HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delay in detecting complications arising from kidney transplant

Introduction

1. This report concerns the care provided by Auckland City Hospital (operated by Health NZ | Te Whatu Ora Te Toka Tumai Auckland (Health NZ))[1] to Ms A between 28 and 29 June 2023. Having considered all the information obtained during the investigation, I find Health NZ in breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code) for the delay in detecting complications after Ms A's kidney transplant.

Recommendations

2. Noting the changes that have been already made as a result of this complaint, I recommend that Health NZ | Te Whatu Ora Te Toka Tumai Auckland:

   (a) Provide a written apology to Ms A for the deficiencies identified in this report. The apology is to be sent to the Health and Disability Commissioner (HDC), for forwarding to Ms A, within three weeks of the date of this report;

   (b) Present an anonymised case study based on these events for the wider education of medical staff at the intra-abdominal/renal transplant ward. The case study should detail the actions taken and decisions made by staff, the results of these actions/decisions, and the appropriate course that should have been taken, factoring in the issues that contributed to the delayed diagnosis. Evidence confirming the content and delivery of the presentation, and to whom it has been presented and when, is to be provided to HDC within six months of the date of this report.

Background

3. Ms A had a history of end-stage kidney disease secondary to focal segmental glomerulosclerosis (a type of glomerular disease with scarring in the kidney), which was diagnosed when Ms A was seven. Ms A received a kidney transplant in December 2014, but that transplant failed and the focal segmental glomerulosclerosis recurred in 2016. Ms A's kidney disease was managed using regular haemodialysis, a type of dialysis used to treat kidney disease. Ms A underwent a live donor kidney transplant at Auckland Hospital on 21 June 2023. Ms A was initially managed in the high-dependency unit then transferred to the intra-abdominal/renal transplant ward.

4. On the morning of 28 June, Ms A reported swelling over her pubic area. At 8pm, Ms A reported a decrease in urine output and increasing abdominal pain. Additional nursing notes state that, at 8.20pm, the renal registrar was advised of Ms A's abdominal pain. At 5am on 29 June, it was documented that Ms A had not passed urine since 8pm the night before. Ms A had a bladder scan at 3am, which noted no urine in the bladder. Both the on-call officer and the registrar were advised of the pain and swelling and reviewed Ms A. However, Health

[1] Additional aspects of Ms A's complaint have been addressed separately.
[2] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

NZ told HDC that no concerns were reported or documented after this review, and there was no documentation of urine output since 7pm on 28 June when 100ml of urine was passed.

5. Ms A was reviewed at 9.20am by the transplant team, where it was noted she had become anuric (not producing urine). A bladder scan showed only 54ml of urine in the bladder, and a doppler ultrasound showed globally reduced renal blood supply secondary to a clotted external iliac artery, the artery that supplies oxygenated blood to the lower limbs and pelvis. Ms A underwent urgent remedial surgery, which was successful.

Clinical case review

6. A subsequent clinical case review concluded that there was a delay in escalation and response after identification of decreased urine output in a transplanted kidney. Contributing factors included systemic issues such as:

- Ward staffing levels;
- Orientation of junior medical staff involved in post-transplant care;
- Lack of explicit direction on the post-transplant protocol[3] regarding duration of monitoring and notification requirements;
- Nursing issues – namely poor monitoring and recording of urine output overnight on 28–29 June 2023 and failure to notify the transplant team of reduced urine output and abdominal pain;
- Clinician issues – namely, the Medical Officer review and management undertaken in the early hours of 29 June 2023 and failure to document that review.

7. As a result of the clinical case review, Health NZ advised that both the clinical guidelines for adult renal transplant recipients – postoperative care and the renal transplant senior medical officer escalation guidance have been updated. Health NZ also advised that both staff and patients are made aware of Kōrero Mai, the process for escalating patient, family, and whānau concerns about deterioration while in hospital. Registrar and house officer orientation covers how to escalate clinical concerns to senior medical officers, and the resident medical officer handbook is in the process of being digitised, which will improve accessibility.

8. Ms A and her whānau were provided with an opportunity to comment on the provisional opinion, and they advised that they agree with the contents of the report. They remain

[3] Health NZ advised that the management of renal transplant patients is based on the Auckland Renal Transplant Group protocol. This states that any acute events in transplant patients should be discussed early with the transplant physician on call (irrespective of the time of day or night). Such acute events include fever, decreased urine output, or pain over the allograft in an inpatient, and bleeding from transplant wound or other sites.

unhappy with Ms A's treatment by Health NZ and have outlined that these events continue to have a significant effect on her.

Analysis

9. Right 4(1) of the Code states that 'every consumer has the right to have services provided with reasonable care and skill'. I consider that several issues with the care provided by Health NZ contributed to a delay in detecting the complications of Ms A's kidney transplant. I have reached this view based on my independent assessment of the information gathered by this Office, including Health NZ's review of the events and response to the complaint, and independent review by in-house clinical advisor, Dr David Maplesden.

10. Having independently considered the information, I agree with the issues identified in Health NZ's clinical case review of these events, which concluded that there was a delay in escalation and response after identification of decreased urine output in a transplanted kidney, which led to an overall delay in identifying a time-critical complication (thrombotic occlusion of the external iliac artery). Contributing factors included staffing levels, poor orientation of junior staff involved in assessing a transplant patient after hours, lack of explicit instructions on the post-transplant protocol, and poor monitoring and recording of urine output overnight. I accept that nursing staff contacted the on-call medical team but failed to notify the transplant team of the reduced urine output and abdominal pain. I also have concerns regarding the review and management undertaken in the early hours of 29 June by clinicians and the failure to document their review.

11. I also note that Dr Maplesden reviewed the complaint and the clinical information received from Health NZ and agreed with the findings of the review (set out above), noting that there was ultimately a delayed diagnosis of the thrombosis that threatened the viability of Ms A's transplanted kidney. I accept this advice. I consider that multiple individuals were involved with Ms A over this time and that, in my view, the responsibility for the deficiencies in care lay with Health NZ.

Conclusion

12. With regard to the delay in staff detecting complications with Ms A's kidney transplant, I consider that Health NZ did not provide service to Ms A with reasonable care and skill. Accordingly, I find that Health NZ breached Right 4(1) of the Code.

Follow-up actions

13. A copy of this report with details identifying the parties removed, except Auckland City Hospital and Health NZ, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner