Capital & Coast District Health Board (now Te Whatu Ora|Health New Zealand Capital, Coast and Hutt Valley)

A Report by the

Health and Disability Commissioner

(Case 20HDC00893)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report relates to the care provided to a man in 2019, by Capital and Coast District Health Board (CCDHB) (now Te Whatu Ora Capital, Coast and Hutt Valley). The investigation relates to the follow-up care he received following corneal graft surgery to his left eye. In particular, the report considers the adequacy of the systems in place for patients of the ophthalmology service to seek timely and appropriate care for postoperative complications.

2. The man experienced pain and other symptoms, but he did not receive the expected postoperative appointment. He attempted to arrange an appointment, but he was not seen for almost a month after his surgery. When eventually the man was seen, he was diagnosed with a corneal graft infection. Subsequently the man underwent surgery to remove the eye.

Findings

3. The Deputy Commissioner found that the system that should have ensured that the man received appropriate postoperative care failed him in multiple respects. He did not receive a discharge summary outlining the operation and postoperative instructions, and the written information he did receive did not give clear information and advice on when and where to seek help. He also did not receive a follow-up appointment one week after his surgery as had been intended.

4. These factors aside, the man attempted to obtain medical attention when he experienced adverse symptoms. However, at this point, CCDHB's systems again let him down. The preoperative information provided on who to contact in the event of an emergency differed from the postoperative information and included an inactive telephone number. The man's calls to CCDHB were transferred to the Eye Clinic, but no one answered the telephone, and there was no answerphone service. In addition, when the man was eventually connected with the booking office after two weeks of repeated calls, the administrative staff did not understand the urgency of the situation. His appointment was scheduled for five weeks after the date of surgery, and at another hospital.

5. The Deputy Commissioner considered that the man was failed by systems that were not fit for purpose, were not current, and did not facilitate care that was timely, appropriate or safe. A series of avoidable communication breakdowns and administrative shortcomings deprived him of the urgent advice and care he needed, despite his repeated attempts to seek help. While any one of the above system deficiencies alone may not have been sufficient to cause the near month-long delay in the man's postoperative review, the Deputy Commissioner considered that their cumulative impact resulted in care that was not reasonable or of an appropriate standard. Accordingly, the Deputy Commissioner found CCDHB in breach of Right 4(1) of the Code.

6. The Deputy Commissioner made adverse comment regarding the standard of adverse event reporting undertaken by CCDHB in this case. The Deputy Commissioner was critical that CCDHB's Root Cause Analysis (RCA) raised concerns about the clinical decision-making of DHB2 staff without involving them in the review process, and considered that the RCA did not provide an accurate and meaningful analysis of this aspect of the man's patient journey.

Recommendations

7. The Deputy Commissioner acknowledged the changes made by CCDHB/Te Whatu Ora Capital, Coast and Hutt Valley since these events. She recommended that Te Whatu Ora Capital, Coast and Hutt Valley conduct an audit to confirm that ophthalmology patients at Te Whatu Ora Capital, Coast and Hutt Valley are receiving discharge summaries and timely follow-up appointments; consider further ways to improve the robustness of the booking system for postoperative follow-up ophthalmology appointments; provide HDC with updated copies of documentation addressing the deficiencies identified in the RCA; and provide the man with a written apology.

8. Te Whatu Ora was referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her son, Mr A, by Capital & Coast District Health Board (CCDHB) (now Te Whatu Ora Capital, Coast and Hutt Valley (Te Whatu Ora)).[1] The following issue was identified for investigation:

- *Whether Capital & Coast District Health Board provided Mr A with an appropriate standard of care in 2019.*

10. This report is the opinion of Deputy Health and Disability Commissioner Dr Vanessa Caldwell and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Mr A	Consumer
Ms B	Complainant/consumer's mother
Te Whatu Ora Capital, Coast & Hutt Valley	Provider

12. Also mentioned in this report:

Dr C	Ophthalmologist
Dr D	Consultant ophthalmologist
Dr E	Registrar
Dr F	Ophthalmologist

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to CCDHB now refer to Te Whatu Ora Capital, Coast and Hutt Valley.

13. Further information was received from Te Whatu Ora 2 and ACC.

Information gathered during investigation

14. This report concerns the care provided to Mr A (in his thirties at the time of events) at CCDHB in 2019. In particular, it concerns the follow-up care he received following surgery to his left eye. Mr A experienced pain and other symptoms but he did not receive his follow-up appointment for one week after the surgery as intended. He attempted to arrange an appointment, but he was not seen for almost a month after his surgery.

15. Mr A experienced corneal graft rejection and developed an infection. Unfortunately, Mr A lost the vision in his eye, and, subsequently, his eye required surgical removal.

Background

16. In 2011, Mr A was diagnosed with keratoconus.[2] In 2017, he received surgery on his right eye (a penetrating keratoplasty),[3] and the same procedure on the left eye was planned for 2019.

Surgery on 22 July 2019

17. Mr A underwent the surgery on his left eye (a full thickness/penetrating keratoplasty and corneal graft) under general anaesthetic at around 8.45am. The surgery was performed by ophthalmologist Dr C.

18. Mr A was managed in the Post Anaesthetic Care Unit (PACU) from 10.20am, then transferred to Second Stage Recovery[4] at around 11.15am, and he was admitted overnight. The clinical notes do not record any issues intraoperatively or postoperatively.

Discharge from hospital 23 July 2019

19. Mr A was assessed by an ophthalmology registrar on the morning of 23 July 2019. The registrar noted the plan to discharge Mr A with a prescription and an outpatient appointment for the following Monday (29 July 2019), as per the postoperative instruction that Mr A was for follow-up with Dr C in one week's time.

20. A nursing note at 9.21am documented that Mr A had been given discharge information and a prescription, and that a follow-up appointment had been booked. The nurse also documented that no concerns had been raised. Mr A was discharged that day.

[2] A condition in which the cornea thins and gradually bulges outward into a cone shape.
[3] A surgical procedure to replace damaged or diseased parts of the cornea with donated corneal tissue.
[4] A service that accommodates day-surgery patients who may be discharged on the day of surgery or who have an expected 23-hour stay.

21. Ms B, Mr A's mother, told HDC that Mr A was discharged with a prescription for eye drops only, and no pain relief, and he did not receive any paperwork advising the date for the follow-up appointment. Ms B said that Mr A did not recall receiving anything from CCDHB.

No discharge summary provided

22. CCDHB told HDC that Mr A should have been given a discharge summary outlining the operation and postoperative instructions.

23. CCDHB stated that the discharging nurse did not recognise that the Ophthalmology Department considered the document "Ophthalmology Procedure Summary" to be the discharge summary. This document listed the postoperative medications Mr A was to take and the frequency and duration of the medications. It also specified that Mr A was to receive his first follow-up at CCDHB on the day after he was discharged,[5] and a second follow-up at CCDHB in one week's time. CCDHB determined that no communication occurred between the Second Stage Recovery service and the Ophthalmology Department regarding the use of this document, and this meant that Mr A did not receive the discharge summary.

24. However, CCDHB advised that Mr A was discharged with the patient information document "corneal graft surgery — postoperative care and advice", which provides postoperative information and advice on when and where to seek help. The document advised patients to "contact a doctor for help" if they experienced signs of corneal graft rejection such as mild or moderate pain, reduced vision, light sensitivity or red eye. It also described corneal graft rejection as an "emergency" that "needs to be seen by a doctor on the same day". Contact details for the Eye Outpatient Department and several after-hours medical centres were provided over the page, with the instructions to dial 111 in an emergency for ambulance assistance, or to contact the telephone health service for free advice if unsure whether to visit a GP or an after-hours medical centre.

Pain relief on discharge

25. CCDHB stated that Mr A was discharged with no prescription for pain relief, and it should have been explained to him that paracetamol should be sufficient for pain relief, and that a requirement for any more pain relief is a reason to return to the hospital for review.

26. CCDHB said that the postoperative information provided to Mr A contained advice to use paracetamol for mild pain, and to seek help if the pain became moderate or severe.

No follow-up appointment scheduled

27. A postoperative appointment for Mr A in one week's time was not booked.

28. CCDHB advised that the process to request a follow-up appointment was followed, namely a fax was sent by Second Stage Recovery to the Ophthalmology Department requesting that

[5] Mr A was assessed by an ophthalmology registrar on the morning on 23 July 2019, one day after his surgery (as outlined in paragraph 19 above).

an appointment be scheduled. CCDHB acknowledged to Mr A[6] that "[a]s with any fax process, there is no certainty that the fax gets to the right person or that it is actioned".

29. CCDHB advised that after the initial fax was sent, no further actions were taken to ensure that a follow-up appointment had been made. It was presumed by the nurse discharging Mr A that the fax would be seen and actioned, and it was presumed by Dr C that the follow-up appointment would be made as he requested.

30. CCDHB was unable to provide a copy of the faxed referral/request sent by Second Stage Recovery to the Ophthalmology Department, as there was not a copy in the patient notes, and the history on the fax machine did not go back that far (at the time of HDC's request).

31. CCDHB advised that at the time of this incident, there were no documented policies or procedures regarding scheduling of follow-up appointments in the Ophthalmology Department post-surgery. Te Whatu Ora advised that currently it is developing "desk files" for the Ophthalmology receptions and booking clerks.

Postoperative deterioration and attempts to contact CCDHB

Mr A's attempts to contact Ophthalmology service

32. Ms B told HDC that Mr A was in serious pain within two days of discharge.[7] He continued to feel unwell postoperatively, and his eye was discharging fluid. He repeatedly telephoned CCDHB and was told that his call would be transferred to the Eye Clinic, but no one answered the telephone. The line automatically disconnected after a certain number of rings, and there was no answerphone service.

33. CCDHB did not have records of these incoming calls, and therefore specific dates were unable to be identified.

34. CCDHB advised that the preoperative information provided to Mr A had an incorrect telephone number listed for patients to use if they were experiencing problems, and the number was not answered or used by staff. This number had been disconnected prior to April 2019 (ie, at least three months prior to events). However, the postoperative information provided had the correct telephone number listed.

Contact with booking office

35. Ms B told HDC that after approximately two weeks of telephone calls with no response, the telephone operators, who by this time recognised Mr A's name and his situation, transferred Mr A to the booking office as a last resort to have his request for an appointment acknowledged.

36. Ms B said that Mr A explained to the booking office staff member that he had had corneal graft surgery performed on 22 July 2019, and he described the problems he was

[6] In response to Mr A's complaint made directly to CCDHB.

[7] On 26 July 2019, Mr A was seen by a GP. The appointment had been arranged by his partner on the day of his surgery to request a sickness benefit form and a medical certificate. The GP told HDC that this was the primary reason for the visit. She prescribed codeine for Mr A on this occasion.

experiencing. Despite this, the appointment was scheduled for 26 August 2019, five weeks after the date of surgery, and at another hospital. Ms B said that the operator ignored Mr A's pleas to have the appointment scheduled earlier.

37. CCDHB advised that it was unable to confirm the staff involved in the telephone conversation or whether the call was escalated. No notes about Mr A's call were taken, and the telephone system could not track the call history.

38. CCDHB said that administrative staff book appointments only on the direction of the clinical team, and the booking clerk would not have had any clinical knowledge, and therefore would not have understood the urgency for Mr A to be seen.

39. CCDHB told HDC that at the time of events it had no documented process to guide the Ophthalmology booking clerk on when to escalate to a clinician, including which conditions or surgeries required urgent assessment if patients made contact. It stated that all administrative staff are now aware that corneal graft patients need to be assessed by a doctor urgently if they make contact with the hospital.

Acute presentation to optometrist and DHB2 20 August 2019

40. Ms B told HDC that Mr A returned to his residence in another region after the surgery. On 20 August 2019, he was experiencing immense pain, and his eye had swollen and was protruding from the socket. Mr A was seen by an optometrist, who contacted the ophthalmologist at DHB2 and arranged for him to be seen at 5pm.

Presentation to DHB2

41. Ms B said that Mr A and his partner presented to the Emergency Department at DHB2 at 5pm with the referral letter from the optometrist, and the duty nurse manager escorted him to the Eye Clinic. Although the Eye Clinic was closed, it was re-opened, and he was examined by Dr D, a consultant ophthalmologist.

Examination and treatment

42. Dr D's clinical notes document that Mr A had a one-day history of painful photophobia[8] and blurring in his left eye. Dr D noted Mr A's history and recent surgery, and that he had a follow-up appointment scheduled for Monday 26 August 2019 with Dr F.

43. Dr D told HDC that on examination, Mr A had very low vision[9] in his left eye and there were no defects to the outer layer of his cornea suggestive of infection.[10] Dr D said that there was evidence of inflammation but swelling limited more detailed assessment of the back of Mr A's eye.

[8] Painful sensitivity to light.
[9] Vision of 6/60.
[10] His cornea had no epithelial defects suggestive of infection, his anterior chamber was formed, and he had keratic precipitates, but no hypopyon and mild–moderate corneal oedema, which limited detailed dilated posterior segment assessment.

44. Dr D diagnosed a left corneal graft rejection and performed an ocular B-ultrasound of Mr A's left eye. Dr D said that no evidence of an infection was found on the scan, and the right eye was within satisfactory limits.

45. Dr D has wide experience[11] in managing postoperative corneal cases and noted that this informed the initiation of standard management, which consists of intense hourly topical steroid eye drops[12] for use day and night, topical eye antibiotic eye drops[13] four times a day, and systemic steroids.[14]

46. Dr D commenced the topical steroid eye drops and antibiotics and then contacted CCDHB (as the place where the surgery had been performed) for advice about administering systemic steroids. Dr D said that there are varying treatment protocols for systemic steroids, which include either admitting patients for intravenous treatment, or administration of oral systemic steroids. Dr D explained that there is much variability among consultants regarding this treatment. Dr D wanted to clarify the surgeon's preference and telephoned CCDHB and spoke with the on-call registrar, Dr E.

Discussion between Dr D and Dr E

47. Dr D recalled discussing CCDHB's corneal graft rejection protocol, including admission, systemic treatment, and referral back to CCDHB within 24 hours to review and assess the treatment Dr D had initiated. Dr D recalled saying that early the next day (within 12 hours) would be satisfactory.

48. Dr E recalled Dr D telephoning to ask the department's practice for treatment of corneal graft rejections, and to say that the topical steroid (prednisolone) eye drop treatment would be increased.

49. Similarly to Dr D, Dr E stated that the practice of administering systemic steroids varies between ophthalmologists, and there is no definite consensus over whether oral or intravenous corticosteroids are best practice. Dr E told HDC that her knowledge was that oral prednisolone was the preferred practice at CCDHB, and she discussed this with Dr D.

50. Dr E recalled that Dr D described swelling of the cornea caused by a build-up of fluid,[15] with inflammatory cellular deposits on the cornea.[16] Dr E said that Dr D advised her that no open sores on the cornea[17] had been found, and Dr D reported poor views of the posterior segment[18] but advised that an ultrasound scan to exclude significant problems with that part of the eye had been undertaken. Dr D also reported that the anterior chamber[19] was

[11] Working in a large tertiary hospital and unit overseas.
[12] Pred Forte 1% drops.
[13] Chloramphenicol 0.5%.
[14] Prednisolone.
[15] Diffuse corneal oedema.
[16] Keratic precipitates.
[17] Ulceration.
[18] The posterior two-thirds of the eye, including the vitreous humour, retina, choroid, and optic nerve.
[19] The space between the cornea and the iris containing the aqueous humour, the fluid produced in the eye.

formed. Dr E told HDC that she agreed with Dr D that these findings were consistent with corneal graft rejection in the absence of other signs to suggest infection.

51. Dr E said that based on the information provided, and considering that Mr A was already under the care of a consultant ophthalmologist (Dr D), she made plans for him to be reviewed the following day so that he could receive long-term care from the sub-speciality surgeons. Dr E brought forward his appointment (from 26 August) and booked him into the acute clinic at 10.30am.

52. Dr E said that she did not call the consultant about this telephone referral for two reasons. First, she did not feel the need to discuss the case with another consultant, as Mr A was already under the care of a consultant ophthalmologist (Dr D), who was happy to manage his care that day and for Mr A to be followed up in CCDHB the next day. Second, in view of Mr A's clinical presentation (as presented to her by Dr D), she was confident in Dr D's assessment that they were dealing with a corneal graft rejection and that treatment had been initiated, and therefore the plan to have him seen in their department the following morning was appropriate.

Discharge and referral

53. Dr D said that at the end of the consultation with Mr A, and following discussion with Dr E and the Emergency Department team at DHB2, Mr A received an oral systemic steroid (prednisolone) at 6.30pm.

54. Dr D's urgent referral letter to Dr F at CCDHB outlined a diagnosis of left corneal graft rejection and noted that Mr A had been advised to increase his steroid treatment until his planned follow-up at CCDHB at 10.30am the next day. Dr D's letter also outlined that this plan had been discussed with Dr E, who advised that Dr F's preferred practice was to provide an oral steroid (prednisolone).[20] The letter stated that oral prednisolone 60mg had been provided, along with a proton pump inhibitor.[21]

55. DHB2 told HDC that Dr D's referral letter did not indicate that an inpatient admission was required, but Dr D had arranged for Mr A's planned appointment to be brought forward from 26 to 21 August 2019.

56. Ms B told HDC that Dr D advised Mr A to get himself to CCDHB immediately, and that transportation or transfer to CCDHB was not arranged. Dr D told HDC that transportation was offered to Mr A but was not accepted. Dr D recalled that Mr A and his partner believed they could manage the intensive hourly overnight eye drops at home and travel to CCDHB the next day.

[20] A steroid used to treat symptoms of inflammation, such as pain and swelling, by decreasing the immune system's response to various conditions, including skin and eye conditions.
[21] Proton pump inhibitors treat symptoms associated with high stomach acid by reducing the amount of acid made by the stomach.

57. Dr D also said that their discussion covered advice and instructions to contact or return to the Emergency Department overnight or in the early hours of the morning for reassessment if Mr A's symptoms worsened, which did not occur.

58. The clinical notes do not record whether the option of admission or the possibility of arranging transport to CCDHB was discussed.

59. Dr D considers that Mr A received timely, appropriate treatment and management, and that an appropriate treatment management protocol and best patient care management were provided.

Presentation to CCDHB and surgery 21 August 2019

60. Mr A was seen in the Emergency Eye Clinic at CCDHB in the morning, then admitted under the Ophthalmology service at approximately 12.30pm, for management of endophthalmitis[22] and an infected corneal graft.

61. At approximately 8.20pm, Dr C and an ophthalmology registrar performed surgery to repair the damage to Mr A's left eye using donor sclera.[23] Mr A was transferred to the Post Anaesthetic Care Unit at approximately 11.30pm. Patient observations were taken every five minutes and were stable when he was transferred to Second Stage Recovery at approximately 1am on 22 August 2019.

62. On 22 August 2019, the ophthalmology registrar informed Ms B and Mr A that there was a poor prognosis for the eye, and that it might need to be removed for pain management. Ms B recalled being advised by the ophthalmology registrar that the replacement cornea required a piece to be cut out and additional tissue resewn/attached, and that the immediate threat was infection to the brain, which was life-threatening.

63. During Mr A's recovery, his infection gradually improved with regular antibiotics and eye drops. He was discharged on 9 September 2019.

Subsequent events

64. On 3 February 2020, Mr A underwent surgery to remove his left eye.

Root cause analysis review

65. CCDHB undertook a root cause analysis (RCA) review, which was completed on 31 August 2020. The key findings were as follows:

> "1. There was not an effective system in place for appropriate redirection of telephone calls for ophthalmology patients.
>
> 2. There was a lack of timely and accurate documentation throughout the patient's journey, leading to a loss of pertinent information being conveyed to the patient and other health providers to allow safe ongoing care.

[22] Inflammation of the intraocular fluids due to infection.
[23] The white outer layer of the eyeball.

- There was no discharge summary for the patient or his GP after the corneal graft procedure.
- The clinic letter to the GP was sent out almost 2 months after the corneal graft procedure.
- The generic 'corneal graft surgery — postoperative care and advice' information sheet does not give clear instruction for seeking help if needed.

3. There was a delay in appropriate treatment for signs and symptoms of the corneal graft rejection. A management plan was sought by the emergency staff at DHB2 in consultation with an ophthalmology registrar at CCDHB. The plan did not include analgesia or antibiotics except topical for the eye, and the patient was not admitted and transported to CCDHB. The follow-up appointment with an eye specialist was for the next day at CCDHB.
4. There was no follow-up appointment given to the patient after his corneal graft surgery."

Dr D's response to RCA

66. HDC provided Dr D with a copy of the RCA undertaken by CCDHB and requested a response.

67. Dr D disagreed with several of the comments made in the RCA, and noted that presumptions and inaccurate conclusions were made, which could have been clarified easily, but unfortunately Dr D was not included in the analysis process.

68. Dr D said that there was no evidence of a "delay in appropriate treatment of signs and symptoms of corneal graft rejection".

69. In relation to the comment that the management plan did not include analgesia or antibiotics except topical for the eye, Dr D said that the topical cycloplegic eye drops that were administered as part of Dr D's examination have a known pain relief effect by relaxing ciliary spasm-inducing pain. Dr D noted that the effect was anticipated to last 12–24 hours. Dr D also noted that Mr A had already taken oral pain relief within two hours of his review at DHB2, which he agreed to continue until his review at CCDHB the next day.[24] Dr D said that therefore, the statement that "there was no evidence that pain medication was administered, prescribed, or advised for the patient during the visit" is incorrect.

70. Dr D said that there was no indication to commence systemic antibiotics at the time of review, as the examination findings (as outlined earlier in this report), along with the negative ocular B-ultrasound scan, ruled out a possible ocular infection at the time of assessment. Dr D noted that the RCA omitted any mention of the ocular B-ultrasound scan use/result, which was part of the examination.

[24] Mr A's patient records show that he received dihydrocodeine 120mg from the optometrist prior to being seen by Dr D.

Further information

CCDHB

71. CCDHB advised that it sincerely apologises to Mr A and his whānau that its systems and processes were not sufficient, and contributed to an unnecessary delay in his care, resulting in the complete loss of his left eye.

72. The clinical notes record a meeting between Mr A, Ms B, Dr E, and Dr C on 24 August 2019, during which the care Mr A had received was discussed, and complaint procedures outlined. Dr E recorded discussion that a corneal suture abscess or loose suture during the initial corneal graft surgery may have been responsible for Mr A's corneal infection and his severe inflammatory response. However, Dr C told HDC that no loose suture was noted upon completion of the procedure, nor during postoperative examinations. Dr C acknowledged that had the planned one-week follow-up taken place as intended, it is possible that a problem such as a loose suture or other complication could have been detected and managed such that Mr A may not have gone on to develop his subsequent infection.

Dr D

73. Dr D was sorry to learn that Mr A had such a difficult time and distress due to his illness.

Response to provisional opinion

74. Ms B was provided with the opportunity to comment on the "information gathered" section of the provisional opinion. Ms B stated that it is "painfully obvious that the systems in place were severely lacking" and highlighted the significant and ongoing impact on Mr A and his family as a result of having to have his eye removed surgically.

75. Te Whatu Ora Capital, Coast and Hutt Valley was provided with the opportunity to comment on the provisional opinion, and it accepted that there were several failings in its systems that resulted in Mr A not receiving the expected standard of care in relation to follow-up and support after he was discharged following the corneal graft surgery to his left eye. It reiterated its regret that Mr A was let down during the period he was trying to obtain advice and care following his surgery.

76. Te Whatu Ora Capital, Coast and Hutt Valley stated that the staff member who completed the RCA attempted to engage with DHB2, and sought its involvement in the review, but this did not occur. Te Whatu Ora Capital, Coast and Hutt Valley stated that this lack of involvement led to the "noted inconsistencies" in the findings of the RCA.

77. Te Whatu Ora Capital, Coast and Hutt Valley agreed that engagement across boundaries with key healthcare workers and providers involved in an adverse event is important, but it stated that it does not have the ability to compel other providers or health workers who are not employees to participate in a review. Te Whatu Ora Capital, Coast and Hutt Valley said that neither the current Te Tāhū Hauora|Health Quality & Safety Commission Adverse Events Reporting Policy 2017, nor the updated 2023 version (taking effect 1 July 2023) require that healthcare providers must work together when undertaking multi-provider adverse event reviews. Te Whatu Ora Capital, Coast and Hutt Valley recognised that there were ongoing difficulties attempting to engage multiple providers across districts during

adverse event reviews, and it suggested that it would be desirable to have a national formalised system to facilitate multi-provider participation in reviews.

78. Dr D was provided with the opportunity to comment on the relevant sections of the provisional opinion. Dr D did not wish to make any additional comments.

Opinion: CCDHB/Te Whatu Ora Capital, Coast and Hutt Valley

Provision of care — breach

79. As a healthcare provider, CCDHB was required to provide services to Mr A with reasonable care and skill and was responsible for its systems in place at the time of events and the actions of its staff. It also had a duty to comply with the New Zealand Health and Disability (CORE) Standards that were in place at the time of these events, which stated:

> "Service Management Standard 2.2: The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."[25]

80. On 22 July 2019, Mr A underwent surgery on his left eye. In my view, the system that should have ensured that Mr A received appropriate postoperative care failed him in multiple respects:

a) He did not receive a discharge summary outlining the operation and postoperative instructions. The discharge summary provided specific instructions regarding the medications Mr A was to take postoperatively, and specified that Mr A was to receive his first follow-up in one day's time at CCDHB, and a second follow-up in one week's time at CCDHB. CCDHB acknowledged that Mr A should have received this document, and said that the discharging nurse was not aware of which document contained these details, owing to a lack of communication between the Second Stage Recovery service and the Ophthalmology Department. There was also a two-month delay before the discharge summary was sent to Mr A's GP.

b) The written information he did receive — the document "corneal graft surgery — postoperative care and advice" — did not give clear information and advice on when and where to seek help. The document suggested the patient's GP, an after-hours number, and the Emergency Department as possible contacts in the event of an emergency (including signs of a corneal graft rejection), but it was not clear who should be contacted in the first instance.

c) Mr A did not receive a verbal explanation of pain-relief options. In addition, the document "corneal graft surgery — post-operative care and advice" that he received provided mixed messages on when to seek help, advising in one section that paracetamol could be used for mild pain, while advising in another section to seek

[25] New Zealand Standard Health and Disability Services (CORE) Standards (NZS 8134:2008).

urgent help from a doctor if there was "mild or moderate pain" (as this could be a symptom of corneal graft rejection). CCDHB acknowledged that it should have been explained to Mr A that a requirement for any pain relief beyond paracetamol would be a reason to return to the hospital for review. CCDHB told HDC that the postoperative information provided to Mr A advised to seek help for moderate to severe pain; however, the postoperative information provided to HDC does not state this.

d) Mr A did not receive a follow-up appointment. It was intended for Mr A to be reviewed by Dr C one week after his surgery, but an appointment was not booked, and no further actions were taken to ensure that a follow-up appointment had been made (it was assumed by discharging staff that this would be actioned). CCDHB believed that the process to request a follow-up appointment was followed by the discharging nurse sending a fax to the Opthalmology Department with Mr A's follow-up requirements. The nursing notes also document that a follow-up appointment had been booked. However, there is no record of the fax/request in the patient notes.

81. I am critical of the management of Mr A's discharge, and that no further action was taken to ensure that he received his intended follow-up at one week post-surgery. It is of great concern that issues with CCDHB's systems meant that there was no certainty that a request for a follow-up appointment would be received by the right person or actioned, and that there were no checks or safeguards in place to ensure that a booking request was actioned. I am also concerned that the lack of communication between departments resulted in Mr A not receiving a discharge summary. It is crucial that patients are provided timely and accurate postoperative instructions upon discharge.

82. These factors aside, Mr A did the right thing when he began to experience adverse symptoms. He attempted to obtain medical attention as directed. However, at this point, CCDHB's systems also let him down in the following respects:

a) The preoperative information provided to Mr A on who to contact in the event of an emergency differed from the postoperative information and included an inactive telephone number.

b) Mr A's calls to CCDHB were transferred to the Eye Clinic, but no one answered the telephone, and there was no answerphone service.

c) When Mr A was eventually connected with the booking office after two weeks of repeated calls, the administrative staff did not understand the urgency of the situation. His appointment was scheduled for five weeks after the date of surgery, and at a different hospital.

83. CCDHB acknowledged that there was not an effective system in place for appropriate redirection of telephone calls for ophthalmology patients. I find this very concerning given the reliance placed on this line of communication as a safety-net for Ophthalmology patients seeking help for complications following surgery.

84. I accept that the administrative staff in the booking office, who do not have clinical knowledge, can book appointments only on the direction of the clinical team. Nonetheless,

I am critical that CCDHB had no documented process in place for the Ophthalmology booking clerk to follow for booking appointments, or any list of conditions or surgeries to guide staff to escalate to a clinician if a patient made contact, especially as no other contact number for a doctor/specialist was provided on discharge for any medical follow-up advice. I consider that it is likely that the urgency of Mr A's situation would have been better understood had such processes been in place.

85. In my view, CCDHB held ultimate responsibility for ensuring that processes were in place that enabled Mr A to receive care of an appropriate standard. I consider that he was failed by systems that were not fit for purpose, were not current, and did not facilitate care that was timely, appropriate or safe. A series of avoidable communication breakdowns and administrative shortcomings deprived him of the urgent advice and care he needed, despite his repeated attempts to seek help. I acknowledge that it cannot be known whether Mr A would have gone on to endure the immense pain, severe infection, and loss of his left eye that occurred, had he received a more timely postoperative review. However, it is clear that he did not receive the necessary and expected opportunity to identify and manage any postoperative complications at one week following his surgery.

86. While any one of the above system deficiencies alone may not have been sufficient to cause the near month-long delay in Mr A's postoperative review, I consider that the cumulative impact resulted in care that was not reasonable or of an appropriate standard. Accordingly, I find that CCDHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Adverse event reporting — adverse comment

87. I am concerned about the standard of adverse event reporting undertaken by CCDHB in this case.

88. CCDHB's RCA stated that there was no evidence that pain medication was administered, prescribed or advised for Mr A. It also stated that there was a delay in commencing appropriate treatment of signs and symptoms of corneal graft rejection during his visit to Dr D. Dr D disagreed with several of the RCA's statements, and noted that presumptions and inaccurate conclusions were made, which could have been clarified easily, but Dr D was not included in the analysis process.

89. DHB2's clinical records show that Mr A had already received oral pain relief from an optometrist prior to presenting to Dr D. Dr D was aware of this and said that Mr A agreed to continue to use this until his review the next day. Dr D noted that the topical cycloplegic eye drops that were administered as part of Dr D's examination also have a known pain-relief effect, which lasts approximately 12–24 hours.

90. Dr D further stated that there were no indications of an infection requiring systemic antibiotic treatment at the time of the review. Dr D also pointed out that the RCA did not mention the ultrasound performed as part of the assessment.

91. Adverse event reviews play a fundamental role in ensuring that consumers receive safe and appropriate health services by fostering learning from adverse events and near misses. The RCA itself stated that its aim was "to understand what events happened, why they happened and what can be done to prevent similar events from occurring in the future". The Te Tāhū Hauora|Health Quality & Safety Commission National Adverse Events Reporting Policy[26] in place at the time of events stated that for such a review to have value, it must be "accompanied by meaningful analysis".

92. In my view, the RCA did not provide an accurate and meaningful analysis of the involvement of DHB2/Dr D in Mr A's patient journey. While the RCA states that the review involved "staff interviews", Te Whatu Ora Capital Coast and Hutt Valley has confirmed that DHB2 staff were not involved. As Dr D has stated, it appears that aspects of the RCA's findings were inconsistent with DHB2's clinical records, and these could have been corrected or clarified had CCDHB involved DHB2 in the review. In my view, it cannot be said that the RCA achieved a full understanding of what occurred, why it occurred, and what could be done to prevent similar events from occurring, without involving the staff who provided care to Mr A in the review.

93. Te Whatu Ora Capital, Coast and Hutt Valley told HDC that CCDHB attempted to engage with DHB2 during the RCA process, but this did not occur. Te Whatu Ora Capital, Coast and Hutt Valley pointed out that it cannot mandate another provider to become involved in an adverse event review, and that multi-provider involvement in a review is not mandated by either the Te Tāhū Hauora|Health Quality & Safety Commission guidelines that were in place at the time of these events, or the updated Te Tāhū Hauora guidelines taking effect from 1 July 2023. While I accept these points, I note that the 2023 guidance is in the context of the health system operating as one service, Te Whatu Ora, and, as such, it would be expected to provide an opportunity for all Te Whatu Ora staff — irrespective of their district — to be involved in reviews that concerned them. I consider that by not providing such an opportunity to Dr D to contribute to this process, CCDHB compromised the fairness and accuracy of the RCA in relation to DHB2/Dr D.

Opinion: Dr D — other comment

94. On 20 August 2019, Mr A saw Dr D at DHB2, following his presentation to an optometrist. Dr D diagnosed left corneal graft rejection, initiated treatment, and made an urgent referral for Mr A to be seen at CCDHB the next day.

95. I note that Dr D contacted CCDHB to discuss the management plan, and spoke with the on-call registrar, Dr E. CCDHB's RCA noted that the plan did not include pain relief or antibiotics other than topical for the eye, and suggested that this may have contributed to a delay in appropriate treatment for signs and symptoms of the corneal graft rejection. Dr D, who was not involved in the RCA process, disagreed with several of the RCA statements about the

[26] National Adverse Events Reporting Policy 2017.

care Dr D provided, and noted that presumptions and inaccuracies in the RCA could have been clarified had Dr D been included in the process.

96. DHB2's clinical records show that Mr A had already received oral pain relief from an optometrist prior to presenting to Dr D. Dr D was aware of this, and stated that Mr A agreed to continue to use this until his review the next day. Dr D also stated that the topical cycloplegic eye drops that were administered as part of the examination also have a known pain-relief effect, which lasts approximately 12–24 hours. Dr D said that there were no indications of an infection requiring systemic antibiotic treatment at the time of the review. Dr D also pointed out that when commenting on the adequacy of the investigative steps undertaken, the RCA did not mention the ultrasound performed as part of the assessment.

97. On the basis of the patient records, I consider that Dr D has provided a reasonable response to the concerns raised in the RCA regarding the appropriateness of the plan agreed between Dr D and the CCDHB registrar, Dr E.

98. Ms B and the RCA both raised concerns that Mr A was not admitted to DHB2, and that transportation from DHB2 to CCDHB was not arranged. Ms B told HDC that Mr A was told to get himself to CCDHB. I note that Ms B was not present when Mr A attended the Emergency Department at DHB2, but has provided this information on Mr A's behalf.

99. Dr D stated that the option of admission was discussed with Mr A and his partner, and they indicated that they could manage the intensive hourly overnight eye drops at home and travel to CCDHB the next day. Dr D said that transportation was offered to Mr A and his partner but not accepted.

100. Dr D also said that their discussion covered advice and instructions to contact or return to the Emergency Department overnight or in the early hours of the morning for reassessment if Mr A's symptoms worsened, which did not occur.

101. In light of the conflicting recollections of this conversation from Dr D and Ms B (on behalf of Mr A), I am unable to make precise findings regarding what Dr D discussed with Mr A in relation to admission and transport to CCDHB.

102. I note that there is no record in DHB2's clinical notes that either the option of admission or the possibility of arranging transport to CCDHB was discussed. I appreciate that certain details can be overlooked by clinicians working in a busy Emergency Department environment. However, the requirement to keep clear and accurate clinical records is a fundamental obligation, both to provide continuity of care and to provide evidence of the care and advice provided. I take this opportunity to remind Dr D of the importance of including the content of such discussions in the clinical record.

Changes made

103. CCDHB advised that in 2018, a review of the processes in place at the time identified the need for a number of Ophthalmology service improvements. CCDHB stated that Mr A's case demonstrated that not all of the service improvements were maintained, and the 2018 findings would be reviewed with a view to reinforcing the relevant improvements.

104. CCDHB advised that the process for follow-up appointments was changed so that the discharging nurse sends a request to the Ophthalmology outpatient reception staff email address, which is checked daily on weekdays by several staff members, and acknowledgement of the request is sent back.

105. CCDHB said that a desk file was put in place for Ophthalmology administrative staff to refer to, to ensure that requests are received and an appointment is scheduled. The desk file includes processes for booking and rescheduling appointments within follow-up time frames, and guidance on answering and escalating telephone calls from patients.

106. CCDHB advised that a yellow card was developed for corneal graft patients. This provides information about which signs and symptoms require urgent medical attention, and information on where to seek help. The cards are given out at both pre-assessment and on discharge.

107. The postoperative information given to patients was also reviewed and updated. The Opthalmology Department contact number for postoperative corneal graft patients was amended to include the triage nurse's cellphone number in addition to the telephone number for the Eye Outpatient Department. The triage nurse is available to help patients with enquiries on weekdays between 8am to 5pm, and after-hours information is also provided.

108. The alternative number available on the discharge information given to postoperative patients is one that is answered by the outpatient booking centre.

109. CCDHB advised that the following changes would also be implemented:

a) Postoperative appointments for corneal graft patients will be booked at their pre-assessment appointment.

b) A standard discharge summary for Ophthalmology patients will replace the Ophthalmology procedure summary document.

c) The document "corneal graft surgery — postoperative care and advice" will be reviewed.

110. During the investigation, CCDHB provided an update on its progress towards implementing these changes:

a) An audit of postoperative follow-up appointments for Ophthalmology patients was undertaken, and this was provided to HDC. The audit found that the majority of patients

had had a Day 1 postoperative review. CCDHB told HDC that the new process put in place of emailing a request for follow-up improved the follow-up process but did not ensure that it was completely reliable. CCDHB advised that it would continue to look at different options of ensuring that it is a robust system, and that making the appointment when surgery is booked may be a solution.

b) Discharge summaries specific for each ophthalmology sub-specialty were being developed. The discharge summary would be provided to the patient on discharge and would replace the procedure summary document.

c) Resources were allocated to documenting all eye administration processes, including booking, managing telephone calls, escalation of clinical problems and scheduling postoperative follow-ups. These formalised documents would be available to all staff to guide their practice.

d) The yellow card continued to be given out at pre-assessment.

e) Written procedures were being reviewed and updated to ensure that the reception team have the information to direct the action they should take. The desk file holds all relevant information pertaining to the clinic, including the process to follow for corneal grafts.

111. Te Whatu Ora Capital, Coast and Hutt Valley advised that it is reviewing the call receiving process for booking clerks, and has identified a script of questions that will now be asked by the first call responder. The questions will establish the seriousness of the caller's condition so that it may be escalated appropriately.

112. In response to the provisional opinion, Te Whatu Ora Capital, Coast and Hutt Valley advised that since the review for Mr A was carried out, it has conducted a review of its adverse event policies and practices and made several improvements. It provided HDC with a draft multi-provider review process, and noted that it intends to raise the issue of multi-provider reviews with Te Whatu Ora Central Region Clinical Board, with the aim that formalising the requirement for joint reviews is considered. Te Whatu Ora Capital, Coast and Hutt Valley considers that its adverse event reporting is robust and compliant with the Te Tāhū Hauora|Health Quality & Safety Commission National Adverse Events Reporting Policy 2017.

Recommendations

113. Having considered the changes made by CCDHB/Te Whatu Ora Capital, Coast and Hutt Valley since these events, I recommend that Te Whatu Ora Capital, Coast and Hutt Valley:

a) Provide a formal written apology to Mr A for the breach of the Code and the systems deficiencies outlined in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Consider further ways to improve the robustness of the booking system for postoperative follow-up Ophthalmology appointments, such as by making the postoperative appointment when surgery is booked or at the pre-assessment appointment. Evidence of any changes that have occurred is to be provided to HDC within six months of the date of this report.

c) Provide HDC with final copies of the discharge summaries under development for each Ophthalmology subspecialty. This information is to be provided to HDC within six months of the date of this report.

d) Provide HDC with final copies of any further formalised documents presently under development to guide Ophthalmology administrators on booking, managing telephone calls, escalation of clinical problems, and scheduling postoperative follow-ups. This information is to be provided to HDC within six months of the date of this report.

e) Provide HDC with an updated copy of the document "corneal graft surgery — postoperative care and advice" that addresses the concerns identified in the RCA. This information is to be provided to HDC within six months of the date of this report.

f) Undertake a further audit of at least 30 postoperative Ophthalmology patients to confirm that they each received a discharge summary, and that their follow-up appointments were not delayed. Reasons are to be provided for any patients who did not receive a discharge summary or follow-up within the expected time frame. The results of the audit are to be provided to HDC within six months of the date of this report.

Follow-up actions

114. Te Whatu Ora|Health New Zealand will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken. The reasons for this referral include the multiple avoidable systemic failures that occurred, the significant public safety risk these failures represented, and the ongoing impact these failings have had on Mr A through the loss of his eye.

115. A copy of this report with details identifying the parties removed, except Te Whatu Ora Capital, Coast and Hutt Valley, will be sent to Te Whatu Ora|Health New Zealand and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

116. The Director of Proceedings decided to institute proceedings in the Human Rights Review Tribunal.