HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate management of man's oral feeding status, leading to aspiration

1. On 31 July 2025, a Commissioner-initiated investigation[1] was commenced into the care provided to Mr A at Health New Zealand | Te Whatu Ora Capital, Coast and Hutt Valley (Health NZ).

2. This report considers the events surrounding an aspiration[2] incident that occurred while Mr A was a patient at Wellington Hospital after having experienced a stroke.[3] It highlights the importance of having robust measures in place to prevent the risk of aspiration events occurring, particularly in the case of patients who have been assessed as having a compromised swallow.[4]

3. Sadly, Mr A died in Wellington Hospital following ongoing respiratory issues. I express my sincere condolences to Mr A's family for their loss.

Information gathered

4. At 4.49pm on 25 May 2022, Mr A arrived at Wellington Hospital Emergency Department via ambulance because he was experiencing speech difficulties suggestive of a stroke. At 4.55pm, Mr A was assessed by the stroke specialist, who was a neurologist. A computed tomography (CT) scan[5] of his head was performed at 5.33pm. The CT scan confirmed that Mr A had experienced a stroke due to a large haemorrhage (bleed) in his left frontal lobe.

5. Mr A was transferred to the Neurological Acute Observation Unit at 9.20pm, and he was made nil by mouth[6] until a swallow screen could be completed to assess whether he had difficulty swallowing. At 10.30pm, Mr A was assessed by a nurse who deemed his swallow not to be 'safe', meaning he was at high risk of aspirating. Intravenous[7] fluids were commenced, and Mr A's condition was monitored using the National Institute of Health Stroke Scale.[8]

6. At 9.40am on 26 May 2022, Mr A was seen by a speech language therapist (SLT), and a formal swallow test was conducted which confirmed that Mr A had a weak cough reflex[9]

[1] Pursuant to section 40(1) of the Health and Disability Commissioner Act 1994.
[2] Aspiration occurs when food, liquid, or other substances are accidentally inhaled into the airway or lungs instead of being swallowed.
[3] A sudden loss of brain function caused by an interruption of blood flow to the brain.
[4] Also known as dysphagia, it occurs when problems in the mouth make it difficult to chew food or move it to the back of the throat. This can be caused by neurological disorders, muscle weakness, or structural issues.
[5] A type of medical imaging.
[6] Not to consume any food, drink, or medications orally.
[7] Fluids administered directly into a vein to restore and maintain fluid balance, provide nutrients, and deliver medication.
[8] A standardised scoring assessment used during a neurological exam after a person has had a stroke.
[9] A vital defence mechanism to help clear the airways of irritants, foreign particles, and secretions.

and therefore was at risk of 'silent aspiration'.[10] The SLT recommended that Mr A remain nil by mouth and receive nasogastric feeding.[11]

7. A CT scan performed at 2.19pm on 26 May showed a marginal increase in the size of the bleeding and the swelling of the brain. Mr A's condition was discussed with the neurosurgical registrar at 2.49pm and, after discussion with Mr A's family, Mr A was scheduled for urgent surgery to remove the blood clot and decrease the pressure on his brain.

8. At 6.30pm on 26 May, Mr A underwent surgery, during which the blood clot was successfully removed and the pressure on his brain relieved, as confirmed by a postoperative CT scan. While in the Post Anaesthetic Care Unit, Mr A required someone to support his head and neck to assist with opening his airway. The nursing notes record that Mr A appeared to aspirate his secretions because, although he could cough them up, he was at times unable to swallow them. Subsequently, Mr A required suction, supplementary oxygen, and the insertion of a nasopharyngeal airway[12] to assist with his breathing.

9. At 11.41pm, a chest x-ray was performed because Mr A had developed a temperature and was showing signs of a chest infection. Antibiotics were commenced, and Mr A returned to the Neurological Acute Observation Unit at 1.30am.

10. Although Mr A was drowsy and not following commands on the morning of 27 May, Health NZ said his condition improved over the following days, and he was able to use single words, follow commands, move his left side, and minimally move his right side.

11. On 30 May, the SLT reassessed Mr A, and he was trialled on a minced,[13] moist diet and thin fluids that would be discontinued if he showed any signs of coughing or throat clearing. The clinical notes do not include any requirement for Mr A to be supervised while eating, but he is documented as having tolerated the minced, moist diet well.

12. On 31 May, the SLT reviewed Mr A again, and he progressed to a soft diet[14] and normal fluids. Again, there was no requirement in the clinical records for Mr A to be supervised when eating, but it is noted that he appeared to tolerate the soft diet well.

13. On 1 June, nursing notes from 11.34am record that Mr A 'ate most of [his] breakfast with supervision'. Mr A was then given a standard diet for his dinner, which was not in line with the soft diet he should have been receiving. Mr A's family noticed that the incorrect meal had been provided and brought it to the attention of the kitchen staff, who replaced it with the correct meal. Nursing notes record that Mr A needed help being 'set-up' for his meal but was able to 'feed himself with supervision'.

[10] The unintentional inhalation of substances into the airway or lungs without any noticeable symptoms. In contrast, overt aspiration is accompanied by coughing or choking.
[11] The delivery of fluids through a tube inserted into the nose, down the throat, and into the stomach.
[12] A tube inserted through the nose into the back of the throat.
[13] Foods that are finely chopped or ground to a size that requires minimal chewing.
[14] Foods of soft texture that are low in fibre and easy to digest.

14. On 2 June, clinical notes record that a dietician reviewed Mr A. He was noted as tolerating a soft diet well, with 'nil issues stated', so nasogastric feeding was stopped.

15. On 3 June, Mr A's wife found him choking on a piece of food during lunch. The nursing notes at 2.25pm record that Mr A's family thought he was not chewing his food properly. They were concerned about his feeding status and asked for a dietician review because they thought he should be returned to a puree diet.

16. Mr A was reviewed by the SLT at 2.40pm. The clinical notes from the SLT record that Mr A's family said he 'had difficult[y] with [the] crust on bread and broccoli'. The SLT therefore recommended a minced, moist diet, and Mr A was returned to that diet.

17. By 4pm, Mr A's oxygen saturation[15] levels had dropped to a level that required him to be placed on supplementary oxygen, and he was also recorded as having developed a cough. Mr A was reviewed by the neurosurgical house surgeon, who determined he had likely aspirated; as a result, Mr A was made nil by mouth. The likely aspiration was confirmed by a chest x-ray at 9.07pm, and intravenous antibiotics were commenced to prevent infection.

18. On 4 June, Mr A was given breakfast despite his nil by mouth feeding status. Health NZ told the Health and Disability Commissioner (HDC) that Mr A's nil by mouth status had not been updated on the computer system, and the healthcare assistant was unaware of the nil by mouth order so assisted Mr A by setting him up for his meal. After his meal, Mr A vomited. He was started on antinausea medication, a plan was made to recommence nasogastric feeding, and the dietician was contacted.

19. The on-call dietician provided a new feeding regimen for Mr A, and he was commenced on nasogastric feeding. However, this resulted in ongoing nausea and vomiting so was stopped at 7.00pm, and intravenous fluids were commenced.

20. On the same day, the neurosurgical house surgeon also reviewed Mr A, and a CT scan was performed because of reduced power in his right hand. The CT showed no new bleeding but ongoing significant brain swelling.

21. Nursing notes on the evening of 4 June record that staff had noticed Mr A was requiring higher levels of supplementary oxygen and he had complained that his breathing had become worse. The on-call house surgeon was asked to review Mr A, and a referral was made to the Patient at Risk (PAR) service.[16] Clinical notes at 10.45pm document that a chest x-ray was performed, which showed signs of change to the left lung, indicating aspiration and the risk of infection. High-flow nasal prongs[17] were used to assist Mr A with his breathing, and regular reviews by the PAR service and the medical registrar continued overnight.

22. At 8.05am on 5 June, a medical emergency team call was initiated because Mr A had low oxygen saturation, high blood pressure and heart rate, and reduced consciousness. Mr A

[15] The amount of oxygen circulating in the blood.
[16] A nurse-led team managed from within the Intensive Care service. The role of the PAR service is to support and educate ward staff in looking after acutely unwell patients.
[17] A non-invasive respiratory support method that delivers heated, humidified oxygen at high flow rates.

was sedated, and a tube was inserted in his airway to aid his breathing (ie, he was intubated). Mr A was admitted to the Intensive Care Unit (ICU) and taken urgently for a CT scan, which showed that his brain swelling had worsened.

23. Over the following days, Mr A's condition continued to deteriorate, and he experienced ongoing respiratory issues that required assistance via a breathing tube. On 6 June, the ICU clinicians planned to stop Mr A's sedation so his level of functioning could be reviewed; however, Mr A was unable to clear his secretions and his oxygen saturation dropped, so he was re-intubated. An MRI[18] performed on 9 June showed a large fluid-filled cavity where Mr A's brain bleed had been, with some residual brain swelling. Health NZ said a residual tumour could not be excluded.

24. Over the course of the following day, Mr A's condition did not improve and, sadly, he later passed away.

Systems Analysis Review (SAR)

25. Health NZ conducted an SAR into Mr A's care and made the following findings:

- All the necessary assessments were performed to ascertain Mr A's suitability to have oral food and fluids and to determine what diet was appropriate.
- Insufficient measures were in place to reduce the risk of aspiration, including that Mr A was not consistently supervised by a nurse or healthcare assistant when eating. Staffing shortages at Wellington Hospital at the time contributed to this.
- Expected processes were not followed to adequately communicate changes in oral feeding status, including:
  - Mr A's nil by mouth status was not updated on the computer system, which meant a meal was provided because not all staff were aware of this change to his feeding status.
  - The sign at Mr A's bedside was not updated to show that he was nil by mouth.
  - Kitchen staff did not properly check Mr A's diet sheet before delivering his meals.

Response to provisional opinion

26. Health NZ was given an opportunity to comment on the provisional opinion and advised it has no further comments.

Opinion: Health NZ — breach

27. On 31 July 2025, I notified Health NZ of HDC's investigation and proposed that HDC adopt the findings of Health NZ's SAR. I proposed that I find Health NZ in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code),[19] as Health NZ acknowledged that insufficient measures were in place to reduce the risk of Mr A aspirating. I also took into consideration the identified areas for improvement and the changes made

[18] Magnetic resonance imaging (MRI) is a scan that creates clear images of structures inside the body using a large magnet, radio waves, and a computer.
[19] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

by Health NZ because of these events. On 21 August 2025, Health NZ accepted HDC's proposed breach finding.

28. Mr A was a vulnerable consumer because of his compromised swallow and limited function as a result of his stroke. It was the responsibility of Health NZ to ensure that all staff were aware of their responsibilities in respect of implementing changes to the feeding status of patients, noting that Mr A's status changed a number of times during his admission at Wellington Hospital.

29. On 1 June, Mr A was given a standard diet for his dinner, which was not in line with the soft diet that he began after an SLT review on 31 May. That incident was identified by Mr A's family. Then, on 4 June, Mr A was given a meal despite a nil by mouth order. These errors occurred because kitchen staff did not properly check Mr A's diet sheet before providing his meals and because his nil by mouth feeding status was not updated on the computer system or on his bedside chart, so changes to his oral feeding status were not adequately communicated to other staff members. In my view, and supported by the findings of the SAR, these errors indicate insufficient processes at Health NZ.

30. I am also concerned about the lack of supervision of Mr A while he was having his meals, resulting in his wife finding him choking on his lunch on 3 June and subsequently aspirating. This shows a lack of consistent supervision of Mr A, likely because there was no documentation stating that Mr A required supervision. In my view, Mr A should have been monitored while he was eating to observe the appropriateness of the meals he was receiving and mitigate the risk of him aspirating, particularly in light of the regular changes to his diet.

31. As supported by Health NZ's SAR, insufficient measures were in place to reduce the risk of aspiration and effectively communicate changes in Mr A's feeding status. As such, I find Health NZ in breach of Right 4(1) of the Code for failing to provide services to Mr A with reasonable care and skill.

Changes made

32. The SAR identified a number of recommendations. Health NZ has advised that the following recommendations have been implemented since the events to improve the process for communicating changes in the feeding status of patients and reduce the risk of aspiration events:

- SLT Professional and Team Leaders met with the Associate Charge Nurse Manager to determine strategies to reduce the potential for harm in patients at risk of aspiration and provide education to staff to ensure the strategies are enhanced. This included confirming the roles and responsibilities of staff when changing the texture of a patient's diet and introducing additional checks to ensure patient information is kept up to date.
- The SAR report was presented to senior staff of the departments involved in Mr A's care.
- Nurse educators on the ward updated their orientation for all new staff to ensure they are aware of the requirement to accurately record changes in a patient's dietary status.

- Orientation and annual staff training includes ensuring staff are aware of the risks associated with patients not receiving the correct food/fluid type, especially patients with a compromised swallow.
- Routine education for SLT ward staff has been reinstated across Wellington Hospital; at the time of the events, staffing shortages meant this was not happening.
- Routine meal tray audits have been reinstated (having been paused as a result of staff vacancies) to provide assurance that the meals received on the ward are of an appropriate texture for the diet code.

Recommendations and follow-up actions

33. I recommend that Health NZ provide HDC with an update on the implementation of the outstanding recommendations from its SAR. Health NZ is to provide a timeframe for their completion and an outline of the proposed mechanisms for monitoring their effectiveness. This information is to be provided to HDC within six months of this report.

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

35. A copy of this report with details identifying the parties removed, except Health New Zealand | Te Whatu Ora Capital, Coast and Hutt Valley and Wellington Hospital, will be sent to the Head of Disability, Director Ageing Well, and Chief Clinical Officer at Health New Zealand | Te Whatu Ora. Health New Zealand | Te Whatu Ora will be asked to consider whether learnings should be taken from the circumstances of this case, including whether there is an opportunity to develop nationally consistent guidelines across all Health NZ hospitals to guide the assessment, monitoring, and management of all patients who are admitted with a compromised swallow, be it as a result of a neurological disorder, muscle weakness, or a structural issue.

Rose Wall
Deputy Health and Disability Commissioner