Decision 21HDC01470
20 October 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Man loses vision in right eye after ED delays

1. On 26 June 2021, HDC received a complaint from Mr A, aged 37 years at the time of events, regarding the care provided to him by Health New Zealand|Te Whatu Ora. Specifically, Mr A's complaint concerned the care he received when he experienced a central retinal artery occlusion (CRAO)[1] on 9 June 2021. Mr A now has permanent vision loss in his right eye. I acknowledge the significant impact these events have had, and continue to have, on Mr A.

Information gathered

2. Industrial action had been organised by New Zealand Nurses Organisation members, and on 9 June 2021, nurses held a strike from 11am to 7pm, which meant that Public Hospital 1 had minimal nursing resources. On the same day, Mr A experienced vision loss in his right eye, with dizziness and nausea. An ambulance was requested at 10.25am, and Mr A was taken to Public Hospital 1's Emergency Department (ED). Mr A arrived at the ED at 11.24am.

3. At 11.34am Mr A was assigned a Triage Code 2 (T2).[2] He was seen by Dr B, a locum doctor, at 4.02pm, more than four hours after the target timeframe for a T2 patient. The outcome of this review was Mr A's transfer to Public Hospital 2 for ophthalmology review, which was appropriate in the circumstances, albeit significantly delayed.

4. Health NZ told HDC that Mr A's triage was recorded on the ED whiteboard, and the formal triage document was completed. The usual practice was for a nurse to be allocated to each patient who had been triaged, but due to the nursing strike, this was not possible. At the time, only one nurse was working in the ED, and remaining staff were relying on volunteers who did not have medical backgrounds. The nurse on duty twice raised the issue of Mr A's wait time with the locum doctor. Unfortunately, the ED had multiple T2 patients, which further contributed to the pressure on ED staff. Additionally, Health NZ noted that the location of the 'eye room' (where Mr A was waiting) on the ED whiteboard was not prominent and may have further contributed to Mr A being overlooked by staff.

5. Public Hospital 1 does not have a resident ophthalmologist, so Dr B sought advice from the Ophthalmology Department at Public Hospital 2. He was advised that Mr A should be seen at Public Hospital 2 ED for an urgent ophthalmology review. No formal arrangement was made for Mr A's transfer of care from Public Hospital 1 to Public Hospital 2. Mr A was discharged with an undifferentiated diagnosis[3] and deemed safe to transfer by private transport.

[1] Sudden blockage of the central retinal artery (the primary blood vessel supplying the retina).
[2] A T2 patient requires treatment within 10 minutes. T2 pertains to life-threatening or important time-critical conditions.
[3] A term that is used when a diagnosis is not finalised, and further investigations may be required to confirm the diagnosis.

Names (except Health New Zealand) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

6. Health NZ has acknowledged that Mr A was not seen within the appropriate timeframe for a T2 patient. It has apologised to Mr A for the delay between him being triaged, seen by a doctor, and transferred to Public Hospital 2.

7. A family member drove Mr A to Public Hospital 2 ED. He arrived at 6.38pm and was triaged at 6.50pm as T3 (to be seen within 30 minutes).

8. At 9.23pm (more than two hours after the target timeframe) Mr A was seen by a staff member, and diagnosed with CRAO. Systemic steroids[4] were trialled in case inflammation was affecting Mr A's vision. Unfortunately, this treatment did not improve Mr A's condition, as by this time he had permanently lost vision in his right eye.

9. Health NZ told HDC that the delay in seeing Mr A following triage at Public Hospital 2 was due to the impacts of the nursing strike, which affected ED staff's capacity to assess patients and send referrals to other services, and the ED being particularly busy that evening. The staff member who attended to Mr A said that at the time, he had four acute patients to see, including a patient who was considered to be more urgent than Mr A. Additionally, Mr A was not considered as urgent because he was referred with an undifferentiated diagnosis, and CRAO was not a likely diagnosis for a person of his age.

10. Health NZ said that at the time of Mr A's presentation and triage, it had already been over six hours since Mr A had experienced loss of vision in his right eye. Health NZ noted the delay in transfer from Public Hospital 1 to Public Hospital 2. The optimal window for intervention and treatment of CRAO is within six hours of the onset of symptoms. Even if treatment had been provided within this window, the prognosis for CRAO is poor, and treatment was unlikely to have changed the outcome. Health NZ noted that timely ocular massage would not have helped with the type of blood clot Mr A experienced. However, it apologised for the unfortunate outcome for Mr A and the distress this caused him.

Concise Event Review

11. A Concise Event Review (CER) was completed by Health NZ following these events to identify the issues that caused a delay in Mr A receiving care. The following findings were made:

a) Normal ED processes were not in place due to the nursing strike. The usual safety precaution of a nurse being assigned to an individual patient did not occur, resulting in minimal responsibility being taken for Mr A.

b) The physical layout of the information on the whiteboard used to display patient triage information made it difficult for staff to be alerted that Mr A, a T2 patient, was in the 'eye room'.

c) The ED was under pressure with continued presentations of urgent patients, and there were limited resources available.

[4] Synthetic derivatives of cortisol, a natural steriod produced in the adrenal glands. They are are used to reduce inflammation.

d) The absence of a specialty ophthalmology service meant that Mr A had to travel to receive ophthalmology review at Public Hospital 2.

e) The locum doctor on duty at the time was unfamiliar with local processes. While the receiving hospital was aware of Mr A's transfer, the locum doctor did not contact Public Hospital 2's ED to inform them of Mr A's imminent presentation.

12. The following recommendations were made in the CER to address the identified concerns:

a) Additional professional support during nursing industrial action to ensure patient safety;

b) Reconfiguration of the whiteboard displaying triage information to ensure that the 'eye room' is displayed more prominently;

c) Development of ophthalmology emergency pathways to utilise visiting ophthalmologists when available and to receive guidance towards the best referral option; and

d) Review of the transfer policy for patients travelling in their own vehicle or being driven by a relative.

Relevant standards

13. EDs in New Zealand follow the Australasian Triage Scale (ATS), which provides for the allocation of a triage code to each presenting patient to ensure patient prioritisation for treatment according to the urgency of the patient's condition. The triage code sets a maximum waiting time before the patient receives a clinical assessment by a nurse or doctor, and subsequent treatment. The ATS sets out a series of indicative clinical descriptors to assist in the allocation of code categories. Triage Code 1 (T1) pertains to imminently life-threatening conditions or the need for immediate treatment. A Triage Code 2 (T2) patient requires treatment within 10 minutes and pertains to life-threatening or important time-critical conditions. Triage Code 3 (T3) pertains to potentially life-threatening, potential adverse outcomes from a delay of more than 30 minutes, or severe discomfort or distress.

14. Each triage code category has a corresponding performance indicator threshold. The ATS provides that 80% of Triage Code 2 patients are to be seen within 10 minutes, and 75% of Triage Code 3 patients are to be seen within 30 minutes.

National ED capacity issues

15. Notwithstanding the cover in response to the nursing industrial action that occurred on 9 June 2021, HDC is mindful that all EDs across New Zealand are often compromised in meeting wait-time targets as a result of capacity issues. This is an ongoing issue that HDC is continuing to monitor and raise with Health NZ.

Responses to provisional decision

16. Mr A was given the opportunity to comment on the 'Information gathered' section of the provisional opinion. He outlined his traumatic experience, and the severe impacts that this event continues to have on his everyday life. Mr A is distressed that he was unable to receive

the care that he required in a timely manner to give him the best chance of a positive outcome. Mr A's further comments and information provided have been addressed in separate correspondence to him.

17. Health NZ was given the opportunity to comment on my provisional opinion. Health NZ advised that it accepts the findings of this report.

Opinion: Health NZ — breach

18. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[5] states that every consumer has the right to have services provided with reasonable care and skill. According to Mr A's assigned triage score of T2, he should have been seen within 10 minutes following triage at Public Hospital 1 ED. I am concerned that from the time of triage to the time of being seen by a doctor, Mr A waited for over four hours. This did not meet the relevant ATS target and was a significant delay for a patient who was suffering from a time-sensitive condition. Based on the information available to me, it is evident that the care provided to Mr A did not meet accepted standards due to multiple systems issues at Health NZ.

19. Health NZ told HDC that the nursing strike action on 9 June 2021 affected the timeliness of Mr A being assessed. However, it is evident that appropriate processes and sufficient resources were not in place to ensure that the usual expectations for patient safety were not compromised while there was a reduced nursing resource.

20. During the industrial action, triaged patients were no longer assigned a nurse. This contributed to Mr A not being seen in a timely manner due to a lack of oversight for individual patients.

21. The configuration of the whiteboard used to display triage information was inadequate. The 'eye room' was not displayed prominently, meaning that patients in this room awaiting care could be overlooked by staff.

22. It is concerning that the locum doctor was not familiar with the correct process for referring patients. This meant that Public Hospital 2 ED was not informed that Mr A would be presenting and requiring an urgent ophthalmology review.

23. In light of the above systems issues evident at the time of the events, which I consider did not support safe practice and contributed to a significant wait time for a patient requiring urgent review, I find that Health NZ breached Right 4(1) of the Code.

Opinion: Health NZ — breach

24. When Mr A presented to Public Hospital 2 ED, he was assigned a triage score of T3, meaning that he should have been seen within 30 minutes. However, he was not seen for over two

[5] The Code can be found on HDC's website at: https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/.

and a half hours following his initial triage. This wait time did not meet the ATS target, and I consider that this delay was unacceptable.

25. Health NZ told HDC that the impacts of the nursing industrial action affected Mr A's wait time. During this time, staff did not have the capacity to send referrals to other services. The ED was also busier than usual, with other patients requiring ophthalmology review. I appreciate the impacts of the absence of nursing resource. However, I expect that organisations will undertake appropriate contingency planning to ensure that patient safety is not compromised during such events, and that there is sufficient resource available to review patients in a timely manner, in line with the relevant triage targets.

26. Health NZ has noted that by the time Mr A first presented to Public Hospital 2 ED, he was already outside the six-hour window in which treatment may have been of benefit. Health NZ also stated that even if treatment had been provided within this timeframe, the prognosis for CRAO is poor, and it is unlikely that the outcome would have been altered. While I appreciate this, I wish to clarify that the role of this Office, and consequently the focus of this investigation, is to assess whether the standard of care was appropriate, irrespective of the outcome. Therefore, while I acknowledge that the delay Mr A experienced at Public Hospital 2 ED was unlikely to have affected the overall outcome, I still consider that the delay was unreasonable.

27. Due to the excessive wait time Mr A experienced before receiving ophthalmology review and receiving a diagnosis of CRAO, I find that Health NZ breached Right 4(1) of the Code.

Recommendations and follow-up actions

28. I recommend that Health NZ provide formal written apologies to Mr A for the issues identified in this report. The apologies are to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

29. I recommend that Health NZ establish a protocol to ensure that locum doctors are aware of the correct process for referring patients to other services. This can be included in an already established or newly created process. A copy of the relevant protocol or process should be sent to HDC within three months of the date of this report.

30. I recommend that Health NZ provide an update on the implementation of each of the recommendations made in the CER, including any amendments to contingency planning protocols in the event of industrial action. Details of any training or education provided to staff regarding the changes should also be included. This report is to be provided to HDC within six months of the date of this report.

31. I recommend that Health NZ review the contingency planning protocols to ensure that in the event of industrial action there is appropriate resource available in critical areas, and that patient safety is not compromised. This can be included in an already established or newly created process. A copy of the relevant protocol or process should be sent to HDC within three months of the date of this report.

32. A copy of this report with details identifying the parties removed, except Health NZ, will be sent to the Health Quality and Safety Commission and the Ministry of Health and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner