Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Te Whatu Ora Tairāwhiti breaches Code for inadequate care provided to an elderly man

19HDC02091

Te Whatu Ora Tairāwhiti (formerly Tairāwhiti District Health Board) breached the Code of Health & Disability Services Consumers' Rights (the Code) for inadequate care provided to an elderly man.

The man, who was in in eighties at the time and has since passed away, was a patient at Gisborne Hospital in 2019. He was suffering from sepsis and chronic wounds in his big toe and heel because of reduced blood flow. This led to an above-knee amputation.

The man's family made a complaint to HDC about the level of care provided to their father. The complaint alleged poor communication with the family and between multi-disciplinary team members, wounds and incontinence not managed adequately, lack of oversight of nutrition and assistance during mealtimes, a head wound that was not investigated adequately, and problems with the condition and availability of equipment. They also complained of a suboptimum state of order and cleanliness.

Aged Care Commissioner Carolyn Cooper found Te Whatu Ora Tairāwhiti breached Right 4(1) of the Code which gives consumers the right to have services provided with reasonable care and skill. She noted a number of shortcomings across wound management, head wound care, incontinence management, nutrition and the multi-disciplinary approach, which amounted to inadequate care of the man.

"In my view, the number and scope of failures points to serious systemic failures in patient care at Gisborne Hospital at the time."

Since this event, Gisborne Hospital has made several improvements to its processes and policies, including working on nursing care standards and forming a consumer council to support the existing methods available for patients and whānau to provide feedback.

Ms Cooper's recommendations included that Te Whatu Ora Tairāwhiti: provide a written apology to the man's family; review various audit tools and audit the regular use of those tools; audit the regular use of the nutrition/hydration section of patient care plans and also carry out an audit of unexplained injuries on the wards; review its wound management assessment and monitoring tools against international standards (or confirm that it uses a wound management and assessment tool for its inpatient ward patients); and report to HDC on the review of its pain management programme.

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.

Learn more: Education