Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Woman's premature discharge from ED highlights the importance of clear communication between clinicians
19HDC01420

The Deputy Health and Disability Commissioner has found MidCentral DHB (now Health New Zealand - Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral) breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services of an appropriate standard.

The decision relates to the care of a woman in her 50s who presented at the Emergency Department with a history of chest pain. She was assessed but discharged after five hours. She died at home later that day following a cardiac arrest.

"This case highlights the importance of clear and unambiguous communication between clinicians, as well as the critical importance of documenting such communication," said Deborah James, who found MCDHB had breached Right 4(1) of the Code.

The findings center on the woman's presentation to ED after two days of transient chest pain (pain that comes and goes). The ED specialist caring for the woman told HDC he wanted the woman to be seen by the Cardiology service as an inpatient. However, there were no records of a discussion between ED and Cardiology staff at that time requesting that she be considered for admission.

Ms James also made adverse comment about the ED specialist.

"While the ED specialist had identified that the woman should have been considered for admission, he did not take sufficient steps to ensure this happened…" She said the ED specialist's documentation of the woman's care and related discussions did not meet the expected standard.

Ms James recommended the event be used to train staff on the importance of adequate documentation, effective communications, and referral processes for specialist services.

MCDHB approved and implemented an action plan to ensure learning from the incident was applied consistently across the organisation.

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.

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendations.

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