Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Adequate policies needed to support safe practices
19HDC01065

The Deputy Health and Disability Commissioner has found Te Whatu Ora Te Toka Tumai Auckland, breached the Code of Health and Disability Services Consumer's Rights (the Code) over the care of an oncology patient.

The male patient was receiving treatment for throat cancer and was admitted to Auckland City Hospital with severe inflammation and ulceration of his digestive tract. While being treated for pain, he received an overdose of morphine which resulted in irreversible brain damage.

Dr Vanessa Caldwell found the provider breached Right 4(1) which ensures people receive services provided with reasonable care and skill. The provider was also found to have breached Right 4(4) which stipulates health and disability services be provided in a way that minimises harm, and optimises the quality of life of a person using that service.

Dr Caldwell was critical that policies were not sufficiently clear to support safe practices. "This is evident in the practices followed by staff that were not in line with the expected standard of care. Opiates are known to suppress breathing and to affect renal function. The risk for this patient was not monitored adequately," she said.

For providing care that fell considerably below the appropriate standard, Dr Caldwell referred Te Whatu Ora Te Toka Tumai Auckland to the Director of Proceedings.

A registered nurse was also found to have breached Right 4(1) which centres on the right of consumers to have services provided with reasonable care and skill. The nurse was also found to have breached Right 4(2) which gives consumers the right to services that comply with legal, professional, ethical and other relevant standards.

Dr Caldwell says "I am critical of the nurse's lack of monitoring and documentation (in particular, the failure to record the Code Red event), and for leaving the man on his own while she sought assistance, instead of undertaking an immediate assessment and raising the alarm."

Dr Caldwell made a number of recommendations for Te Whatu Ora Te Toka Tumai Auckland including education for nursing staff, consideration for a quick reference guide for management of opioid overdose and providing the man and his family a formal apology.

Dr Caldwell recommended that the nurse provide a written apology to the man and undertake further training on emergency procedures, local policy on observations, and documentation.

Since the event Te Whatu Ora Te Toka Tumai Auckland has made a number of changes to improve support for nurses and non-palliative patients, developed appropriate policies and training and expanded access to the Acute Pain Service for oncology ward patients with acute pain.

The Registered nurse has undertaken basic life support training and developed processes to prevent a similar occurrence in future.

27 March 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).