Systems to support continuity of care

Robust systems are vital in general practice to ensure timely follow-up of test results and to ensure quality and continuity of care between the healthcare providers involved in a consumer's care. Particular challenges can arise in this area when there are staff absences A recent case published by HDC[1], highlights the importance of having such systems in place.

Mrs A, a 37-year-old woman, consulted Dr B at a natural health clinic regarding the management of her hypothyroidism. Dr B is a vocationally registered general practitioner (GP), but the natural health clinic was not a general practice. The clinic advised patients that they should see Dr B for blood tests, general health review and health planning, but continue to see their regular GPs for any other needs, including urgent care issues. Throughout the time she was seeing Dr B, Mrs A remained enrolled with her GP, Dr C, at a medical centre.

At the time of the events the natural health clinic was small (Dr B being the sole doctor and sole director of the enterprise), and had recently had a high influx of new patients.

Dr B ordered four sets of blood tests for Mrs A over a period of 14 months. On all occasions, abnormal HbA1c results (the screening test for diabetes) were returned. Dr B did not communicate these results to Dr C and, after advising Mrs A to make lifestyle changes following the first elevated HbA1c result, did not take any action on two subsequent results. Dr B ordered a fourth set of blood tests after Mrs A reported a one-week history of fuzzy eyesight and recurrent thrush. Dr B did not communicate this last result, which showed a significant change in HbA1c level, to Mrs A in a timely manner as Dr B did not review the result prior to going overseas for three days.

The day before Dr B returned from overseas, Mrs A advised Dr B that she was feeling generally ill, and complained of a number of symptoms, including increased "cloudiness", perpetual thirst, and unexpected weight loss. Mrs A told Dr B the next day that she had been passing excessive urine and had painful flanks. Dr B told Mrs A about the change in her HbA1c level and advised her to consult with her enrolled GP within the week. The following day, Mrs A was admitted to hospital, where she was diagnosed with ketoacidosis secondary to untreated type 1 diabetes.

The Commissioner found the care Dr B and the natural health clinic provided to Mrs A was deficient in several respects. There was a pattern of poor communication of abnormal test results, a lack of coordination with Mrs A's GP, and a failure to provide appropriate advice to Mrs A regarding her significantly elevated HbA1c result.

As the clinician who ordered the tests, Dr B had a responsibility to communicate the results and their implications to Mrs A. In this respect, Dr B failed to provide Mrs A with information that a reasonable consumer would expect to receive and, accordingly, breached Right 6(1) of the Code. The Commissioner also found that Dr B's clinical management of Mrs A in light of her HbA1c results and following her reported symptoms in September was deficient. The Commissioner considered that Dr B failed to provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical that there was no communication with Dr C in the time that Dr B was providing care to Mrs A, and in particular that Dr C was not informed of Mrs A's

[1] 16HDC01577

final HbA1c result which was significantly elevated. Medical Council of New Zealand standards are clear on the need for timely communication of information to the consumer's principal health provider to ensure that the patient receives appropriate care. Accordingly, the Commissioner found that Dr B failed to comply with professional standards, in breach of Right 4(2) of the Code.

The Commissioner found that the natural health clinic had not implemented any measures to handle its increased workload, failed to arrange for another health professional to process test results over the period that its GP was overseas, and did not have a system in place to ensure that patients' GPs were advised of test results and the treatments provided. The Commissioner considered that the natural health clinic failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner recommended that the GP arrange for a peer to audit all blood test results received within the last month, with focus on appropriate follow-up of abnormal results and communication with principal health providers and undertake further training on the diagnosis and management of diabetes. He asked the Medical Council of New Zealand to consider whether a review of the GP's competence is warranted.

The Commissioner also recommended that the natural health clinic develop a written policy for the management of test results, and update the questionnaire provided to new patients to indicate that results and consultation notes will be provided to their usual GP unless the patient withholds consent.

As illustrated by this case, without robust processes and systems in place, practices can be particularly vulnerable to the effects of staff absence and increased workload. The Royal New Zealand College of General Practitioners' document *Aiming for Excellence*[2] states that practices should have an "effective system for the management of clinical correspondence, test results, and other investigations". As the Commissioner has previously stated: "Medical practices have a responsibility to ensure that they have effective systems in place for … test results, and patient follow-up. It is essential that those systems are robust and support clinicians in providing good quality care."[3] This must include having effective processes in place for recognition and management of time-critical investigation results when there is planned or unplanned absence of the clinician ordering the test.

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[2] Royal New Zealand College of General Practitioners, *Aiming for Excellence*, RNZCGP Standard for New Zealand General Practice 2011–2014 (2011).
[3] 15HDC00660