-day routine. He was unable to communicate his needs to the various staff caring for him," Ms Wall said.

"All these considerations required staff to adjust their usual practice to accommodate the unique situation they were faced with. This case reinforces the significance of clear communication. It is the cornerstone of providing safe and effective care to patients, even more so when the patient is particularly vulnerable and reliant on others to keep them safe."

A number of changes have been made since the events, including a review of handover documentation, which now includes a field to record patients' dietary needs.

The wards that were involved in the man's care have been asked to ensure that dietary requirements are part of the shift handover, and the wards must ensure that the patient information board correctly reflects both the patient's individual dietary needs and any assistance they may require.

Ms Wall made several recommendations, which included that the DHB provide training to all relevant staff on the handover processes and the handover practice expectations, and on the importance of the dietary requirements of patients, so that they are aware of the risks in failing to adhere to any dietary plans and/or restrictions.

Waitematā DHB will also be referred to the Director of Proceedings, in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

21 August 2023

ENDS

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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