Delay in advising consumer of MRI scan results and arranging follow-up
16HDC01980, 15 June 2018

District health board ~ Otolaryngologist ~ Vestibular schwannoma ~ MRI scan ~ Test result follow-up ~ Rights 4(1), 6(1)

A woman had an appointment with an otolaryngologist/head and neck surgeon for significant right-sided hearing loss. The surgeon referred the woman for a magnetic resonance imaging (MRI) scan. The MRI scan was performed and the written report (available electronically that day) stated that a vestibular schwannoma (a benign tumour of the balance nerve) was seen. No action was taken in respect of the results at that time, and it was not noted that the MRI report results were still "unacknowledged" in the electronic system until nine months later.

The MRI results were identified as still being "unacknowledged" at that time as part of a project to address the clinical risk of unacknowledged results. That day, the surgeon was alerted to the unacknowledged result and arranged for the woman to be seen by another specialist, but did not contact her to advise her of the result. The woman was first made aware of the result when she was seen by the specialist a few months later. Subsequently, the woman underwent surgical removal of the tumour.

At the time of these events, the district health board (DHB) had both an electronic and a paper-based results system. The surgeon routinely used the paper-based system. While access logs show that he viewed the report the day after it was issued, the surgeon cannot recall this and said that he did not receive a paper copy of the woman's result and, accordingly, did not action it. At the time, there was no requirement that clinicians acknowledge test results in the electronic system.

Findings

The Commissioner was critical of the surgeon for the delay in arranging follow-up in a timely manner after the woman's MRI, and for the woman not having been advised of the results at the time, but considered that this was not solely attributable to the surgeon. However, in not conveying to the woman the result of the MRI scan once he was alerted to it, and not explaining the delay in advising her and arranging follow-up, it was held that the surgeon breached Right 6(1).

The Commissioner considered that the lack of a clear, effective, and formalised system for the reporting and following up of test results meant that this result was not appropriately acknowledged, actioned, and communicated to the woman by the surgeon. In addition, there was no process to ensure that reports or results did not go unacknowledged by clinicians for any length of time. When such a policy was implemented, the failure to send out a weekly compliance summary report to the surgeon after the implementation of the new policy contributed to the result not being picked up. It was held that the DHB did not provide services to the woman with reasonable care and skill, and breached Right 4(1).

Recommendations

The Commissioner recommended that the DHB provide a copy of its most recent audit of its new electronic system in relation to acknowledgement of electronic laboratory/radiology results, and that the DHB and the surgeon provide written apologise to the woman.