



Health New Zealand breaches the Code for delays in scheduling a colonoscopy

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In a report published today, Deputy Health and Disability Commissioner Deborah James has found MidCentral DHB (now Health New Zealand | Te Whatu Ora Te Pae Hauora O Ruahine o Tararua MidCentral) breached the Code of Health and Disability Services Consumers' Rights (the Code) for delays in providing a colonoscopy to a female in her 40s.

The woman at the centre of the report, attended her medical centre with a three-month history of bowel changes and occasional abdominal pain. The nurse practitioner (NP) who assessed the woman sent a referral to Health New Zealand for further investigation to rule out malignancy.

Delays in processing the referral, which were attributed to human error, meant the woman did not have her colonoscopy for 18 weeks. She was diagnosed with rectal cancer at the time of the colonoscopy.

For failing to have robust systems in place for managing referrals and identifying when referrals were not progressing, Ms James found Health New Zealand breached Right 4 of the Code which gives people the right to an appropriate standard of care | Tuatikanga.

“As a result of errors causing delays with the woman’s referral, she did not receive timely or appropriate services,” Ms James said. “A referral process that relies on human accuracy has inherent fallibilities. A previous case issued by this Office highlights the importance of systems safeguards to identify errors when they occur.”

Several human errors were not rectified promptly due to a lack of robust systems. A transcribed letter from a gastroenterologist was emailed to the wrong clinician and the clinician did not pick up the error, marking the email as unread and taking no corrective action.

Ms James also found Health New Zealand breached the Code for providing the NP with inaccurate information when she rang to clarify the status of the referral, which meant that action to expedite the stalled referral was not initiated immediately.

“I am concerned about the quality of information provided by Health New Zealand when the NP contacted the booking office about a referral that was not progressing as expected, and that Health New Zealand did not have in place a process to document such contact and the action taken in response to a referrer’s concerns, or a patient’s concerns.”

Ms James noted that a well-coordinated referral process requires the co-operation and smooth transfer of information between primary and secondary care providers.

Ms James' report also made an adverse comment about the NP for failing to document the digital rectal examination in the referral to Health NZ, noting the importance of this information to referral timeframes and triaging.

In addition, while Ms James acknowledged that the NP had followed up with Health New Zealand on the woman's referral progress and made a second referral, she made an educational comment that although it may not be possible to track all referrals, those for patients with a suspicion of cancer should be distinguished from other requests and followed up promptly.

She also reminded the NP of the importance of clear communication between providers and strong signalling of the urgency of referrals when anticipated timeframes have been exceeded.

Since the events, Health New Zealand has made changes to its practice, outlined in the report. Ms James was also reassured that Health New Zealand MidCentral is progressing the implementation of an electronic referral and triage system to replace the manual systems.

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Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's '[Latest Decisions](#)'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website [here](#).

HDC promotes and protects the rights of people using health and disability services as set out in the [Code of Health and Disability Services Consumers' Rights](#) (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an [animated video](#) to help them understand their health and disability service rights under the Code.

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