Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Capital and Coast DHB breached Code for inadequate postoperative care following man's eye surgery

20HDC00893

Capital and Coast District Health Board (CCDHB) (now Te Whatu Ora Capital, Coast and Hutt Valley) breached the Code of Health & Disability Services Consumer's Rights (the Code) for poor postoperative care following a man's eye surgery. Unfortunately, the man experienced corneal graft rejection and developed an infection, resulting in lost vision and subsequent surgical removal of his eye.

The man, in his thirties at the time, did not receive a discharge summary outlining the operation or postoperative instructions following eye surgery, and the written information he did receive did not give clear information 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.

After experiencing pain and other symptoms, the man attempted to obtain medical attention. However, 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, and there was no answerphone service. 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 follow up appointment was scheduled for five weeks after the date of surgery at another hospital.

Unfortunately, the man experienced corneal graft rejection and developed an infection, resulting in lost vision and subsequent surgical removal of his eye.

Health and Disability Deputy Commissioner, Dr Vanessa Caldwell, found CCDHB breached Right 4(1) of the Code, for not providing the man with a service of reasonable care and skill.

Dr Caldwell said the man was failed by systems that were not fit-for-purpose, or current, and did not facilitate care that was timely, appropriate, or safe. She said a series of avoidable communication breakdowns and administrative shortcomings deprived the man of the urgent advice and care he needed, despite his repeated attempts to seek help.

"I acknowledge that it cannot be known whether he would have gone on to endure the immense pain, severe infection, and loss of his left eye that occurred, had he received a timelier postoperative review. However, it is clear he did not receive the

necessary and expected opportunity to identify and manage any postoperative complications at one week following his surgery as would be expected."

Dr Caldwell was also critical of the standard of adverse event reporting by CCDHB. After an event like this, an internal review can be a useful way to understand what when wrong and what is needed to put in place to ensure it doesn't happen again. The review that was undertaken in this case was not thorough and did not involve all the necessary parties to reach a reasonable understanding of the key issues.

CCDHB advised HDC that since the events several changes have been made, including developing a desk file for administrative staff that includes processes for booking and rescheduling appointments within follow-up time frames, and guidance on answering and escalating telephone calls from patients. The postoperative information given to patients was also reviewed and updated and a card developed for corneal graft patients, advising which symptoms require urgent attention and where to seek help.

Dr Caldwell recommended further actions, including that CCDHB provide a formal written apology to the man, conduct an audit to confirm that ophthalmology receive discharge summaries and timely follow-up appointments, and look at ways to improve the booking system for postoperative follow-up ophthalmology appointments.

Te Whatu Ora was also referred to the Director of Proceedings, in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994, to decide whether any legal proceedings should be taken.

18 September 2023

ENDS

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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