Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Care provided by Te Whatu Ora Colonoscopy Services

21HDC00481, 13 November 2023

This case concerns the care provided by Te Whatu Ora to a woman who requires five-yearly surveillance colonoscopies.

The results of a surveillance colonoscopy noted that four polyps were removed, and two biopsies were carried out, all of which were reported as normal. It was recommended that five-yearly surveillance colonoscopies continue.

Despite these results, the woman received a telephone call from the colonoscopy clinic two days later advising that the reporting specialist had referred her for a further urgent colonoscopy, which was scheduled accordingly.

Prior to the urgent colonoscopy appointment, the woman left voicemails for the referring specialist to confirm the reasons for the further procedure, to which she received no response.

At the colonoscopy appointment, the woman asked the registered nurse undertaking the consenting process why the colonoscopy was required. The nurse provided no reasoning for the colonoscopy and did not record the query in the patient's clinical records or follow up with the specialist who was to undertake the colonoscopy.

During the procedure, the specialist undertaking the colonoscopy (who was not the referring specialist) noted that the findings on the referral form were not consistent with what was being seen in the colonoscopy in real time.

The specialist performing the procedure contacted the referring specialist and it was picked up that there had been an accidental mix-up of National Health Index (NHI) numbers, and the incorrect patient was having the urgent colonoscopy.

After the woman's sedation had worn off, the specialist informed her that there had been a mix-up with NHI numbers, resulting in her having an unnecessary colonoscopy.

Post-colonoscopy the woman received a verbal apology from the referring specialist. She also received a letter from the Clinical Quality and Risk Manager, who apologised and advised the woman that an adverse event review (AER) would be undertaken to determine the cause of the NHI number mix-up. The AER found the following:

1. The referring specialist made a documentation error when using the Gastro Admin email and accidently attached the incorrect NHI number to the email.
2. The report results stating that all tests were normal were available the next day, but no one looked at or questioned the results with the referring specialist.

3. The telephone call from the woman was a missed opportunity for the administrative staff to identify the error of urgent booking, and it is unclear why this did not occur.
4. The consent process was performed by a registered nurse, and neither the nurse nor the specialist who performed the procedure looked at previous reports when the woman questioned why she needed the procedure.

Findings

The Deputy Health and Disability Commissioner, Vanessa Caldwell, considered that a serious incident had occurred, which had resulted in a patient receiving a colonoscopy she did not require. This was identified in the AER completed by Te Whatu Ora. In addition, this type of incident is captured in the Te Tāhū Hauora|Health Quality and Safety Commission's 'always report and review list'. Two previous HDC cases found a breach of the Code of Health and Disability Services Consumers' Rights (the Code) in similar circumstances.

The Deputy Commissioner considered that Te Whatu Ora failed to provide services to the woman with reasonable care and skill. As such, she found Te Whatu Ora in breach of Right 4(1)[1] of the Code.

Recommendations

Te Whatu Ora made the following recommendations in the AER to prevent the reoccurrence of a similar event:

Finding	Recommendation
1	Although this administrative error occurred in a private setting, this is a good prompt for Gastroenterology services to discuss and look at their room set-up to review whether it has the risk of an identification mix-up, eg, files on top of each other for procedure lists.
1	Attach supporting report to an email when making an urgent referral.
2 & 3	Clear administration guidelines for following up with the relevant gastroenterologist when reports and referrals do not align or when a patient is questioning the reasoning for a procedure.
4	Relevant reports/test results to be checked pre-procedure.
4	Consent process to include a 'two check' process, and forms to change to support this process.
4	A departmental consent policy that the doctor completes the consent form for a procedural list given that there is a higher risk of complications with these procedural scopes than with non-procedural scopes. This should also include planned procedural lists, especially for patients with procedures that may require an endoscopic mucosal resection (EMR).

Te Whatu Ora confirmed and provided evidence that it has complied with these recommendations. The Deputy Commissioner is satisfied that the recommendations were an appropriate response to the incident and will mitigate a similar incident occurring. Therefore, the Deputy Commissioner made no further recommendations and decided to publish this case summary on the HDC website for educational purposes.

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