Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00226)

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to a man by Te Whatu Ora Tairāwhiti (previously Hauora Tairāwhiti)[1] following his request for Post-Exposure Prophylaxis (PEP)[2] medication for Human Immunodeficiency Virus (HIV[3]) exposure.

3. The following issue was identified for investigation:

- *Whether Te Whatu Ora provided the man with an appropriate standard of care on 29 January 2021.*

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to Hauora Tairāwhiti now refer to Te Whatu Ora Tairāwhiti.
[2] PEP is a course of HIV treatment (antiretroviral medications) that can be taken within 72 hours of an HIV exposure to prevent an HIV infection.
[3] Human immunodeficiency virus (HIV) is an infection that attacks the body's immune system. In most cases, HIV is a sexually transmitted infection and can be treated and prevented with antiretroviral medications (ART).

Names have been removed (except Te Whatu Ora Tairāwhiti and the advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Background

4. On 29 January 2021, the man presented to Te Whatu Ora Tairāwhiti (Te Whatu Ora) Emergency Department (ED) requesting HIV PEP medication, as he was concerned about potential HIV exposure due to having had unprotected sex. The man told HDC that he approached the ED 'around 5pm' as online information suggested that this was the correct place to request the medication after hours.

5. The man stated that when he asked the receptionist for the medication, she did not understand what he was saying. He told HDC that he was then questioned 'loudly and rudely' about his request by an ED nurse[4] in the presence of other patients. The man explained his concerns about HIV exposure to the ED nurse but was told to call his general practitioner (GP) for the treatment as the ED was for emergencies.

6. The man stated that he told the ED nurse that the online information advised attending the ED to request the medication, but the ED nurse again insisted that he call his GP. The man left the ED without treatment or assessment, so no clinical documentation was done by the ED nurse. The man told HDC that he felt humiliated and discriminated against.

7. Te Whatu Ora apologised that the man was made to feel humiliated and embarrassed in the ED reception area but stated that the provision of HIV PEP 'is more complex than "I need some PEP", it demands a proper consultation', which in the majority of instances is most appropriately carried out in primary care, where a 'fuller' consultation can occur. Furthermore, Te Whatu Ora stated:

> 'The prescription of PEP involves an appropriate clinical assessment, where the degree of risk is assessed, contacting testing needs and patient testing needs now and in the future are assessed, advice is offered and follow up is arranged.'

8. Te Whatu Ora told HDC that as '[t]he window of opportunity for prescription of PEP is 72 hours', it did not provide HIV PEP to the man, as it was thought that the timeframe allowed for a GP visit. Te Whatu Ora apologised for not explaining this to him.

Responses to provisional opinion

9. The man was given an opportunity to respond to the information gathered during this investigation but had nothing further to add.

Te Whatu Ora

10. Te Whatu Ora was given the opportunity to respond to the provisional opinion. Te Whatu Ora's response has been incorporated into this report where relevant and appropriate.

[4] Te Whatu Ora has been unable to identify the staff member involved, as discussed below.

Opinion: Te Whatu Ora Tairāwhiti — breach

Introduction

11. In his complaint to HDC, the man raised concerns about the care provided to him by Te Whatu Ora; in particular, whether it was acceptable to deny him the HIV PEP medication, as well as concerns about confidentiality and the manner in which the ED nurse spoke to him.

12. I have undertaken a thorough assessment of the information gathered in light of the man's concerns. To assist my assessment of the care provided by Te Whatu Ora, I sought independent advice from an emergency medicine specialist, Dr Martin Watts (Appendix A), and in-house clinical advice from Dr David Maplesden (Appendix B).

Standard of care — breach

Failure to assess, and denial of HIV PEP at ED

13. The issue before me is whether the provision of HIV PEP to patients can be carried out in an ED, and therefore whether it was acceptable to deny the man HIV PEP treatment.

Online information regarding HIV PEP

14. As noted in paragraph 4, the man stated that he presented to the ED because online information had suggested that this was the appropriate place to request HIV PEP after hours. However, Te Whatu Ora told HDC that its website (at the time of events) did not state that it would provide or give HIV PEP outside of GP hours.

15. Although the man did not state which online source he used for this information, both my independent advisor, Dr Watts, and my in-house advisor, Dr Maplesden, referenced several websites that advise attendance at ED as the appropriate place to go following an HIV exposure event outside of GP hours. The websites, which all appear on an internet search for such advice, include the Burnett Foundation Aotearoa (formerly New Zealand AIDS Foundation & Ending HIV NZ) and the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). The websites state:

- 'PEP means taking medicine to prevent HIV infection after a possible exposure. It needs to be taken within 72 hours of possible exposure, **the sooner the better** … Head to your GP, your local after-hours clinic, or the emergency department at your local hospital **as soon as you can — as the longer you leave it, the less chance it will be effective**.'[5] (Emphasis added.)

- 'To be effective, initiation of PEP needs to occur within 72 hours, **the earlier the better** … People requiring PEP during business hours should be encouraged to present to … prescribing GPs or sexual health clinics … [I]n cases that require attention outside of business hours, people should present to their nearest hospital ED.'[6] (Emphasis added.)

[5] https://www.burnettfoundation.org.nz/learn/staying-safe/pep/.
[6] Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV: Australian National Guidelines (2016) https://www.pep.guidelines.org.au/.

16. Furthermore, Te Whatu Ora Tairāwhiti's website provides information about sexually transmitted diseases,[7] and although it does not specifically state that it will provide or give HIV PEP outside of GP hours, it does include a link to further information about HIV,[8] which then directs the person to the Burnett Foundation's website, which gives the directions as noted above in paragraph 15. This information was on Te Whatu Ora Tairāwhiti's website at the time of events.[9]

17. Based on the evidence before me, I consider that it would be reasonable for a person following this chain of information to assume that Te Whatu Ora Tairāwhiti would provide HIV PEP, given that the information available online at the time of events recommended attendance at the ED following an HIV exposure event.

18. In addition, I consider Te Whatu Ora's assertion that its website was not explicit about providing HIV PEP outside of GP hours unacceptable, given that Tairāwhiti ED expressly (and as is usual practice in EDs throughout the country) operates to provide urgent and emergency care outside of business hours. To assert that an ED cannot provide a service outside of business hours is contradictory to the aims of EDs, and it is unreasonable to suggest that just because a service is not explicitly stated on a hospital website, it cannot be provided.

Provision of HIV PEP in EDs

19. As discussed in paragraphs 7 and 8, Te Whatu Ora told HDC that it did not provide HIV PEP to the man as the provision of HIV PEP requires a full consultation and risk assessment, which is most appropriately carried out in primary care.

20. Dr Watts advised that there is no reason for an appropriate and 'fuller' consultation not to be carried out in an ED, and there seems to have been a failure of knowledge regarding the need for, and availability of, HIV PEP.

21. Te Whatu Ora told HDC that at the time of this incident, there had been no previous documented requests for HIV PEP, and there were no policies or protocols in place for the assessment and treatment of HIV PEP, other than a guideline for dispensing HIV PEP starter packs (discussed below), which may have resulted in the man being redirected to his GP to receive care.

22. A copy of Te Whatu Ora Tairāwhiti's PEP for HIV Starter Kit Policy at the time was provided to HDC, although this is a guideline for which medications are to be prescribed,[10] including doses and potential side effects; there is no information regarding the management of patients who request HIV PEP, such as patient exposure information and risk assessment. As such, Dr Watts recommended that the policy be updated to include a brief guide to risk assessment prior to treatment. I note that a guideline for HIV PEP use is being developed by

[7] https://www.hauoratairawhiti.org.nz/your-health/healthy-living/sexual-health/stis-sexually-transmitted-diseases/.
[8] https://www.justthefacts.co.nz/hiv-aids-symptoms-treatment.
[9] This page was last modified on 26 March 2019, prior to the events.
[10] Emtricitabine and tenofovir disoproxil.

Te Whatu Ora Tairāwhiti, which, in its draft form, outlines the assessment and management of individuals who potentially have been exposed to HIV in non-occupational settings.

23. Dr Watts advised that all New Zealand EDs should be able to perform an appropriate risk assessment of the need for HIV PEP and should then be able to provide timely access to HIV PEP when required, which is covered by the Ministry of Health guidelines.[11] Dr Watts advised that the man's management was not consistent with this level of care and there had been a significant departure from accepted practice.

24. In response to the provisional opinion, Te Whatu Ora stated that the man was not denied care, but rather he was redirected to a GP. However, Te Whatu Ora concurred that patients should have timely access to HIV PEP after assessment in the ED and stated that patients should be able to get an assessment completed through any healthcare provider if they require HIV PEP, which is no different from performing a risk assessment for other infectious disease exposures and simply requires a history of the exposure and a risk assessment, taking 5–10 minutes. Te Whatu Ora told HDC that details of the HIV PEP assessment are available on regional HealthPathways,[12] and the Burnett Foundation has an online tool for patients to complete a self-risk assessment.

25. Te Whatu Ora stated that the normal process in larger centres is to discuss cases that require HIV PEP with the infectious diseases specialist, and electronic tools are also available to make it easier for clinicians to undertake a risk assessment before discussion with the infectious diseases specialist. However, these resources are not available locally in Tairāwhiti.

26. Te Whatu Ora told HDC that Tairāwhiti ED is one of the smallest in New Zealand, with just 11 beds, and it has limited access to some specialist services such as an infectious diseases specialist, which is different from the resources available in other hospitals in New Zealand. Furthermore, Te Whatu Ora said that the number of HIV cases in the Tairāwhiti community is low, and these are managed with the support of a clinician from Hawke's Bay, but in the majority of instances, HIV PEP treatment is not required.

27. Te Whatu Ora told HDC that in normal circumstances, the triage nurse at Tairāwhiti ED would discuss the matter with the emergency medicine specialist, who would provide the appropriate assessment and treatment. Te Whatu Ora accepted that the man should have been reviewed by an emergency medicine specialist to determine whether he met the criteria for HIV PEP. Te Whatu Ora offered an apology to the man that this did not occur at the time.

[11] https://www.health.govt.nz/our-work/diseases-and-conditions/hiv-and-aids/hiv-and-aids-information-health-professionals (accessed 2021).
This website was last updated on 14 February 2023 and now reflects the establishment of Te Whatu Ora. The links provided on this webpage refer users to the Australian PEP guidelines, which cover people who present to EDs for PEP (as referred to in paragraph 15 of this report).
[12] HealthPathways is an online information portal used by clinicians to access evidence-based local guidance and plan patient care through healthcare systems.

28. The Pharmaceutical Management Agency (Pharmac) advised Te Whatu Ora that '[p]rescriptions for PEP require a named specialist[13] to apply for Special Authority criteria on behalf of their patient for the medicine to be funded'. In response to the provisional opinion, Te Whatu Ora told HDC that as Tairāwhiti does not have any of the named specialists to prescribe HIV PEP, the emergency medicine specialist would need to contact an infectious diseases specialist in Waikato for advice. Te Whatu Ora stated that HIV PEP medication can subsequently be dispensed from ED or through pharmacies, although ongoing treatment and follow-up would require the input of an infectious diseases specialist.

29. In response to the provisional opinion, Te Whatu Ora told HDC that its clinicians do their best to provide a high standard of care but unfortunately, due to resource constraints (such as facilities, location, and access to specialist care), inequities in care do occur. Te Whatu Ora stated that there are strong linkages with primary care and iwi providers, and in most cases, patients are managed in a shared-care model.

30. I accept Dr Watts' advice that all New Zealand EDs should be able to provide timely access to HIV PEP when required. Although I acknowledge the resource constraints faced by Te Whatu Ora Tairāwhiti, and the lack of frequency with which this situation occurs may have contributed to a lack of knowledge about what was required, it is clear that there was a well-established process in place to provide appropriate assessment and treatment for the provision of HIV PEP, and in this instance, it was not followed. Furthermore, by Te Whatu Ora's own admission, HIV PEP medication was able to be dispensed from the ED, alongside having a guideline for dispensing HIV PEP starter packs. This affirms that, notwithstanding the resource constraints, the ED did, in fact, have the ability to supply HIV PEP as needed.

31. I therefore accept Dr Watts' advice that the man's management was not consistent with accepted practice. I consider that Te Whatu Ora should have assessed the man and provided him with HIV PEP medication if needed when he presented to ED on 29 January 2021.

32. An assessment to determine the need for treatment is as much a provision of care as providing the treatment itself, and therefore to assert that the man was not denied care, but admit that he was not provided with an appropriate assessment for HIV PEP, is paradoxical. Failure to provide this assessment is not in keeping with the standards of care expected and, as such, I consider that Te Whatu Ora denied the man appropriate care and treatment.

[13] A 'named specialist' is a clinician defined by Te Whatu Ora as:
1) The clinician must hold an appropriate specialist qualification in internal medicine, paediatrics, or sexual health.
2) The clinician should have received appropriate training in HIV medicine as part of their advanced training programme. For example, infectious diseases physicians or sexual health physicians all undergo a substantive component of training with respect to HIV management as a core component of their advanced training programmes.
3) The clinician should have experience of supervised management of HIV infection over a period of time, the general recommendation being that such care would normally involve at least 5–10 HIV infected persons over a period of at least 2–3 years.

Advice to seek HIV PEP from GP

33. The issue to be determined is whether, as stated by Te Whatu Ora, primary care was the most appropriate place to seek HIV PEP in the circumstances, and, therefore, whether it was acceptable to redirect the man to his GP for treatment.

Provision of HIV PEP in primary care

34. The man disputed the notion that an HIV PEP consultation is most appropriately carried out in primary care. He stated that sending a patient who presents at the ED to primary care for an HIV PEP consultation may put the patient at risk of HIV infection, due to delays in accessing the medication if waiting for a primary care appointment, and the need for HIV PEP to be started within 72 hours of exposure.

35. Te Whatu Ora subsequently agreed that patients who present to the ED requesting HIV PEP or who are assessed as at risk should not be redirected to their GP, and it accepted that a redirection to the man's GP would have delayed the assessment and, if required, the provision of HIV PEP.

36. In response to the provisional opinion, Te Whatu Ora stated that patients presenting to Tairāwhiti ED are not normally redirected to another healthcare provider and, as such, there are no policies in this regard. This is different from other EDs where patients may be redirected to after-hours providers using a voucher scheme[14] or to a Telehealth provider.[15]

37. As discussed in paragraph 28 above, prescriptions for HIV PEP medication require a named specialist. Furthermore, Pharmac advised Te Whatu Ora:

> 'GPs cannot prescribe PEP as the prescription cannot be endorsed, nor can they prescribe PEP even through a specialist recommendation as the criteria states that the application must come from a named specialist.'

38. The advice from Pharmac parallels that of Dr Maplesden, who advised that HIV PEP prescribing is complex and time critical and requires specialist knowledge and authorisation of prescribing. He referred to the Midland Community HealthPathways, which advises to 'seek acute infectious disease advice as soon as possible (within 72 hours) regarding PEP'[16], and to an article published by the Best Practice Advocacy Centre New Zealand (bpac[nz]), which states that the Special Authority application for HIV PEP medication can be made only by a named HIV specialist.[17]

[14] During busy periods where the wait time is excessive, EDs can give vouchers to non-urgent patients. The voucher covers the cost of a visit to an after-hours clinic or a GP, helping to ease pressure on EDs and ensure that patients are seen in a timely manner.
[15] Telehealth is the use of information and/or communication technology to deliver health or medical care when patients and care providers are not in the same physical location. For example, illnesses can be diagnosed and treatment provided via secure video conference.
[16] https://midland.communityhealthpathways.org/88220.htm.
[17] https://bpac.org.nz/2019/prep.aspx.

39. Dr Maplesden further advised that while there may be a minority of GPs who have done additional training in this area, in general he would not regard primary care as the most appropriate place to seek HIV PEP.

40. I accept Dr Maplesden's advice and acknowledge the information provided by Pharmac. Based on the information before me, it is apparent that the prescription of HIV PEP requires specialist input, and therefore I consider that primary care is not the most appropriate place to seek HIV PEP.

72-hour window of opportunity

41. As discussed in paragraph 8, Te Whatu Ora told HDC that '[t]he window of opportunity for prescription of PEP is 72 hours' and the timeframe for prescription of HIV PEP in which the man had come to the ED and asked for it would have met the 72-hour period by going to primary care.

42. The man stated that the ED nurse did not ask him when he had had unprotected sex or for how long he had potentially been exposed to HIV before presenting to the ED. I note that this would be imperative in determining the timeframe for starting HIV PEP.

43. As there is no clinical documentation because the man left the ED without treatment or assessment, I am unable to determine exactly what communication occurred between the man and the ED nurse. Te Whatu Ora has not disputed the man's version of the event, and in fact, in response to the provisional opinion, it stated that staff did not take a detailed exposure history in the triage area. It therefore appears that the nurse did not make any enquiries relating to the time of possible exposure and, as such, I am very critical that this was not done when Te Whatu Ora's rationale for redirection included knowledge of the time-critical nature of intervention.

44. Dr Watts advised that there is no '72-hour window of opportunity' to start HIV PEP, and he would not recommend using this term as it does not reflect the urgency of need. Dr Watts said that '[e]xpert opinion is that PEP may be effective up to 72 hours post exposure, but that the earlier it is given the more likely it will be effective'.

45. Dr Maplesden also advised that the prescription of HIV PEP is a time-critical process, with efficacy reduced as time passes after exposure, and there is not a 'magic "cut-off" at 72 hours'.

46. I accept this advice and also note the cited resources highlighted in paragraphs 15 and 38, which reinforce the need to prescribe HIV PEP as soon as possible.

47. I appreciate Te Whatu Ora's subsequent agreement that patients who present to the ED requesting HIV PEP should not be redirected to their GP. However, given the time-critical factor involved in starting HIV PEP, I remain concerned that, at the time, the man was redirected to his GP. Further, although it may not be an issue in this case, the potential for the cost of accessing a GP as a barrier for this urgent intervention should not have been overlooked. I note that sexual health clinics are another specific option for providing people

with expert information, support, and treatment in this area, and it is important to provide this option as an alternative to a GP in an appropriate referral.

48. Furthermore, Dr Watts advised that it is not acceptable to triage patients away from the ED unless a clear, appropriate, and timely alternative care pathway can be provided, which I note is also the position of the College of Emergency Nurses New Zealand (CENNZ), which does not support the practice of triaging away from the ED.[18]

49. I accept Dr Watts' advice, and, given the conclusions drawn above that primary care is not the most appropriate place to seek HIV PEP, and the time-critical factor involved in starting HIV PEP, I consider that an appropriate and timely alternative care pathway could not have been provided in this case, and therefore it was not acceptable for Te Whatu Ora to redirect the man to his GP for treatment.

Conclusion

50. Overall, as outlined above, there were significant issues with the lack of care the man received at Te Whatu Ora. In particular:

- There were policies and processes in place to provide appropriate assessment and treatment for the provision of HIV PEP, but in this instance, they were not followed.
- Te Whatu Ora failed to provide the man with timely assessment to establish whether he should be prescribed HIV PEP medication.
- It was not acceptable to redirect the man to his GP for treatment, given that primary care is not the most appropriate place to seek HIV PEP and commencement of HIV PEP is time critical.

51. The above actions and/or failures by Te Whatu Ora, and its failure to adhere to policies and procedures, demonstrates poor care and a lack of knowledge regarding the need for, and availability of, HIV PEP. These failures had a negative impact on the care provided to the man. I acknowledge the resource constraints faced by Tairāwhiti ED at the time. However, I remain of the view that these failures were unacceptable.

52. Accordingly, for failing to provide the man with an assessment to establish whether he should be prescribed HIV PEP, and for inappropriately redirecting him away from the ED and to his GP, I find that Te Whatu Ora denied the man access to appropriate care and treatment. Therefore, I find Te Whatu Ora in breach of Right 4(1)[19] of the Code of Health and Disability Services Consumers' Rights (the Code).

[18] 'Triaging away refers either to a refusal to provide further care in the emergency department, or advice to the patient that they do not need care in the emergency department, based solely on the outcome of the triage interview.' Position statement on Triaging Away, New Zealand Nurses Organisation: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/resources/publications.

[19] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

Privacy — breach

53. Under Right 1(2) of the Code, every consumer has the right to have his or her privacy respected.

54. The man stated that he felt humiliated because the ED nurse was 'super loud' and asked in the waiting area why he thought he might have been exposed to HIV, after he had explained why he was there. He told HDC that at least one patient was within earshot, as the reception window is close to the seats outside ('approximately 1.5m' away), and people were sitting there.

55. In response to the provisional opinion, Te Whatu Ora agreed that patients presenting to the ED should have the right to have their privacy respected, but it stated that in the man's situation, the only information obtained was the presenting complaint, and triage staff did not take a detailed exposure history in the triage area.

56. Te Whatu Ora acknowledged that the ED reception desk is open to the waiting room, and that conversation is muted by the glass protective barrier (due to infection control requirements), which makes it difficult for both staff and patients to make themselves heard and has the potential for unintended appearances of breaches of confidentiality. Te Whatu Ora told HDC that the layout of most EDs in New Zealand and Australia are quite similar and the design of most triage areas, including Tairāwhiti ED, are not well suited to having confidential conversations. Furthermore, Te Whatu Ora stated that there are no EDs in New Zealand that triage in a private area.

57. In response to the provisional opinion, Te Whatu Ora told HDC that the process for obtaining the presenting complaint is similar to other EDs in New Zealand. Te Whatu Ora stated that triage staff will enquire about the nature of the presenting complaint and, if the matter is a sensitive one, staff will move the patient to a private space to have a confidential conversation. Te Whatu Ora told HDC that currently there are no formal policies or guidelines specifically relating to conducting confidential conversations in the ED, although staff are aware that confidential discussions need to take place in a 'fast track' room. Te Whatu Ora stated that this process is 'religiously followed' by the triage staff, and it apologised that this did not happen on this occasion.

58. Dr Watts advised that EDs are required to provide care that is timely, private, and confidential. He acknowledged the difficulties placed on EDs by department layout and design and the large numbers of patients accessing EDs every day, and he noted that many EDs struggle with the issue of privacy.

59. Nonetheless, Dr Watts advised that the discussion of the man's sexual health in the public area was a significant departure from expected practice, particularly as Te Whatu Ora had a confidentiality process (albeit informal) that was not followed.

60. Dr Maplesden also expressed concern that a patient was required to recount the type of information required for ascertaining HIV exposure risk while in potential earshot of other patients.

61. I accept this advice and consider that it was not acceptable to discuss the man's sexual health in a public area. I am of the opinion that as soon as the nature of the man's presenting complaint was established, specifically that he was concerned about HIV exposure, the appropriate step of using a 'fast track' room should have been taken to discuss the man's request for HIV PEP, given the sensitive nature of the request. Although I acknowledge that the conversation was short and a detailed exposure history was not taken in the triage area, any further questions about the presenting complaint, including why the man thought he might have been exposed to HIV, should have been conducted in private.

62. I am therefore critical that Te Whatu Ora failed to provide the man with a confidential environment to maintain his privacy and dignity. I also consider that a formal policy or guideline would have assisted Te Whatu Ora staff in the management of confidential and sensitive conversations.

63. For these reasons, I consider that Te Whatu Ora failed in its responsibility to ensure that the man's privacy was respected. Accordingly, I find that Te Whatu Ora breached Right 1(2)[20] of the Code.

64. Te Whatu Ora told HDC that the Australasian College of Emergency Medicine will be releasing a document on undertaking a sexual history in EDs, specifically looking at the privacy elements and managing HIV PEP requests, and I will make a recommendation on this.

Manner of ED nurse — adverse comment

65. The man told HDC that the ED nurse was rude and unprofessional and spoke to him in an impatient tone. He also questioned whether the ED nurse was being racist towards him.

66. Te Whatu Ora apologised to the man and told HDC that there is no excuse for its staff to make patients or members of the public feel unwelcome. Te Whatu Ora said that one of its doctors spoke to the staff member involved, who apologised that the man felt humiliated, embarrassed, and discriminated against. Te Whatu Ora stated that it was not the nurse's intention to make the man feel this way.

67. HDC sought a statement from the ED nurse, but subsequently Te Whatu Ora told HDC that it was unable to identify the staff member involved in the interaction with the man. Te Whatu Ora said that despite reviewing the roster and contacting the staff working on 29 January 2021, no one could recall the man's presentation. Furthermore, the doctor who had spoken to the staff member about the case at the time (as per paragraph 66 above) was unable to recall the name of the individual.

68. Although I acknowledge the passage of time since this event occurred, I am concerned that Te Whatu Ora could not identify the ED nurse involved. Given that there had been no previous documented requests for HIV PEP (as per paragraph 21), I find it disconcerting that none of the staff working on the day could recall this first-of-its-kind presentation.

[20] Right 1(2) states: 'Every consumer has the right to have his or her privacy respected.'

69. As a registered health professional, the ED nurse had a responsibility to provide services with reasonable care and skill, in a manner that respected the individual. Certainly, I would consider it inappropriate if the man was treated disrespectfully when requesting HIV PEP, especially given the need for healthcare providers to provide a non-judgemental, safe environment for people with possible HIV exposure to seek support. As emphasised in the Australian PEP guidelines:

> 'The experience of presenting for PEP can be stressful in itself. Research has documented cases where people stated they did not re-present for PEP due to a previous negative experience and then later seroconverted.[21] Therefore, it is important that clinicians respond to each presentation in a non-judgemental way, using non-stigmatising language.'[22]

70. I note that the above wording has been used in the proposed guideline for HIV PEP use being developed by Te Whatu Ora Tairāwhiti (as per paragraph 22) and I encourage Te Whatu Ora to highlight the importance of providing a non-judgemental and safe environment in its proposed teaching sessions for staff on the management and assessment of patients who require HIV PEP (as discussed under the section 'changes made since events' below).

71. Whilst I am unable to obtain further information from the ED nurse involved about the manner in which the conversation occurred, it is not disputed that the man was questioned about the reasons for his request for HIV PEP in an area that did not protect his privacy, and without any assessment was told to see his GP as this did not constitute an emergency. I find that the man reasonably interpreted these actions as disrespectful even if that was not intended. Further, I share Dr Watts' concern about the dismissive tone of the initial response from Te Whatu Ora Tairāwhiti,[23] which indicated that it may not have taken this issue seriously and could be viewed as indictative of the man's experience. I remind Te Whatu Ora Tairāwhiti of the importance of treating people who are seeking help with compassion and care and ensuring that their mana and dignity is upheld.

72. I also note that no clinical documentation was completed, which would have identified the staff member involved. Dr Maplesden expressed concern that the consultation was not documented, and I share his concern. I therefore emphasise the importance of ensuring that documentation on patients who present to the ED is completed, even if they seek treatment at another facility.

[21] The transition from infection with HIV to the detectable presence of HIV antibodies in the blood. When seroconversion occurs (usually within a few weeks of infection), the result of an HIV antibody test changes from HIV negative to HIV positive.
[22] Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV: Australian National Guidelines (2016) https://www.pep.guidelines.org.au/.
[23] Recommendations for future improvements (point number four of Dr Watts' report).

Changes made since events

73. Since these events, Te Whatu Ora has made, or is in the process of making, the following changes:

a) Te Whatu Ora will provide HIV PEP to patients in the first instance, as well as recommending a visit to their GP for a more comprehensive consultation.

b) A guideline for HIV PEP use is being developed by the ED Deputy Head of Department, which is a modified version of the Wellington ED guidelines.

c) An educational session was completed on 8 March 2023 for GPs and hospital doctors on HIV PEP and PrEP[24] use. The session was delivered by a Family Planning and Reproductive Health specialist.

d) The ED is planning to organise additional teaching sessions for staff on the assessment and management of patients who require HIV PEP.

e) Te Whatu Ora is working with the Midlands region to ensure that clinicians at Te Whatu Ora Tairāwhiti have access to infectious diseases specialists for advice.

f) Te Whatu Ora is currently exploring options regarding the appropriate redirection of patients to another healthcare provider, as part of managing the increased workloads during busy seasons, which include having a GP based in the ED and the use of Telehealth services.

g) A proposal to the Health Infrastructure Unit was submitted in 2021 to redesign and expand the ED, including creating triage nurse assessment rooms for private conversations with patients. In the interim, Te Whatu Ora will continue to use the 'fast track' areas for confidential conversations with patients and anticipates that with the redesign of the ED, this issue of confidentiality in the ED will be addressed.

h) Te Whatu Ora has stressed the need to ensure that documentation is completed for patients who present to the ED, even if subsequently they self-discharge or seek treatment at another facility.

Recommendations

74. I recommend that Te Whatu Ora:

a) Provide a written apology to the man for the deficiencies in care identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding.

b) Amend the proposed guideline for HIV PEP to reflect the decision by Pharmac to widen funding access to HIV PEP,[25] by removing reference to 'non-occupational exposure' and editing the definitions of access criteria, as per the changes made to the Pharmaceutical

[24] Pre-exposure prophylaxis (PrEP) is medicine taken to prevent HIV before a person is exposed.
[25] Decision to widen access to antiretrovirals and nitrofurantoin - Pharmac | New Zealand Government.

Schedule. Te Whatu Ora is to provide HDC with a copy of the finalised and approved guideline for HIV PEP within three months of the date of this report.

c) Provide training to staff on the guideline for HIV PEP. Evidence that this has been done, in the form of training material and attendance records, is to be sent to HDC within six months of the date of this report.

d) Provide an update on the proposed teaching sessions for staff on the management and assessment of patients who require HIV PEP, including any plan for ongoing or refresher training. Evidence confirming the content of the training and delivery, in the form of training material and attendance records, is to be provided to HDC within six months of the date of this report.

e) Provide HDC with evidence of the education session on HIV PEP and PrEP use, including staff attendance records, within three months of the date of this report.

f) Develop and implement a policy or written process for conducting confidential discussions in private (guided by the Australasian College of Emergency Medicine's document on undertaking a sexual history in EDs) and provide a copy of this to HDC within six months of the date of this report.

g) Use this case as a basis for developing education/training on conducting confidential discussions for staff. Evidence confirming the content of the training and delivery, in the form of training material and attendance records, is to be provided to HDC within six months of the date of this report.

h) Provide an update on the progress of working with the Midlands region to ensure that clinicians at Te Whatu Ora Tairāwhiti have access to infectious diseases specialists for advice. This update is to be provided to HDC within six months of the date of this report.

i) Provide an update on the progress of appropriate redirection of patients to another healthcare provider. This update is to be provided to HDC within six months of the date of this report.

j) Provide an update on the proposal to the Health Infrastructure Unit, including the creation of triage nurse assessment rooms. This update is to be provided to HDC within six months of the date of this report.

k) Provide ongoing education to staff on the requirement of documenting all presentations to the ED, even if subsequently the patient self-discharges or seeks treatment at another facility, using this case as a basis for the education. Evidence that this has been done, in the form of educational material, is to be sent to HDC within six months of the date of this report.

Follow-up actions

75. Te Whatu Ora will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

76. I consider that it is in the public interest to refer this matter to the Director of Proceedings in light of the seriousness of the departures identified in the care Te Whatu Ora provided — in particular, the denial of care in a time-critical situation, where delay in obtaining treatment for a significant and life-long condition may have put the man's wellbeing at serious risk. Furthermore, the denial of care to a person from a vulnerable population group, where access to resources is already limited, along with the initial responses to this complaint, paints a very concerning picture at a systems level, and there is a high public interest in holding the organisation accountable to ensure that changes are made to allow for the provision of equitable opportunities to all groups.

77. A copy of this report with details identifying the parties removed, except Te Whatu Ora Tairāwhiti and the advisors on this case, will be sent to the New Zealand Sexual Health Society, the Australasian College for Emergency Medicine, the Burnett Foundation Aotearoa, and Body Positive Incorporated, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to Commissioner

The following independent advice was obtained from Dr Martin Watts, an emergency medicine specialist:

'Report To: The Health and Disability Commissioner
Te Toihau Hauora, Hauatanga

Complaint: **[Patient] / Hauora Tairāwhiti**

Date: **7th October 2021**

Reference: **C21HDC00226**

Report provided by **Dr Martin Watts,** MB, ChB, DCH, FACEM, Emergency Medicine Specialist. Emergency Medicine Consultant with 15 years clinical practice at Specialist level, including time as Emergency Department Clinical Leader.

I have read the HDC Guidelines for Independent Advisors and have followed them. I am not aware of any conflict of interest related to this case.

Thank you for referring this case for review.

My findings are based on the information provided to me by the HDC.

1. Outline of accepted ED practice for the provision of HIV PEP to patients:
   a. The standard of care is that all New Zealand EDs should all be able to perform an appropriate risk assessment of the need for HIV PEP. They should then be able to provide timely access to HIV PEP when required. This is covered by Ministry of Health guidelines. [The man's] management was not consistent with this level of care.
   b. There has been a significant departure from accepted practice (denial of care).
   c. This would be viewed as substandard care by peers.
   d. Education is required to ensure that all Triage staff are aware that this type of presentation may occur and must be properly assessed by the ED.

2. The appropriateness of the current process in place for the management of patients requesting PEP:
   a. There is a clear guideline for the provision of PEP medication, including starter pack, doses and potential side effects provided. This is accepted standard of care.
   b. This guide is in line with standard accepted practice.
   c. The guideline itself would be viewed as good.
   d. The only issue is a knowledge gap about the availability of this guide and therefore its use.

3. The communication of sexual health information at Reception/Triage:
   a. Emergency Departments are required to provide care that is timely, private and confidential.

b. Bearing in mind the difficulties placed on EDs by Department layout and design and the large numbers of patients accessing EDs every day, privacy is an issue that many EDs struggle with. It does appear that the ED has a policy for discussing confidential issues but this was not followed. This would be a significant departure from expected care.
c. Many peer EDs would admit to difficulties maintaining privacy based on the issues outlined in answer "b" above.
d. A local response to systems and processes based on local resources should aim to improve privacy and confidentiality.

4. Recommendations for future improvements:

Education and knowledge dissemination. This seems to be a failure of knowledge regarding the need for and the availability of HIV PEP. There is a clear guideline for which medications to prescribe, and this could be added to with a brief guide to risk assessment prior to treatment decisions.

It is not acceptable to Triage patients away from the ED unless a clear, appropriate and timely alternative care pathway can be provided.

Regarding the response from Hauora Tairāwhiti. The response itself raises concerns about how seriously this complaint has been taken and the background knowledge around PEP.

There is no "72 hour window of opportunity" to start PEP and I would not recommend using this term as it does not appreciate the urgency of need. Expert opinion is that PEP may be effective up to 72 hours post exposure***, but that the earlier it is given the more likely it will be effective***.

There is no reason at all that an appropriate and "fuller" consultation cannot be carried out in the ED. This would be expected in most peer EDs.

Advice websites linked via the Ministry of Health and Australasian Societies (including those endorsed by the Australasian College for Emergency Medicine) advise attendance at ED following an exposure event out of hours.

References:

1) HIV PEP is covered by the Ministry of Health Website with guidelines.
https://www.health.govt.nz/our-work/diseases-and-conditions/hiv-and-aids/hiv-and-aids-information-health-professionals

2) Linked to the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) provides guidance on Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV. This is endorsed by the Australasian College for Emergency Medicine.
https://www.ashm.org.au/HIV/hiv-management/PEP/

"To be effective, initiation of PEP needs to occur within 72 hours, the earlier the better. Emergency Departments (ED) are busy environments with competing demands. People requiring PEP during business hours should be encouraged to present to the existing options of s100 prescribing GPs or sexual health clinics with levels of staffing able to meet this ad hoc demand where this is available. In geographical areas where these options are not available, or in cases that require attention outside of business hours, people should present to their nearest hospital ED. Training for ED staff should include the necessity to triage, assess and treat these patients with the appropriate priority."

3) The New Zealand AIDS foundation has advice on its website.

   https://www.nzaf.org.nz/awareness-and-prevention/preventionhost-exposure-prophylaxis-pep/

   Note this states "If you are HIV negative and you know or think you may have been exposed to HIV during sex, for example, a condom broke or you didn't use one, you should visit the emergency department of your local hospital as soon as possible."

4) A further New Zealand resource.
   https://www.endinghiv.org.nz/protect-test/protect/pep/'

Appendix B: In-house clinical advice to Commissioner

The following clinical advice was obtained from Dr David Maplesden, general practitioner:

'**TO**: [HDC]
FROM: David Maplesden
CONSUMER: [Patient]
PROVIDER: Tairāwhiti DHB
FILE NUMBER: C21HDC00226
DATE: 22 August 2021

I have reviewed the information on file. There do not appear to be any ED notes on file for the interaction in question and these should be obtained. I believe [the man] has valid concerns about the service provided to him by Tairāwhiti DHB and I believe the current policy and process in place in ED appears inadequate.

1. New Zealand AIDS Foundation provides the following information on its website regarding access to post-exposure HIV prophylaxis (PEP)[1] (my emphases in bold):

If you are HIV negative and you know or think you may have been exposed to HIV during sex, for example, a condom broke or you didn't use one, ***you should visit the emergency department of your local hospital as soon as possible*** *…* ***Head to the emergency room as soon as you can — the longer you leave it, the less chance it will be effective.*** *When you get there, the first people you encounter may not have heard of PEP but make sure you insist that you have potentially been at risk of HIV transmission and need to initiate emergency PEP within 72 hours.* ***Most A&E/Emergency departments should have a supply of PEP but may need a little time to get prescription approvals.*** *The clinical staff may need to ask you some pretty personal questions to assess your likelihood of exposure — this may feel a little awkward, but they're just trying to make sure you get the care you need. So, it's important to be honest …*

2. BPAC published an article on prescribing of pre-exposure HIV prophylaxis (PrEP) in 2019[2] when GPs gained access to prescribing the relevant drugs (although Special Authority still required). This involves a complex but not time critical process compared with PEP prescribing which is complex, time critical and may require specialist input depending on the assessed level of risk. There is brief reference in the article to PEP prescribing as below (my emphases in bold):

Emtricitabine with tenofovir disoproxil is also a first-line option in the emergency treatment (within 72 hours) of a recent exposure to a potential source of HIV, including needle-stick injury, sexual assault or other high-risk sexual exposure. A 28-day course of daily emtricitabine with tenofovir disoproxil, with or without an additional antiretroviral, may be prescribed fully subsidised with Special Authority approval.

[1] https://www.nzaf.org.nz/awareness-and-prevention/prevention/post-exposure-prophylaxis-pep/ Accessed 22 August 2021
[2] https://bpac.org.nz/2019/prep.aspx Accessed 22 August 2021

Discussion with an infectious diseases physician or referral to the local emergency department is recommended. N.B. The Special Authority application for PEP can only be made by a named HIV specialist and uses a different form than for PrEP.

3. Midland Community HealthPathways[3] provides brief reference to use of PEP as: *Seek acute infectious disease advice as soon as possible (within 72 hours) regarding PEP. See ASHM — Post-Exposure Prophylaxis (PEP).* This advice reinforces the fact that prescribing of PEP requires specialist knowledge and authorisation of prescribing, and while there may be a minority of GPs who have done additional training in this area I would not regard primary care in general as the most appropriate place to seek PEP. [The man] also points out that community pharmacies are unlikely to stock the medications required for PEP, and delays in accessing the medication if waiting for a primary care appointment may reduce the efficacy of the regime (this being a time critical process with efficacy reduced as time passes after exposure, not a magic 'cut-off' at 72 hours). The Pathway refers to the relevant Australian PEP guidelines[4] on which management decisions should be based. The guidelines contain templates for ED management of requests for PEP which may be of use in developing a robust local protocol (see Appendix 1).

4. The complaint from [the man] also raises issues regarding privacy of health information and respect. I am unable to comment further on these issues but I would be very concerned if a patient was required to recount the type of information required for ascertaining HIV exposure risk while in potential earshot of other patients. I would also be concerned if the consultation was not documented.

5. I recommend brief EA is sought from an ED specialist regarding the following issues:

(i) Accepted practice for ED management of patients requesting post-exposure HIV prophylaxis (PEP) and whether [the man's] management was consistent with accepted practice

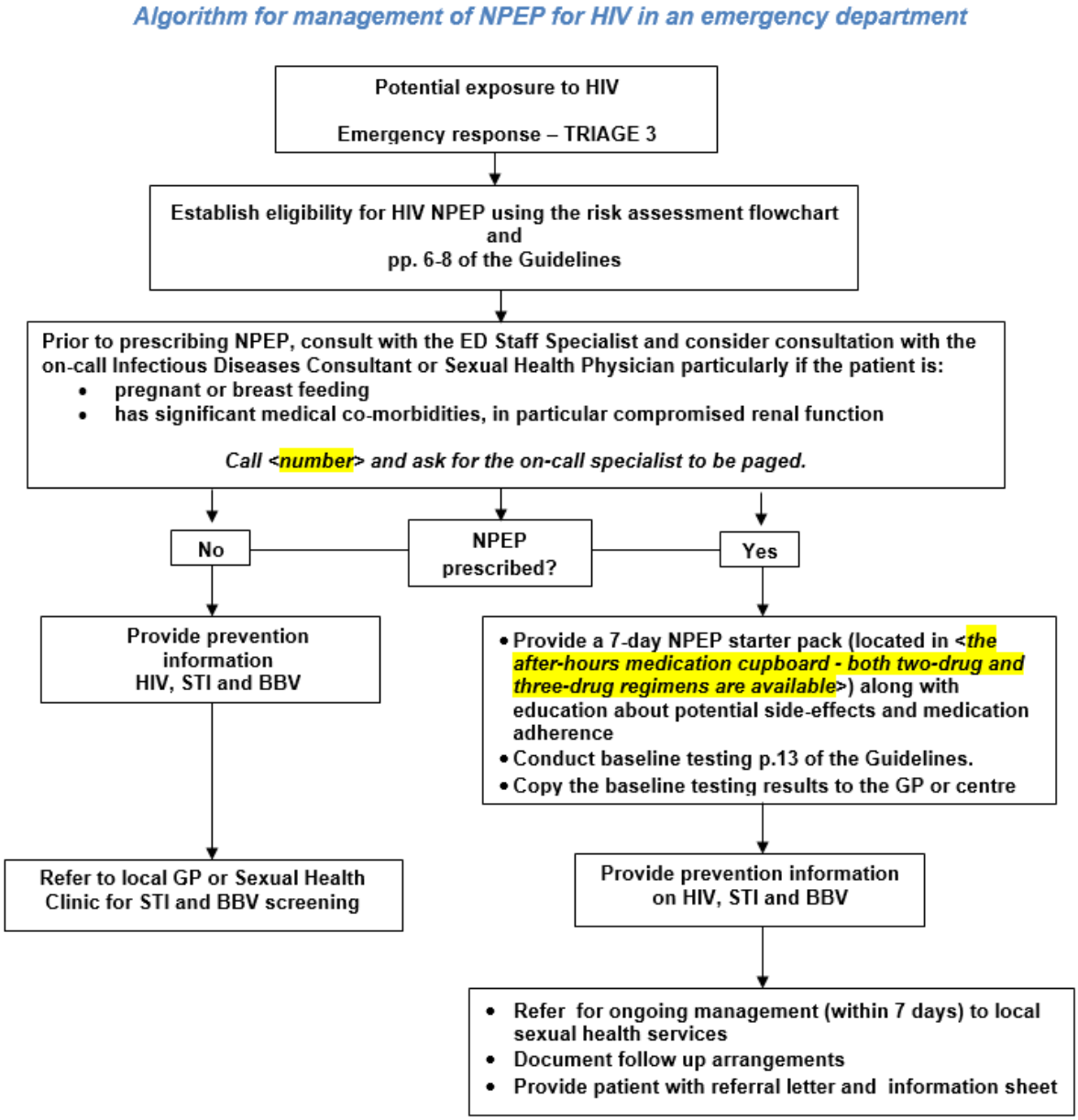
(ii) Appropriateness of the current process in place in [the] Hospital for management of patients requesting PEP (per the current guideline document provided in the response)

(iii) Any recommendations for improving robustness of the current process (if required)

(iv) Any other comments on [the man's] management of the DHB response'

[3] Midland Community HealthPathways "Human Immunodeficiency Virus" https://midland.communityhealthpathways.org/88220.htm Accessed 22 August 2021
[4] https://www.ashm.org.au/HIV/hiv-management/PEP/ Accessed 22 August 2021

Appendix 1[5]



[5] https://www.ashm.org.au/HIV/hiv-management/PEP/ Accessed 22 August 2021