Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Shortcomings in care for man undergoing chemotherapy
19HDC01148

The Deputy Health and Disability Commissioner Deborah James has issued a number of recommendations to a private outpatient oncology clinic, a registered nurse and an oncologist following their care of a man in his 40s who was having chemotherapy.

In her report, issued today, Ms James found that aspects of care provided by Canopy Cancer Care Ltd (Canopy), the registered nurse and oncologist breached the Code of Health and Disability Services Consumers' Rights.

The man was receiving chemotherapy from the clinic and became unwell on the third day of treatment. He presented to the clinic for acute care, following a phone call to the clinic's triage service. A few hours after receiving treatment, he returned home but sadly died that evening from a cardiac event.

Ms James found Canopy breached Right 4(1) of the Code, which gives consumers the right to services provided with reasonable care and skill. The breach concerned the lack of guidelines in place for the assessment and management of chemotherapy patients who present to the clinic unwell, including timely blood screening.

Ms James says, "A heavy reliance on decision-making and coordination by individual clinicians, without the support of a formal strategy for the management of acute patients, led to gaps in the care provided."

Ms James also found the clinic breached Right 4(2), which gives consumers the right to services that comply with legal, professional, ethical and other relevant standards, in relation to the administration of IV prescription medicine that was contrary to legislation.

Ms James found the clinic breached Right 4(5), which gives consumers the right to co-operation among providers to ensure quality and continuity of services, by failing to have clear roles and responsibilities in place to enable accessible assessment and record-keeping tools to ensure continuity of care.

Ms James also made an adverse comment about the quality of Canopy's complaint handling.

The registered nurse also breached Right 4(2) of the Code by administering IV prescription medicine to the man contrary to legislation, and for keeping inadequate records.

Ms James noted that the nurse's actions appeared well intentioned and had been affected by some systemic issues. However, she said, "this decision reflects the important role of nurses in upholding individual practice standards despite challenging healthcare environments."

Ms James found the oncologist who provided acute care to the man breached Right 4(1) and Right 4(2) of the Code for not conducting timely blood testing and for retrospectively

authorising a prescription for the IV medicine given by the nurse. Adverse comment was also made about the oncologist's clinical record keeping and communication.

Ms James also made an adverse comment about the standard of record-keeping by a second oncologist, who saw the man and his wife at the man's initial appointment.

Ms James noted that, following this event, Canopy had identified gaps in their service and subsequently developed Management of Acute Patient Guidelines. She also acknowledged that the tragic event had prompted each provider, both group and individual, to reflect on the care they provided.

Ms James made several recommendations to Canopy, including that they:

- Provide a written apology to the man's family
- Audit staff clinical records and Clinical Nurse Educator training
- Review and update specific aspects of its Management of Acute Patient Guidelines
- Review its blood screening and referral processes to ensure that urgent screening is available
- Review its prescribing processes and related charts to ensure that they comply with legislation and accepted practice

Ms James recommended that the registered nurse provide a written apology to the man's family. She noted that the nurse had already satisfied the vocational training recommendations.

Ms James recommended that the oncologist provide a written apology to the family and complete appropriate clinical documentation and prescribing refresher courses.

"I take this opportunity to express my deepest sympathies to the man's family for their loss," Ms James said.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

13 November, 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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