HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Health New Zealand breaches Code for multiple system failures in management of woman's echocardiogram

20HDC01130

The Aged Care Commissioner has found Waikato DHB (now Health New Zealand | Te Whatu Ora Waikato) breached the Code of Health and Disability Services Consumers' Rights (the Code) for multiple system failures which resulted in delays in actioning GP referrals and notifying the results of an echocardiogram to a patient.

The woman at the centre of the report, was initially referred by her GP to Thames Hospital for an echocardiogram. She experienced significant delays in getting the echocardiogram done and learning the results which indicated severe heart valve disease and other heart disease.

Given the history of delays with Health New Zealand, the woman then sought private medical treatment for her heart condition.

Carolyn Cooper found Health New Zealand breached Right 4 of the Code – the right to an appropriate standard of care | Tautikanga – for failing to provide services with reasonable care and skill.

The breach covered several shortcomings in care. First, there was a delay in triaging the first referral and performing the echocardiogram. Later, there was a delay in communicating the echocardiogram results to the woman's GP. Finally, there was a lack of action taken once errors were identified.

Ms Cooper said, the first referral exceeded the recommended timeframe for triage by ten working days. It then took around six months for the echocardiogram to be performed, which ideally should have been undertaken within six weeks.

In addition, the echocardiogram results were not sent directly to the GP who referred the woman for the test. This resulted in an additional delay in the woman learning of the results and treatment being scheduled.

"I am critical that Health New Zealand did not have a robust referral management pathway at the time of events with the appropriate safety net in place to ensure that patients did not fall through the cracks if a human error occurred," Ms Cooper said.

"Without the woman's active participation in following up her echocardiogram appointment and then result, it is possible that Health New Zealand would not have identified the omissions, which could have caused significant harm to her."

No further systemic investigation was undertaken by Health New Zealand for the errors and delays once they were clear.

“There appears to have been no urgency shown by Health New Zealand for the lack of action taken on the echocardiogram and no escalation for any investigation once Health New Zealand was aware that the woman’s significantly abnormal results had not been actioned,” Ms Cooper said.

“As this Office has stated previously, it is the responsibility of healthcare organisations to ensure that there are robust systems in place to minimise the risk of errors, such as those outlined in the report,” said Ms Cooper.

Ms Cooper made an adverse comment about Health New Zealand for not actioning the event monitor after the second referral. She also made an adverse comment about the cardiologist who reviewed the woman’s report for failing to make the appropriate management recommendations in the echocardiogram report.

Ms Cooper reminded the medical centre where the woman’s GP worked of the importance of escalating any concerns raised to the appropriate provider, to ensure quality and co-ordination of care.

Since the events, Health New Zealand, the cardiologist and medical centre have made changes to their practice, which are outlined in the report. In addition, Ms Cooper made several further recommendations for Health New Zealand.

27 May 2024

Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's 'Latest Decisions'.

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 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Read our latest Annual Report 2023

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

Learn more: Education Publications

For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709