

## Delays in ED assessment and treatment of disabled man and inadequate provision of resources

---

1. This Office received a complaint from Mr A and Mrs A ('the complainants') about the care provided to their late brother and brother-in-law (respectively), Mr B, by Health New Zealand | Te Whatu Ora Capital, Coast and Hutt Valley (Health NZ) after he presented to the Emergency Department (ED). The complaint alleged that Mr B's ED wait time was too long, with no consideration given to his specific support needs relating to his tetraplegia. This meant that Mr B struggled for an excessively long time in his wheelchair without adequate support or clinical intervention.
2. EDs are specifically designed to provide immediate and urgent care to people who have a serious illness or injury. This investigation has highlighted the important considerations that must be given to disabled people who present to an ED, to ensure that they receive an appropriate standard of care that meets both their basic health *and* disability needs. The investigation also highlighted the duty of care obligations carried by EDs when delays occur and patients remain in the acute care setting for extended periods. In this context, a person's disability must be accommodated, and recognition must be given to a disabled person's needs being different from those of an able-bodied person.

### Summary of events

3. Mr B (aged 64 years at the time of events) was a long-term tetraplegic.<sup>1</sup> At approximately 6.44pm on 12 March 2021, Mr B presented to the Wellington Hospital ED on the advice of his general practitioner (GP)<sup>2</sup> for treatment of a foot ulcer and hypoxia,<sup>3</sup> on the background of a chesty cough.<sup>4</sup> Mr B was accompanied by his friend and carer, Ms C, and was triaged on arrival as a category 3.<sup>5</sup>
4. As there was no space available in the medical ward or the clinical treatment area of the ED, Mr B remained in the ED waiting room on his specialised wheelchair. The complainants told HDC that during this time, Ms C repeatedly asked for a bed for Mr B, but the nurses could not source a hospital bed with a pressure-relieving mattress. Mr B's support person, who

---

<sup>1</sup> Tetraplegia is a form of paralysis that affects both arms and both legs.

<sup>2</sup> On the same day, Mr B had been seen by his GP, who referred him to the general medical service at Wellington Hospital.

<sup>3</sup> Low oxygen saturation.

<sup>4</sup> Mr B had a history of pneumonia (an infection in one or both lungs) with type 2 respiratory failure (low blood oxygen levels and high carbon dioxide levels) in 2019.

<sup>5</sup> All EDs in New Zealand use the Australasian Triage Scale. A category 3 is defined as 'Potentially life-threatening' or 'Situational urgency' or 'Humane Practice' and is to be assessed medically within 30 minutes: [https://www.safetyandquality.gov.au/sites/default/files/2024-04/emergency\\_triage\\_education\\_kit\\_-\\_australasian\\_triage\\_scale\\_-\\_descriptors\\_for\\_categories.pdf](https://www.safetyandquality.gov.au/sites/default/files/2024-04/emergency_triage_education_kit_-_australasian_triage_scale_-_descriptors_for_categories.pdf)

remained with him, described how extremely tired and exhausted he became as a result of this experience.

5. At approximately 11.55pm, some five hours after he first presented, Mr B was placed in a clinical treatment cubicle and was seen by an ED registrar, who noted Mr B's normal vital signs and assessed him as '[s]afe to [await] medical [review]'. Clinical records show that a hospital bed was requested for Mr B at 3.33am on 13 March 2021, and a call was made to request a pressure-relieving mattress<sup>6</sup> at the same time.<sup>7</sup> At this point, Mr B had been in the ED in his wheelchair for close to nine hours with some baseline recordings and assessments occurring after the initial triage to determine his relative priority for treatment.
6. Eventually, around 5am on 13 March 2021, Mr B was commenced on intravenous (IV) flucloxacillin<sup>8</sup> for his foot ulcer, during which he collapsed suddenly with a clinical presentation consistent with anaphylactic shock.<sup>9</sup> The antibiotic was stopped immediately; however, Mr B required immediate resuscitation and treatment, including intubation.<sup>10</sup> Mr B was stabilised and transferred to the Intensive Care Unit (ICU) for ongoing care.
7. Sadly, Mr B deteriorated in the ICU and passed away in late March 2021 from community-acquired pneumonia, with a secondary cause of anaphylaxis due to flucloxacillin. I offer my sincere condolences to Mr B's family.
8. The scope of this investigation is limited to Mr B's experience while in the ED and does not extend to his reaction to the IV antibiotic. The consideration of Mr B's anaphylactic reaction has been addressed through a separate HDC process.

### **Provider response**

9. Health NZ stated that it recognised that Mr B had a mobility disability and that he was tetraplegic. Health NZ told HDC that Mr B was given a higher triage score (category 3) due to his tetraplegia, and a person without tetraplegia or immobility in similar circumstances would have received a triage score of 4.
10. Health NZ acknowledged that the amount of time Mr B spent waiting in the ED 'exceeded the time recommended for impaired mobility' and apologised for the delays that occurred. It stated that the delay in assessing Mr B was due to the inability to put him in an assessment space and an overcrowded ED operating at 140% of its capacity. In addition, the hospital was operating at 102–103% capacity, which confirmed that there were no free ward beds in the hospital and therefore no suitable area for transfer of Mr B.
11. Health NZ stated that it 'endeavor[s] to prioritise patients with disabilities to be placed in an appropriate bed and cubicle space', and it recognised that it could have been more

---

<sup>6</sup> Health NZ told HDC that the ED has a supply of hospital equipment to transfer patients onto if required; however, if there are special requirements for pressure-relieving support, an order is placed through 'Essential (Medical Supplier)', who delivers the equipment from offsite the same day, as due to space constraints in the ED, the equipment must be stored in other areas and needs to be inflated before a patient can be put on it.

<sup>7</sup> Clinical notes show that there was no answer and a note was made to follow up again at 4am.

<sup>8</sup> A penicillin-based antibiotic.

<sup>9</sup> An acute, severe allergic reaction.

<sup>10</sup> A procedure to protect and maintain the airway.

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

considerate of Mr B's disability. Health NZ told HDC that, in hindsight, it should have arranged to accommodate him in an assessment space earlier. Health NZ stated: 'We regret not taking this initiative sooner, and we assure you that the above case has served as a valuable learning experience for our staff.'

12. Health NZ apologised for the 'unacceptable delay' that occurred in obtaining a hospital bed and a pressure-relieving mattress for Mr B. Health NZ stated that the request for an appropriate bed and mattress for Mr B was completed in the correct timeframe, but 'a delay in delivery to the area occurred' and '[m]easures are now in place to prevent this from occurring again'. In addition to the lack of fundamental equipment, the complainants highlighted in their complaint to HDC that Mr B's hygiene needs were not attended to (for example, it appears that staff did not check or empty Mr B's urine bag or provide pressure wound care the entire time he was in the ED).
13. Health NZ told HDC that when the ED is running out of bed space, some ED patients waiting for admission beds are moved to a 'limited number of over census bed spaces' on its wards,<sup>11</sup> as per the Health NZ Capital, Coast and Hutt Valley 'Over Census Patient Management' policy (first issued 16 September 2019) in order to relieve the pressure on the ED; however, this policy applies only during the day, as it involves the deployment of nurses from non-clinical areas to assist in the management of decanted patients.

### **Responses to provisional opinion**

#### *The complainants*

14. The complainants were given the opportunity to respond to the provisional opinion. While they were relieved to read the conclusions reached in the provisional opinion and felt 'encouraged' by the expectations of Health NZ, they stated that it was 'distressing' and '[a]larming' to read that Wellington Regional Hospitals were 'still scoring so low nationally' with regard to ED wait times (as per paragraph 24). The complainants stated that they hope what happened to Mr B 'never happens to anyone or any disabled person again' but expressed their concern as to whether 'concrete change will happen' 'if the same management are still there from 2021'.

#### *Health NZ*

15. Health NZ was given the opportunity to respond to the provisional opinion. Health NZ accepted the recommendations and follow-up actions and again apologised to Mr B's family for the care he received.

### **Independent clinical advice**

16. Independent clinical advice was obtained from emergency medicine specialist Dr Martin Watts (Appendix A). While Dr Watts acknowledged that Mr B's triaging took into account his tetraplegia (had he not been tetraplegic, likely he would have been given a triage category of 4, not 3), he also highlighted that Mr B required specialised care, which he did not receive, including specific equipment to manage his tetraplegia (for example, a specialised mattress and lifting equipment). In addition, appropriate staff should have been to hand with the knowledge on how to deliver the clinical care required of an immobile

---

<sup>11</sup> Health NZ stated that 'over census' spaces 'refer to spaces that do not generally function as a ward bed space (e.g. treatment rooms)'.

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

person, including, for example, the provision of regular physical turns. In summary, Dr Watts identified the following deficiencies in the care provided to Mr B:

- There was a significant delay in allocating Mr B an appropriate physical space with appropriate equipment for his physical care = **severe departure**.
- There were inadequate resources (physical and staffing) to provide adequate care = **severe departure**.
- Mr B's medical assessment should have commenced within 30 minutes of his triage = **severe departure**.

17. However, Dr Watts noted that delays in care are common in many EDs, the causes of which are multifactorial and complex. Furthermore, Dr Watts advised that the 'Over-Census Patient Management' policy is almost solely related to finding further physical bed spaces and needs more clarity regarding what additional human resources (nursing, medical, and support staff) could be accessed if required.

### **Final decision**

18. Right 4(3) of the Code of Health and Disability Services Consumers' Rights (the Code) provides that '[e]very consumer has the right to have services provided in a manner consistent with his or her needs'.
19. As a tetraplegic, Mr B required specialised care, including an appropriate physical assessment location and specialised equipment, and an ED should be equipped to respond appropriately and provide this care. While Mr B's triaging score took into account his tetraplegia, I am critical that his unique support needs as a tetraplegic were not taken into consideration and provided for during his time in the ED.
20. Mr B was triaged as a category 3, meaning that assessment and treatment should have commenced within 30 minutes (as per the Australasian Triage Scale); however, Mr B waited nearly 10 hours before treatment commenced. Although I acknowledge that the ED and hospital were overcrowded at the time of events (which contributed to the prolonged delay in undertaking a medical assessment), and I note Dr Watts' advice that delays in EDs are common, as recognised by Health NZ, the delay in Mr B's assessment and treatment was excessive. Furthermore, I consider that an appropriate space and equipment consistent with Mr B's needs should have been provided until the medical assessment and treatment could be undertaken. While I acknowledge that nursing staff completed some basic baseline recordings and assessments, I am also extremely concerned that other basic nursing cares, including the provision of hygiene and pressure wound cares, were omitted during this time. These omissions put Mr B at serious risk of further harm.
21. For failing to provide Mr B with services in a manner consistent with his specific needs, I find Health NZ Capital, Coast and Hutt Valley in breach of Right 4(3) of the Code.

### **Concluding remarks**

22. I recognise that one of the reasons the complainants brought their concerns to the attention of the Health and Disability Commissioner was to ensure that constructive change occurred as a result of Mr B's experience at Wellington Hospital ED four years ago. By highlighting

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

their concerns, they asked that acceptable maximum waiting times in EDs be instituted, with procedures put in place to avoid a similar situation arising in the future.

23. I acknowledge that in the intervening period the government has implemented a target for all Health NZ ED wait times, which refers to 95% of patients admitted, discharged, or transferred within six hours. The ED wait-time target is part of a broader set of health targets aimed at improving access and efficiency within the healthcare system.
24. I recognise that the implementation of an ED wait-time target will go some way to alleviating the likelihood of Mr B's experience being repeated. However, while the target is 95% of patients being seen within six hours (by 2030), data as at October 2025 shows that around 73.9% of patients presenting at EDs across the county are being seen within that timeframe, with Wellington Regional Hospital's ED identified as having the longest wait times in the country (with 53%).<sup>12</sup> This suggests that further work has yet to occur at a national level, and more specifically within Health NZ Capital, Coast and Hutt Valley, to achieve the expected efficiency gains.
25. While I support the efforts being made to reduce ED waiting times, I remain concerned about disabled people's experiences of health services and whether sufficient attention is being given to ensuring disabled people's support needs are being appropriately met.

### **Recommendations and follow-up actions**

26. I recommend that Health NZ Capital, Coast and Hutt Valley:
  - Provide a written apology to Mr B's family for the deficiencies in care identified in the final report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr B's family.
  - Review the 'Over Census Patient Management' policy in light of Dr Watts' advice and report back to HDC on any recommended changes or amendments, within three months of the date of this report.
  - Report back to HDC on the learnings taken from this case, including any changes to practice instigated as a result, within three months of the date of this report.
  - Report back to HDC on the measures that are now in place, and any further work planned, to ensure that the specific support needs of disabled consumers admitted to ED are identified and managed appropriately. This information is to be provided to HDC within three months of the date of this report.
27. A copy of this report with details identifying the parties removed, except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case, will be sent to the Ministry of Health | Manatū Hauora and the Australasian College for Emergency Medicine and placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.
28. A copy of this report with details identifying the parties removed, except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case, will also be sent to the Head of

<sup>12</sup> [Health targets performance – Health New Zealand | Te Whatu Ora](#)

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

Disability in the Office of the Chief Executive, Health New Zealand | Te Whatu Ora. I will be asking the Head of Disability to consider whether any further learnings can be taken from this case to improve the experience of disabled people in EDs and will request a report on the changes that will be introduced at a national level as a result.

Rose Wall

**Deputy Health and Disability Commissioner**

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

### Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from emergency medicine specialist Dr Martin Watts on 1 September 2024:

<b>'Complaint:</b>	<b>Mr [B]/Health NZ Capital, Coast and Hutt Valley</b>
<b>Our ref:</b>	<b>21HDC02532</b>
<b>Independent advisor:</b>	<b>Dr Martin Watts</b>

I have been asked to provide clinical advice to HDC on case number 21HDC02532. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	<p>Bachelor of Medicine, Bachelor of Surgery (MB ChB)</p> <p>Diploma in Child Health (DCH)</p> <p>Fellow of the Australasian College for Emergency Medicine (FACEM)</p> <p>More than twenty years of experience working in clinical Emergency Medicine, including time in leadership roles.</p>
Documents provided by HDC:	<ol style="list-style-type: none"> <li>1. Letter of complaint (dated 14 October 2021)</li> <li>2. Health NZ Capital, Coast and Hutt Valley's responses to complainants (dated 17 November 2021 and 24 May 2022)</li> <li>3. Health NZ Capital, Coast and Hutt Valley's responses to HDC (dated 1 February 2022 and 10 May 2024)</li> <li>4. Clinical records from Health NZ Capital, Coast and Hutt Valley covering the period 12–31 March 2021.</li> <li>5. Clinical records from [non-subject medical centre] covering the period 1 February–31 March 2021.</li> <li>6. Health NZ Capital, Coast and Hutt Valley's adverse event reports covering the period 13–28 March 2021.</li> <li>7. Health NZ Capital, Coast and Hutt Valley ED shift report 12–13 March 2021.</li> <li>8. Health NZ Capital, Coast and Hutt Valley "Triage in the Emergency Department" policy (dated 22 October 2020).</li> <li>9. Health NZ Capital, Coast and Hutt Valley Anaphylaxis guidelines (January 2019).</li> <li>10. Health NZ Capital, Coast and Hutt Valley "Pressure Injury Prevention and Management" policy (dated 12 February 2019).</li> </ol>

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

	<p>11. Health NZ Capital, Coast and Hutt Valley “Over Census Patient Management — District Wide” policy (dated 29 March 2023).</p> <p>12. Health NZ Capital, Coast and Hutt Valley “Pro-Equity People-based Commissioning” policy (dated 5 November 2021).</p> <p>13. Health NZ Capital, Coast and Hutt Valley “Safe Medicine Administration” policy (dated 15 March 2021).</p>
Referral instructions from HDC:	<p>Health NZ Capital, Coast and Hutt Valley</p> <ol style="list-style-type: none"> <li>1. Whether the triaging and management of Mr [B] in Health NZ Capital, Coast and Hutt Valley ED was appropriate. In particular: <ul style="list-style-type: none"> <li>• Whether the category 3 triage score given to Mr [B] was appropriate;</li> <li>• Whether Mr [B]’s needs as a tetraplegic were appropriately taken into consideration and provided for; and</li> <li>• Whether the assessment of Mr [B] by the ED doctor was reasonable.</li> </ul> </li> <li>2. The adequacy of Health NZ Capital, Coast and Hutt Valley’s staffing levels and/or resources at the time of Mr [B]’s admission.</li> <li>3. The adequacy of Health NZ Capital, Coast and Hutt Valley policies and procedures at the time of events, and whether these were followed appropriately.</li> <li>4. Any other matters you consider warrant comment.</li> </ol>
Brief summary of clinical events	<p>Mr [B], a long-term tetraplegic, was referred by his GP to the inpatient medical team for a foot ulcer and the finding of low oxygen saturations on the background of a chesty cough. This was on 12 March 2021.</p> <p>He was triaged in the Emergency Department (ED) as a triage category 3.</p> <p>Mr [B] had a prolonged wait to see the inpatient medical team, and during this time his vital signs remained stable and he had a brief assessment by the ED doctor on duty.</p> <p>Mr [B] was eventually commenced on treatment for an infection in his foot. During the administration of intravenous flucloxacillin (a penicillin-based antibiotic) he suddenly collapsed with a clinical presentation consistent with anaphylactic shock (an acute, severe allergic reaction).</p> <p>Mr [B] required immediate resuscitation and treatment, including intubation, a procedure to protect and maintain his airway.</p> <p>Following this and his initial stabilisation, he was transferred to the Intensive Care Unit (ICU) for ongoing care. Sadly, he failed to</p>

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.*

	improve and deteriorated on the ICU and died [in late] March 2021.
--	--

Question 1: Whether the triaging and management of Mr [B] in Health NZ Capital, Coast and Hutt Valley ED was appropriate. In particular:

- Whether the category 3 triage score given to Mr [B] was appropriate

List any sources of information reviewed other than the documents provided by HDC:	(1) College of Emergency Nurses NZ, The NZ Triage Course Clinical Decision Tool for Adults. (2) Guidelines on the implementation of The Australasian Triage Scale in Emergency Departments. Australasian College for Emergency Medicine 2016.
Advisor's opinion:	The decision taken at 1844 hours to triage the patient as a triage 3 on the Australasian Triage Scale (ATS) was appropriate. This is based on comparing the patient's documented triage assessment and recorded vital signs with the standard guidelines referenced above and also discussion with an expert Triage Nurse educator and trainer.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Triage is a brief assessment taking five minutes or less for each patient. This is done using a standard tool and should be reproducible throughout New Zealand and Australian Emergency Departments. This includes vital signs where indicated.
Was there a departure from the standard of care or accepted Practice?  <ul style="list-style-type: none"> <li>• No departure</li> <li>• Mild departure</li> <li>• Moderate departure</li> <li>• Severe departure</li> </ul>	There was no departure from standard care and accepted practice.  <i>Although the triaging was appropriate, a category 3 score suggests that a patient has a medical assessment within 30 minutes of triaging. This has not happened, but triaging itself was appropriate.</i>
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The triaging is appropriate and well documented. This would be viewed as a good standard of care by peers.  (Consulted with Senior Nurse [...], [Medical Professional] at Southland Hospital Emergency Department.)
Please outline any factors that may limit your assessment of the events.	Triage is acknowledged to be only a brief assessment at a point in time. It is not a full assessment. Notwithstanding, a thorough triage has been documented. Mr [B] waited a long time from initial triage to full assessment in the ED (18:44 to 23:55 hours). A re-assessment was performed.

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

	Triage re-assessment was appropriate and is covered in the local policy provided "Triage in the Emergency Department".
Recommendations for improvement that may help to prevent a similar occurrence in the future.	None.

Question 2: Whether the triaging and management of Mr [B] in Health NZ Capital, Coast and Hutt Valley ED was appropriate. In particular:

- Whether Mr [B]'s needs as a tetraplegic were appropriately taken into consideration and provided for.

List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	<p>Mr [B]'s triaging took into account his tetraplegia. Had he not been tetraplegic, he would have likely been given a triage category of 4.</p> <p>Mr [B] required specialised care, including equipment because of his tetraplegia. An ED should be able to provide this care.</p>
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	<p>Accepted care would be to provide an appropriate physical location for the assessment of a tetraplegic patient. Most ED physical spaces would be appropriate. Standard practice would be to provide appropriate medical equipment to manage a tetraplegic patient, such as specialised mattresses and lifting equipment. Appropriate staffing should also be provided with the knowledge that additional clinical care is required such as physical turning of the patient.</p>
<p>Was there a departure from the standard of care or accepted Practice?</p> <ul style="list-style-type: none"> <li>• No departure</li> <li>• Mild departure</li> <li>• Moderate departure</li> </ul>	<p>There was a clear delay in providing standard care. There were significant delays in allocating Mr [B] an appropriate physical space with appropriate equipment for his physical care.</p> <p>This was a severe departure from accepted practice.</p>

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

<ul style="list-style-type: none"> <li>• Severe departure</li> </ul>	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed by peers as a failure to provide appropriate care.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in the future.	There were appropriate policies in place (discussed later). There were problems following these due to a lack of support resources out of hours.

Question 3: Whether the triaging and management of Mr [B] in Health NZ Capital, Coast and Hutt Valley ED was appropriate. In particular:

- Whether the assessment of Mr [B] by the ED doctor was reasonable.

List any sources of information reviewed other than the documents provided by HDC:	<p>(1) Australasian College for Emergency Medicine. Guideline; Responsibility for care in Emergency Departments.</p> <p>(2) New Zealand Resuscitation Council Guideline: Anaphylaxis</p>
Advisor's opinion:	<p>Mr [B] was referred by his GP and accepted by the inpatient medical team. Whilst waiting for the inpatient medical team he was reviewed by the ED Registrar at 23:55 hours. At this brief assessment he appeared stable, the doctor was aware of Mr [B]'s vital signs and checked his blood results and ordered a chest X-ray. This is good practice, ensuring that the patient at this point was clinically stable and facilitating investigations which were required.</p> <p>The second ED doctor's involvement was when the patient collapsed during administration of flucloxacillin medication. As anaphylaxis was the likely cause of this sudden deterioration, the patient was treated initially for this. The notes suggest that the treatment provided was quite appropriate in the situation and were consistent with the guidelines referenced above (2). The involvement</p>

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

	(and leadership) of the ED doctor in a patient under the care of the inpatient medical team was quite appropriate as the patient was still in the ED at this time.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	<p>Patients are commonly referred by other providers such as GPs to specialist inpatient teams, as in this case. Whilst the patient is waiting for these specialist teams in the ED, the ED does have a duty of care and responsibility for the patient. This does not necessarily include a full assessment of stable patients. This is standard practice. This is covered in the guideline referenced above (1).</p> <p>The ED doctor attended when the patient experienced a sudden deterioration after being administered medication. This is the expected standard. From the notes provided it appears that appropriate algorithms for anaphylaxis were followed.</p>
<p>Was there a departure from the standard of care or accepted Practice?</p> <ul style="list-style-type: none"> <li>• No departure</li> <li>• Mild departure</li> <li>• Moderate departure</li> <li>• Severe departure</li> </ul>	There has been no departure from accepted practice by the ED doctor involved.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The ED doctor was able to provide a brief assessment and review at 23:55 hours, was aware of the patient and took steps to expedite his care. This would be viewed as good practice by this ED doctor. There was appropriate care provided when the patient collapsed.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in the future.	Ensure that ED staff continue to be aware of the duty of care for patients in the ED as stated in reference (1).

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

Question 4: The adequacy of Health NZ Capital, Coast and Hutt Valley’s staffing levels and/or resources at the time of Mr [B]’s admission.

<p>List any sources of information reviewed other than the documents provided by HDC:</p>	<p>Australasian College for Emergency Medicine. Position Statement, Access Block.</p> <p>Australasian College for Emergency Medicine. Position Statement March 2021; ED Overcrowding</p>
<p>Advisor’s opinion:</p>	<p>Information provided suggests that the local nursing staffing levels were at “normal” levels during the days when Mr [B] was in the ED.</p> <p>Shift reports show that the ED capacity was above 100% for a substantial part of the days 12<sup>th</sup> and 13<sup>th</sup> of March 2021, particularly in the late evening and overnight.</p> <p>A large part of this problem is probably related to the number of patients physically in the ED waiting for a ward bed. If these patients were removed (transferred to the ward) then the ED might have been able to function at, or around its capacity. There are also notably some patients with significantly long length of stays (LOS) in the ED. Multiple patients staying in the ED for prolonged periods waiting for beds are a common cause of “access block” in EDs. Although access block is primarily seen in the ED it is commonly the result of a system wide resource issue encompassing bed capacity, staffing and efficiency.</p>
<p>What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.</p>	<p>The ideal target for EDs is to have most patients (95%) seen, treated and discharged or admitted to an inpatient bed within 6 hours of arrival in the ED.</p> <p>Best practice is that patients are seen within the timeframe suggested by their triage category. In this case Mr [B]’s medical assessment should have commenced within 30 minutes of his triage.</p> <p>Implicit in the descriptors of Triage Categories 1 to 4 is the assumption that the clinical outcome may be affected by delays to assessment and treatment beyond the recommended times.</p>
<p>Was there a departure from the standard of care or accepted Practice?</p> <ul style="list-style-type: none"> <li>• No departure</li> </ul>	<p>There was a clear departure from standard of care.</p> <p>There were inadequate resources (physical and human, in some combination) to provide adequate care.</p>

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.*

<ul style="list-style-type: none"> <li>• Mild departure</li> <li>• Moderate departure</li> <li>• Severe departure</li> </ul>	This is a severe departure from accepted standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	It is not uncommon at all for delayed care to occur in many New Zealand EDs. Current literature suggests delays are common. The causes of this are multifactorial and complex.
Please outline any factors that may limit your assessment of the events.	The ED shift reports are in depth but clearly suggest the issues appear to be as discussed above.
Recommendations for improvement that may help to prevent a similar occurrence in the future.	Access block and ED overcrowding are complex and multifactorial issues and demand an appropriate response. Such a response is likely to be a hospital and system-wide response as discussed in the documents referenced above. The ED is only one part of a complex flow system.

Question 5: The adequacy of Health NZ Capital, Coast and Hutt Valley policies and procedures at the time of events, and whether these were followed appropriately.

List any sources of information reviewed other than the documents provided by HDC:	
<b>Policies and procedures reviewed:</b>	<ol style="list-style-type: none"> <li>1. "Triage in the Emergency Department" (document 8)</li> <li>2. "Anaphylaxis Policy" (document 9)</li> <li>3. "Pressure Injury Prevention and Management" (document 10)</li> <li>4. "Over Census Patient Management" (Document 11)</li> <li>5. "Pro-Equity People-based Commissioning Policy" (Document 12)</li> <li>6. "Safe Medicine Administration Policy" (Document 13)</li> </ol>
Advisor's Opinion:	<ol style="list-style-type: none"> <li>1. "Triage in the Emergency Department" is consistent with Australasian and New Zealand triage guidelines.</li> <li>2. "Anaphylaxis Policy" Consistent with NZ Resuscitation Council Guidelines.</li> <li>3. "Pressure Injury Prevention and Management" A detailed guide for nursing staff. Consistent with standard care and well referenced with publications in this area.</li> </ol>

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

	<ol style="list-style-type: none"> <li>4. “Over Census Patient Management”. Local policy (by necessity). This policy is almost solely related to finding further physical bed spaces. The need for additional human resources is covered by a single (vague) sentence and there is no mention at all of additional medical staff being sought.</li> <li>5. “Pro-Equity People-based Commissioning Policy” is detailed and overarching and more a systems document than detailing individual care for groups such as the disabled.</li> <li>6. “Safe Medicine Administration” is comprehensive and of a good standard.</li> </ol>
<p>What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.</p>	<ol style="list-style-type: none"> <li>1. Triaging was of acceptable standard and was consistent with local and Australasian standards.</li> <li>2. Treatment of Anaphylaxis was accepted practice.</li> <li>3. “Pressure Injury Prevention” standards are as per stated in the document. This appears to be appropriate and well referenced.</li> <li>4. It is necessary to have an over-census policy when there is a risk of this occurring. This is a local document and based on local resources. There are some areas where improvements might occur.</li> <li>5. The policy on Pro-Equity Commissioning is acceptable.</li> <li>6. The “Safe Medicine Administration” policy is of a good standard and comprehensive. It is well written and appears to be part of the organisational culture.</li> </ol>
<p>Was there a departure from the standard of care or accepted Practice?</p> <ul style="list-style-type: none"> <li>• No departure</li> <li>• Mild departure</li> <li>• Moderate departure</li> <li>• Severe departure</li> </ul>	<p>There was a departure from the standard of care regarding pressure injury prevention (3). This was a moderate departure (there was no resulting pressure injury although the potential for such an injury occurred).</p> <p>The over census policy is a local document. It is not altogether clear if this was followed, or whether even this was overwhelmed by the volume of patients in the ward and ED.</p> <p>The policies used — 1, 2, 5 and 6 (as numbered above) did not show any departure from standard of care or accepted practice.</p>
<p>How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted</p>	<p>The policies and procedures as provided would be viewed as relatively standard and normal by peers.</p> <p>They are largely comparable with those in a similar sized hospital where the advisor is employed.</p>

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.*

Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in the future.	The “Over Census” policy should be reviewed. More clarity should be defined regarding what additional human resources (nursing, medical and support staff) could be accessed if required.

Question 6: Any other matters warranting comment.

List any sources of information reviewed other than the documents provided by HDC:	
Advisor’s opinion:	<p>The patient was seen in the community by an appropriately qualified practitioner (GP) who judged that he required inpatient care from a specialist medical team (internal medicine in this case). The clinician referred the patient directly to this team.</p> <p>Ideally the accepting team should see the patient in a timely manner and commence admission and treatment.</p> <p>If this was the case, then the ED involvement would be minimal (the ED does provide an appropriate physical space for assessment and is usually well set up to arrange access to acute testing such as laboratory and radiology). The ED team would not be expected to duplicate the GP’s assessment.</p> <p>Apart from triage and facilitating appropriate investigations, the ED should have no need to be involved if the system is functioning well. In this case, the ED doctor performed a brief assessment when it was clear that the patient had waited too long for specialist review. This was the correct thing to do. The ED also intervened correctly when the patient had a sudden deterioration and collapsed.</p>
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	From the ED perspective, the care was appropriate and would be considered usual practice.

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.*

	The long delay in inpatient team review is below that expected. This may be for a number of reasons, including work volume versus resources.
<p>Was there a departure from the standard of care or accepted Practice?</p> <ul style="list-style-type: none"> <li>• No departure</li> <li>• Mild departure</li> <li>• Moderate departure</li> <li>• Severe departure</li> </ul>	There is a severe departure of care from the inpatient medical team in their delayed assessment of a referred acute patient.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be judged as a significant delay in care by peers.
Please outline any factors that may limit your assessment of the events.	I am unable to comment on the inpatient medical teams' resources available and the other competing medical work, which may have been more urgent.
Recommendations for improvement that may help to prevent a similar occurrence in the future.	The delays to assessment and treatment are likely complex and multifactorial. If this is a recurrent issue at this hospital, then there is clearly a mismatch between the resources available and the demand for care. It is noted that demand is often variable and unpredictable, and staffing for normal workload and flow is not always able to respond to peaks in demand, leading to prolonged waits for assessment and treatment. This is likely to be a whole-of-system or whole-of-hospital issue.
<p>Name: Dr Martin Watts</p> <p>Date of Advice: 1 September 2024'</p>	

*Names have been removed (except Health NZ Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*