Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

District health board breaches Code for inadequate assessment of elderly woman's risk of deep vein thrombosis

22HDC00815

The Deputy Health and Disability Commissioner has found a district health board (DHB) (now Te Whatu Ora) failed to provide an appropriate standard of care in its management of risks relating to a woman's surgery for a broken ankle.

Sadly, the woman died from a pulmonary embolism five days after being discharged from hospital following her surgery for the fracture.

Dr Vanessa Caldwell said the DHB failed to provide the woman with services with reasonable care and skill and therefore breached Right 4 (1) of the Code of Health and Disability Services Consumers' Rights.

Dr Caldwell found the DHB's assessment procedures for venous thromboembolism (VTE), where a blood clot or thrombus occurs in a deep vein, on admission were inadequate and that the woman's specific risk factors, were not considered by staff appropriately. She found that as a result, the management of the woman's discharge was inadequate.

"There were missed opportunities for staff to assess Ms A's condition critically and put in place a management plan to address the risks appropriately…. I consider this to be a service delivery failure for which, ultimately, Te Whatu Ora is responsible."

She recommended the organisation formally apologise to the woman's family for the failings identified. She also recommended it review its policy on assessing and managing VTE risk, and its recommended preventative measures on admission and discharge.

Other recommendations included:

- Te Whatu Ora to provide training to all current staff who were involved in the woman's care on awareness of VTE's, assessment processes for VTEs and risks associated with foot and ankle surgery.
- Completion of an audit following the review of Te Whatu Ora's updated VTE Policy of at least 15 patients to determine compliance with the new policy.

Evidence of these recommendations being carried out is to be provided to HDC within six months of her report.

Te Whatu Ora has made several changes since this report. This includes creating a mandatory field for VTE assessment in electronic admission documents, reinstating mandatory online learning on VTEs for all resident medical officers (RMO), ensuring

VTE risk and assessment is included in the RMO orientation and teaching, and reviewing its preoperative process in the use of the Acute Theatre Health Questionnaire.

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

30 October 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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