General Practitioner, Dr A

Medical Centre

A Report by the Deputy

Health and Disability Commissioner

(Case 17HDC00334)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Ms B, aged 52 years at the time of these events, consulted Dr A on 4 December 2015 regarding abnormal vaginal bleeding. Dr A referred Ms B for a pelvic ultrasound.

2. The ultrasound report, which was sent to Dr A on 17 March 2016, identified a 43mm heterogeneous mass. The report stated: "The mass within the endometrial cavity may represent a submucosal fibroid. However other pathologies must be considered and an urgent gynaecological referral is recommended."

3. The ultrasound result was removed from Dr A's in-tray on 13 April 2016. Dr A stated that he did not review the report, and was unable to explain how it was missed.

4. On 18 April 2016, Ms B telephoned the medical centre and enquired about her ultrasound result. She spoke with RN C, who referred the matter to Dr A through a task message. The task message was marked as "done" on 20 April 2016; however, Dr A said that he did not see the task message and no action was taken.

5. On 7 November 2016, Ms B telephoned the medical centre and requested a form for blood tests. Ms B stated that she informed RN C that she (Ms B) had been experiencing bright yellow discharge. RN C documented that Ms B's vaginal bleeding had mostly settled, but that there was some spotting and pain. It is unclear whether or not Ms B's symptoms were conveyed to Dr A.

6. On 28 November 2016, Ms B consulted Dr A regarding menstrual pain. According to Dr A, there was no discussion about irregular bleeding or the ultrasound scan, and he did not review the previous consultation notes. In contrast, Ms B stated that she and Dr A had a discussion about fibroids.

7. Ms B had a blood test later that day, and telephoned the medical centre on 8 December 2016 to enquire about the results. RN C informed Ms B that the results looked postmenopausal, and asked Dr A for confirmation. Dr A wrote in the notes: "[M]enopausal pattern but she's still having periods!" There is no reference in the clinical notes of any follow-up from RN C or Dr A.

8. On 18 January 2017, Ms B consulted with a locum GP at the medical centre and obtained an urgent gynaecology referral. Following further investigations, Ms B was diagnosed with stage IV endometrial cancer, with metastases in the lungs and pelvis.

Findings

9. By failing to take appropriate action on Ms B's ultrasound scan result, RN C's task message requesting follow-up, and Ms B's blood test results, Dr A failed to provide services to Ms B with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

10. As Dr A was acting within the authority granted by the medical centre in consulting with Ms B, referring her for a pelvic ultrasound, and managing her test results, The medical centre is vicariously liable for Dr A's breach of the Code.

11. Adverse comment is made about RN C's failure to check Ms B's clinical history when Ms B reported vaginal bleeding and pain on 7 November 2016.

Recommendations

12. It is recommended that Dr A provide an audit of his clinic records to ensure that abnormal results have been communicated and followed up appropriately. It is also recommended that Dr A provide an apology to Ms B for his breach of the Code.

13. It is recommended that the Medical Council of New Zealand undertake a competence review of Dr A.

Complaint and investigation

14. The Commissioner received a complaint from Ms B about the services provided by Dr A at the medical centre. An investigation was commenced and the following issues were identified for investigation:

- *Whether Dr A provided Ms B with an appropriate standard of care in 2016.*
- *Whether the medical centre provided Ms B with an appropriate standard of care in 2016.*

15. This report is the opinion of Kevin Allan, Deputy Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

16. The parties directly involved in the investigation were:

Dr A	General practitioner (GP)/provider
Ms B	Consumer/complainant
Medical centre	Provider

17. Information from Registered Nurse (RN) RN C was also reviewed.

18. Independent expert advice was obtained from in-house clinical advisor GP Dr David Maplesden (**Appendix A**), and in-house nursing advisor RN Vivienne Josephs (**Appendix B**).

Information gathered during investigation

Background

19. On 25 June 2015, Ms B (52 years of age at the time of these events) attended the medical centre and saw a GP regarding a fall sustained two days previously. During the consultation, Ms B mentioned that she had been having erratic periods, including a heavy bleed. The

GP's management plan was to consider referring Ms B for an ultrasound if she experienced further heavy bleeds.

20. Ms B returned to the medical centre on 4 December 2015 and consulted with her regular GP, Dr A.[1] Dr A recorded: "10 day period March heavy, ongoing continuous bleeding sometimes heavy not cyclical." He ordered a full set of blood tests. The results, which were received on the same day, indicated that Ms B was perimenopausal.[2]

Ultrasound referral and result

21. On 12 December 2015, Dr A referred Ms B for a pelvic ultrasound.

22. The ultrasound was performed on 17 March 2016 and was reported on by a registrar in consultation with a consultant radiologist. The report states:

> "Within the endometrial cavity, there is a 43mm round heterogen[e]ous mass with vascularity demonstrated on Doppler flow … The mass within the endometrial cavity may represent a submucosal fibroid. However other pathologies must be considered and urgent gynaecological referral is recommended."

23. The report was sent to the medical centre on 17 March 2016.

24. The medical centre's "Management of Test Results" policy from May 2014 states:

> "All results are received by download and filed in each provider's inbox. It is each provider's responsibility to check their inbox and deal with results appropriately. Results can either be filed to the patient, tagged (this keeps the result in the inbox) or allocated as a task to the practice nurses (if allocated as a task the result will also stay in the inbox until the task is achieved)."

25. The practice management system records that Dr A removed Ms B's ultrasound scan result from his in-tray on 13 April 2016 at 8.48am. Dr A stated that he did not review the report at this time. He told HDC that his usual practice is to look at all incoming reports and that he will contact the patient if there is an urgent matter, but most communication occurs through the practice nurse. He stated: "I am unable to explain how this report was missed on my part; every doctor's nightmare."

26. Ms B told HDC that Dr A had advised her that he would call her about the scan result, but she did not hear from him for a month following the scan. Ms B telephoned the medical centre of her own accord on 18 April 2016 and spoke with a practice nurse, RN C. Ms B stated that RN C mentioned that the ultrasound had identified a mass that might be a fibroid, and that a referral was recommended, but that nothing had been done by Dr A. Ms B further told HDC that RN C said, "I'm sure [Dr A] has seen all this," and that she would "go back and ask". Ms B recalled responding that she would know that "everything is OK" if she did not receive a call by the weekend.

[1] Vocationally registered since 27 November 1987.
[2] The period around the onset of menopause (the natural cessation of menstruation) that is often marked by various physical signs such as hot flashes and menstrual irregularity.

27. RN C told HDC that where an ultrasound had indicated other pathologies (such as in this instance), it was her usual practice to inform the patient that other possibilities would need to be excluded. Further, RN C stated that she does not recall saying that she would get back to Ms B with any concerns. RN C told HDC: "In this case where potentially serious pathologies need to be investigated it is preferable that communication occurs directly between the doctor and the patient rather than via the nurse."

28. Following her conversation with Ms B, RN C sent the following task message[3] to Dr A:

> "Advised re mass seen ? fibroid. Heavy bleeding has stopped, still some red [per vaginam] spotting in the daytime and [per vaginam[4]] fluid loss overnight orange/brown in colour. Task [Dr A] re ? Further investigation as per [ultrasound scan] comment. Can you call [Ms B] and discuss as needed."

29. Dr A said that he did not see the task, so no action was taken. The medical centre's policy on the "Management of Test Results" states:

> "Tagged/task allocated results can not be removed from the inbox until they are untagged by the doctor or the task has been completed by the practice nurse."

30. Dr A told HDC:

> "There are no records available on who removed the task from the system and so I can only speculate about possible causes of this error. I know that I would never deliberately remove a task that had not been resolved. On rare occasions, inadvertent deletions can occur when deleting a task listed above or below. This can also happen when the user clicks on the wrong task. In addition, tasks in the past [have] been lost with some computer crashes."

31. The practice management software shows that Dr A marked the task as "done" at 4.08pm on 20 April 2016.

Further communication between Ms B and the medical centre

32. On 30 May 2016, Dr A completed a disability allowance form for Ms B. He said that he did not see Ms B on this occasion and did not review her notes given his familiarity with her. On 22 June 2016, Ms B consulted with Dr A in relation to additional WINZ documentation. There is no mention in the notes of any discussion about Ms B's gynaecological status or the ultrasound report.

33. On 7 November 2016, Ms B telephoned the medical centre and requested a form for blood tests. Ms B told HDC that she also mentioned being able to feel the uterine mass, and that she had bright yellow discharge. She recalled that RN C attributed her symptoms to the fibroid. Ms B further stated that she made the following entry in her diary at the time:

> "I rang [RN C]. Said not worried about it and 43mm and [fibroids] do hurt especially after heavy work. Would fax to [the laboratory] the tests and contact [Dr A]! I said

[3] A feature in medical software that is used to monitor important tasks or results.
[4] Through the vagina.

> 'Tell [Dr A] the discharge is funny colours but that the very heavy bleeding had stopped'. She said 'will tell [Dr A]!'"

34. RN C documented in Ms B's clinical notes:

> "[Per vaginam] bleeding mostly settled, just some [per vaginam] spotting at times. Concerned re sometimes gets pain ? Related to Fibroid, can be after heavy physical work — mowed lawns by hand. Wants to get [blood tests] and then pluck up the courage to come back and see [Dr A]."

35. RN C told HDC that she encouraged Ms B to make an appointment, and denied that Ms B had disclosed symptoms other than what had been documented. RN C stated that Ms B did not mention that she had undergone any investigation relating to a fibroid or mass. RN C said that she did not remember having spoken to Ms B previously, and so was not prompted to look at Ms B's results or last contact. RN C clarified that it was Ms B who had attributed the pain to the fibroid. In contrast, Ms B told HDC that RN C had assured her: "[T]here is nothing about what you're telling me that would make me think it was anything other than a fibroid."

36. It is not clear whether or not Ms B's symptoms were conveyed to Dr A.

37. Ms B clarified that her comment about "plucking up the courage" to see Dr A was an offhand remark that she had made because she was "in so much pain and he had done nothing [for her] so far". She said that she was not told to see the doctor, and that she did not hear back from anyone at the medical centre.

38. Ms B presented to Dr A on 28 November 2016, complaining of menstrual pain. Dr A told HDC: "I took that at face value and simply prescribed some naproxen[5] without any further discussion." The examination notes refer to the need for more effective pain relief and a review of Ms B's hormone levels. Dr A said that there was no discussion about irregular bleeding or the ultrasound scan, and he did not review the previous consultation notes. Dr A stated: "Unfortunately there would not be sufficient time in every consult to review patients' previous notes as a matter of course." In contrast, Ms B told HDC that they had a conversation about fibroids, and that Dr A had advised her against taking oestrogen as it made fibroids grow. She also recalled that Dr A had told her that fibroids can be "very painful".

39. A blood test performed later that day was indicative of menopause. On 8 December 2016, Ms B called the medical centre and enquired about the result. RN C recorded:

> "[Blood test] results look like post menopausal. [Per vaginam] bleeding has settled. I will check with [Dr A] re results and call [Ms B] back as needed.
>
> Management notes: Do results confirm post menopausal? See my notes Thanks [RN C]."

40. In response, Dr A wrote: "[M]enopausal pattern but she's still having periods!"

[5] A non-steroidal anti-inflammatory drug, used to alleviate pain, inflammation, and fever.

41. RN C said that she cannot recall whether she called Ms B back. There is no reference in the clinical notes to any further telephone conversations with Ms B, and Ms B told HDC that she did not hear back from anyone.

Gynaecology referral and diagnosis of endometrial cancer

42. On 18 January 2017, Ms B returned to the medical centre and consulted with a locum GP. The consultation notes refer to complaints of pain in the groin and left buttock, as well as irregular periods. These were reported to last for a few days, starting with some bright bleeding, "not really like her usual periods". The locum documented his concern about "a rocky low abdominal mass", and noted that the ultrasound report from March 2016 had referred to a 43mm mass potentially being a fibroid. He wrote, "[D]oesn't feel like a fibroid now," and sent an urgent gynaecology referral on the same day.

43. A transabdominal ultrasound was performed on 20 January 2017. Following a CT scan on 27 January 2017, Ms B was diagnosed with stage IV endometrial cancer, with metastases in the lungs and pelvis.

44. Dr A said:

> "My missing the original ultrasound has been fundamental in this missed diagnosis. Regrettably future communications both on the phone and even in person with the nurse and myself have not alerted me to this scan report. With hindsight it is with much regret that the visits I had with [Ms B] especially in June 2016 did not include review of her gynaecological status nor discussion on the ultrasound report which I had no knowledge of but which [Ms B] had been advised about."

Changes to practice

45. The medical centre told HDC that it is at a loss to see how Ms B's scan result could have been filed without Dr A seeing it, and that it has made a number of changes to prevent a similar error from occurring again. These changes include:

- In addition to recording an actioned task on a patient's clinical records, the details of the task are now copied into a return message to the clinician who initiated the task. This allows the person initiating the task to check whether it has been completed without the need to check the patient's clinical record.

- If the person dealing with the task has concerns about the seriousness of the result, that person is to speak to the patient's clinician in person about the concerns, in addition to sending the task and putting an alert in the patient's warning box.

- The medical centre is working with its Primary Health Organisation to upgrade the practice management software, and will be moving to a new, more user-friendly system.

The medical centre's policy for management of test results

46. The medical centre provided a copy of its policy entitled "Management of Test Results". The policy outlines that either the requesting doctor can advise the patient that the medical centre will contact the patient within the week, or the requesting doctor can ask the patient

to contact the medical centre for the result. The policy states that where a patient enquires about his or her test result,

> "the practice nurse taking the phone call advises the patient of their results, documents this and advises the patient whether or not a further consultation with the doctor is required (either by phone or in person). The practice nurse notifies the doctor that further follow-up is required and loads this request in to that doctor's task box. Results that require urgent attention are acted on immediately by the doctor ringing the patient. At the end of the week the doctor will notify those patients who have not called in to obtain their results (either by letter or allocating this as a task to the practice nurse)."

Responses to provisional opinion

47. Ms B was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. Her comments have been incorporated into this report, where appropriate.

48. Dr A, RN C, and the medical centre were provided with an opportunity to comment on the provisional opinion. Dr A and RN C had no comments to make. The medical centre stated: "We deeply regret that Ms B's ultrasound result was not acted on." It also stated that Dr A has extended his consultation times to 15 minutes to allow him more opportunity to review previous consultations and write more complete medical records.

Opinion: Dr A — breach

Ultrasound report

49. Dr A referred Ms B for a pelvic ultrasound on 12 December 2015. The ultrasound was performed on 17 March 2016 and the report was sent to the medical centre on the same day. The report stated:

> "Within the endometrial cavity there is a 43mm round heterogen[e]ous mass with vascularity demonstrated on Doppler flow … The mass within the endometrial cavity may represent a submucosal fibroid. However other pathologies must be considered and urgent gynaecological referral is recommended."

50. The practice management software records that Dr A removed the ultrasound scan result from his in-tray on 13 April 2016.

51. Dr A stated that, while it is his usual practice to look at all incoming reports and to contact his patients directly about urgent matters, he did not review Ms B's ultrasound scan result and is unable to explain how it was missed on his part.

52. On 18 April 2016, Ms B called the medical centre to enquire about the result of the ultrasound scan. RN C subsequently sent the following task message to Dr A:

> "Advised re mass seen ? fibroid. Heavy bleeding has stopped, still some red [per vaginam] spotting in the daytime and [per vaginam] fluid loss overnight orange/brown

> in colour. Task [Dr A] re ? Further investigation as per [ultrasound scan] comment. Can you call [Ms B] and discuss as needed."

53. The practice management software shows that Dr A marked the task message as "done" on 20 April 2016. Dr A told HDC that he did not see the task, and that he "would never deliberately remove a task that had not been resolved".

54. My in-house clinical advisor, GP Dr David Maplesden, commented:

> "[W]hatever the underlying cause of these sequential errors, I remain of the view it represents a severe departure from expected standards of care and had a profound effect on [Ms B's] subsequent management."

Subsequent consultations

55. On 22 June 2016, Ms B consulted with Dr A in relation to WINZ documentation. The notes do not mention any discussion about Ms B's gynaecological status or the ultrasound report.

56. At a further consultation on 28 November 2016, Ms B complained of menstrual pain. Dr A told HDC that he took this information "at face value and simply prescribed some naproxen without any further discussion". Ms B recalled that Dr A had spoken to her about fibroids at this consultation; however, in his response to HDC, Dr A denied that any discussion about the ultrasound scan had occurred. The consultation notes document the need for more effective pain relief and a review of Ms B's hormone levels. I accept the information in the consultation notes; however, I am unable to make a factual finding on whether there was discussion about fibroids or the ultrasound scan at this consultation.

57. Dr Maplesden is moderately critical of Dr A's failure to review Ms B's notes adequately at subsequent consultations. Dr Maplesden stated:

> "[T]his led to missed opportunities to recognise earlier the need to review her ultrasound report and consider urgent gynaecology assessment … I do not believe a brief review of the previous two or three consultation notes, which are usually readily visible in the patient's [practice management software], is a particularly onerous or time consuming task but has some importance in facilitating continuity of care."

Blood test results

58. Ms B had blood tests on 28 November 2016. On 8 December 2016, RN C recorded:

> "[Blood test] results look like post menopausal. [Per vaginam] bleeding has settled. I will check with [Dr A] re results and call [Ms B] back as needed.
>
> Management notes: Do results confirm post menopausal?"

59. Dr A responded: "[M]enopausal pattern but she's still having periods!"

60. Dr Maplesden advised that Dr A ought to have recognised that such bleeding was abnormal, or at least that it required prompt review and referral if it recurred.

Conclusion

61. Ms B's abnormal ultrasound examination warranted an urgent gynaecological assessment, and this was outlined clearly in the report. I am critical that the report remained in Dr A's in-tray for 27 days, and that he then removed it without taking appropriate action. It is deeply concerning that Dr A also marked RN C's task message, which would have served as a reminder to follow up on the result, as "done" without acting upon it.

62. Dr A did not review the preceding notes during Ms B's subsequent consultations on 22 June 2016 and 28 November 2016. Furthermore, Dr A did not take any action after noting the discordance between Ms B's blood test results, which were consistent with menopause, and her reports of ongoing bleeding. I agree with Dr Maplesden's concerns about the care provided by Dr A.

63. It is well established that doctors owe patients a duty of care in handling patient test results, and that the primary responsibility for following up abnormal results rests with the clinician who ordered the tests. In this case the ultrasound report contained explicit instructions to arrange further assessment, and Dr A failed to do so. As outlined above, there were also several missed opportunities for Dr A to follow up on Ms B's ultrasound result.

64. Dr A failed to take appropriate action on Ms B's ultrasound scan result, RN C's task message requesting follow-up, and Ms B's blood test results. These omissions lead me to conclude that Dr A failed to provide services to Ms B with reasonable care and skill. Accordingly, I find that Dr A breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[6]

Opinion: RN C — adverse comment

65. RN C spoke with Ms B over the telephone on three occasions: 18 April 2016, 7 November 2016, and 8 December 2016.

18 April 2016

66. On 18 April 2016, Ms B contacted the medical centre to enquire about her ultrasound scan result. Although there is some dispute regarding what was said during this conversation, it is agreed that RN C informed Ms B that a mass had been identified on ultrasound, that it was possibly a fibroid, and that RN C would follow up with Dr A.

67. Following this conversation, RN C sent a task message to Dr A via the practice management software, and asked that he contact Ms B.

68. My in-house nursing advisor, RN Vivienne Josephs, agreed with RN C's submission that it was more appropriate for Dr A, as the GP who ordered the investigation, to discuss the abnormal ultrasound result with Ms B. RN Josephs advised that RN C's task message to Dr A was sufficient to meet her obligations as a nurse.

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

7 November 2016

69. Ms B told HDC that when she requested blood tests on 7 November 2016, she also mentioned to RN C that she was able to feel the uterine mass, and that she had bright yellow discharge. Ms B said that she wrote in her diary that RN C had attributed these symptoms to the fibroid. RN C denied that these symptoms were mentioned by Ms B.

70. RN C documented that Ms B's vaginal bleeding had "mostly settled" but that Ms B had some spotting at times. RN C also documented that Ms B was concerned about occasional pain. RN C told HDC that she encouraged Ms B to make an appointment, but Ms B declined. Ms B said that she was not told to see the doctor. RN C stated that she did not remember having spoken to Ms B about the ultrasound result previously, and therefore was not prompted to review the previous records.

71. RN Josephs is critical that RN C did not review the previous entries in Ms B's clinical notes, given Ms B's reported symptoms of vaginal bleeding and pain. RN Josephs stated that if Ms B was informed that her symptoms were normal and was not advised to see her GP, this would be a significant departure from an acceptable standard of practice.

8 December 2016

72. On 8 December 2016, Ms B called the medical centre and enquired about the results of her latest blood test. RN C recorded:

> "[Blood test] results look like post menopausal. [Per vaginam] bleeding has settled. I will check with [Dr A] re results and call [Ms B] back as needed."

73. Dr A wrote: "[M]enopausal pattern but she's still having periods!"

74. RN C cannot recall whether or not she called Ms B back. Ms B stated that she did not hear from anyone at the medical centre following the telephone conversation, and there is no reference to any further telephone conversations with Ms B in the notes.

75. RN Josephs advised that RN C fulfilled her professional obligations by informing Dr A of the blood test results and Ms B's telephone call. RN Josephs commented that, while Dr A's apparent surprise at the finding might have prompted RN C to further discuss the implications of that finding, the failure to do so was not a departure from accepted standards.

Conclusion

76. I accept RN Josephs' advice that RN C's actions on 18 April 2016 and 8 December 2016 met accepted standards.

77. I note the discrepancy between Ms B's recollection of her telephone call on 7 November 2016 and what was documented by RN C on that date. Having carefully weighed up the evidence, I am unable to make a factual finding regarding the exact symptoms reported by Ms B, or whether she was encouraged to make an appointment with Dr A.

78. However, I share RN Joseph's view that Ms B's concerning reports of vaginal bleeding and pain ought to have prompted RN C to check Ms B's clinical history, and I am critical that this was not done.

Opinion: Medical centre — breach

79. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. Dr Maplesden reviewed the medical centre's policy for the management of test results and advised that the processes in place were consistent with accepted practice.

80. I am satisfied that the medical centre's policy for the management of test results was adequate, and consider that the errors that occurred did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

81. In addition to any direct liability for a breach of the Code, under section 72(3) of the Health and Disability Commissioner Act 1994, an employing authority is vicariously liable for any acts or omissions of its agents unless the acts or omissions were done without that employing authority's express or implied authority.

82. Dr A is a partner and director of the medical centre. He is not an employee; however, he was authorised to act as a GP on behalf of the medical centre when he was providing care to Ms B, and was therefore an agent of the medical centre. I also consider that in consulting with Ms B, referring her for a pelvic ultrasound, and managing her test results, Dr A was acting within the authority granted by the medical centre. As such, I find that the medical centre is vicariously liable for Dr A's breach of Right 4(1) of the Code.

Recommendations

83. I recommend that Dr A:

a) Arrange for a peer to undertake an audit of his clinical records to ensure that all abnormal results for tests he has ordered in the last three months have been communicated to patients and followed up appropriately. Dr A should provide evidence to this Office of this audit and its outcome within three months of the date of this report.

b) Provide a written apology to Ms B for the failures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms B.

84. I recommend that the Medical Council of New Zealand undertake a competence review of Dr A.

Follow-up actions

85. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, and the District Health Board, and they will be advised of Dr A's name.

86. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to the Commissioner

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

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her by [Dr A] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file: complaint from [Ms B]; response from [Dr A]; GP notes [the medical centre]; statement from [the medical centre] practice nurse [RN C]; clinical notes [the DHB].

2. [Ms B] states that [Dr A] arranged for her to have a pelvic ultrasound after she presented a history of irregular vaginal bleeding. The ultrasound was undertaken in March 2016 and showed a mass with further urgent investigation advised. [Ms B] indicates she was not notified of this result or the results of blood tests despite ringing for results. In January 2017 [Ms B] saw a locum GP because of hip pain and ongoing bleeding. He referred [Ms B] for urgent gynaecology review and in February 2017 further investigations revealed advanced endometrial cancer (Stage IV squamous cell carcinoma) with local invasion and metastases to bone, lymph nodes and lungs. [Ms B] is currently receiving palliative care. She is concerned that [Dr A] did not inform her of the ultrasound result from March 2016 and failed to investigate the mass despite the recommendations in the report.

3. [Dr A] states he does not recall reading [Ms B's] ultrasound report until January 2017. *It was downloaded on 17 March 2016 to [Ms B's] file. I am unable to explain how this report was missed on my part; every doctor's nightmare.* He states that [Ms B] did not complain to him of any ongoing gynaecological issues until 28 November 2016 when she *requested pain relief for what she described as dysmenorrhoea together with repeats of other medication. I took that at face value and simply prescribed some Naproxen without any further discussion. She also requested a review of hormones and I ordered FSH, LH oestradiol. There was no further discussion as to irregular bleeding or any other issue. In particular there was no reference to the previous ultrasound scan.* [Dr A] states: *It is my practice to go through all incoming reports and anything of urgency I will contact the patient but most communication is done via the practice nurse.* He states his nurse communicated with [Ms B] regarding her blood result, and that *the nurse advised me in 2017 that she had told [Ms B] in April 2016 of a mass ?fibroid, and that further investigation is recommended and subsequent discussion to be on the basis of a presumed fibroid and not the potential for other pathology.* He denies any discussion with the nurse at that time regarding the ultrasound result.

4. Practice nurse [RN C] states she spoke with [Ms B] on 15 April, 7 November and 8 December 2016. *I recall the conversations but not all the details of them. In particular, I advised [Ms B] to make an appointment to follow up with her GP but she declined to make an appointment* [unclear which date she is referring to]. *Regarding [Ms B's] blood test results, I consulted [Dr A] to confirm what the results meant and as far as I can recall I did call [Ms B] back.*

5. I have reviewed the practice policy titled 'Management of Test Results'. Extracts include:

(i) *Patients are advised by the requesting doctor during the consultation that initiated the test that they either 1) will be notified of their results within a week or 2) should ring through or email for their results in the next 48 hours.*

(ii) *The practice nurse taking the phone call* [from patients enquiring after their results] *advises the patient of their results, documents this and advises the patient whether or not a further consultation with the doctor is required (either by phone or in person). The practice nurse notifies the doctor that further follow-up is required and loads this request in to that doctor's task box. Results that require urgent attention are acted on immediately by the doctor ringing the patient. At the end of the week the doctor will notify those patients who have not called in to obtain their results (either by letter or allocating this as a task to a practice nurse).*

(iii) *Tagged/task allocated results can not be removed from the inbox until they are untagged by the doctor or the task has been completed by the practice nurse.*

(iv) *All phone calls or conversations with the patient regarding their results are documented in the clinical record.*

(v) The policy appears similar to result management policies I have reviewed from other practices although does not specifically address the issues of management of the results in-box when a doctor is away or a locum doctor is ordering tests. In other respects, the policy appears to be consistent with RNZCGP recommendations[1].

6. Clinical notes review

(i) [Ms B] was aged 53 years at the time of her diagnosis. She had never been sexually active and was therefore not on the national cervical screening programme. The first reference to any issues with dysfunctional uterine bleeding is a consultation dated 25 June 2015 (Dr […]) which was primarily for hip and shoulder pain following a fall, and for repeat of usual medications. [The doctor] noted additionally: *periods a bit erratic — one heavy … do bloods as usual — if further heavy bleeds consider uss.* Haemoglobin was normal and FSH and LH results were consistent with menopause (FSH 83.8 IU/L, LH 29.7 IU/L).

(ii) The next consultation was with [Dr A] on 4 December 2015. Notes include: *10 day period March heavy, ongoing continuous bleeding sometimes heavy, not cyclical.* Blood pressure and pulse were satisfactory and BMI was 17.1. There is no abdominal or pelvic examination recorded. Blood tests were ordered and showed haemoglobin and ferritin within the normal range, and reproductive hormone results suggestive of peri-menopause (elevated FSH, LH and oestradiol). It appears a pelvic ultrasound scan was ordered on 12 December 2015 with triage note received on 15 December 2015: *Ultrasound Pelvis Female referral: Priority — Category C: Target wait time — 12 weeks, Estimated wait time 14–22 weeks.*

[1] https://oldgp16.rnzcgp.org.nz/assets/documents/Standards--Policy/Publications/PolicyBriefApr16.pdf Accessed 27 March 2017

(iii) The ultrasound was undertaken on 17 March 2016. Clinical data was: *Dysfunctional uterine bleeding past year worsening. Non cyclical often very heavy. No PH of Cx smear as not indicated. Post menopausal bleeding. Last bleed Saturday 12/2.* The ultrasound report included: *Transabdominal scan (a transvaginal scan was unable to be done). Uterus: Anteverted. Endometrium: Within the endometrial cavity, there is a 43mm round heterogenous mass with vascularity demonstrated on Doppler flow. Ovaries: Normal bilaterally. Trace free fluid is seen in the right adnexa. No pelvic mass is seen. Kidneys: Normal. Right = 108 mm, left = 105 mm. COMMENT: The mass within the endometrial cavity may represent a submucosal fibroid. However other pathologies must be considered and urgent gynaecological referral is recommended.*

(iv) On 26 February 2016, [practice nurse] recorded: *P/C to [Ms B] — advised no evidence of breast cancer on recent mammogram. [Ms B] had mentioned breast changes at the time of her mammogram — letter from breast screening clinic advised to have these reviewed by a GP. Management Notes. [Ms B] will call back to make an appt.* On 29 February 2016 [Dr A] provided [Ms B] with a prescription for her regular medications (phone script).

(v) On 18 April 2016 Practice nurse [RN C] has recorded: *P/c with [Ms B] re USS test results, advised re mass seen ?fibroid. Heavy bleeding has stopped, still some red PV spotting in the daytime and PV fluid loss overnight orange/brown in colour. Task [Dr A] re ?further investigation as per USS comment.* **There is no record of the task message apparently sent from [RN C] to [Dr A] and a copy of this should be obtained (such messaging should be auditable in the PMS).** I note there is no documentation confirming the outcome of any discussion with [Dr A], and no note that [Ms B] had been advised to attend for an appointment.

(vi) On 30 May 2016 [Dr A] recorded: *DA completed in absentia — other immune system, anxiety, other cardiovascular.* I am unsure what 'DA' refers to in this context. On 10 June a repeat prescription was provided for [Ms B's] regular medications (phone script) and on 22 June 2016 a note was provided for authorized consumables ([Ms B] was apparently seen at this time). On 26 and 28 September 2016 prescriptions were provided for [Ms B's] regular medications (phone script). There is no reference to the ultrasound result or gynaecological issues in any notes between 18 April and 28 September 2016.

(vii) On 7 November 2016 practice nurse [RN C] recorded: *P/c with [Ms B] asking for a form from [Dr A] for usual blood tests she has. PV bleeding mostly settled, just some PV spotting at times. Concerned re sometimes gets pain ? related to Fibroid, can be after heavy physical work — mowed lawns by hand. Wants to get Bt and then pluck up the courage to come back and see [Dr A].* [Ms B] had blood tests undertaken on 16 November 2016. Haemoglobin and ferritin levels were within the reference range.

(ix) The next consultation note is dated 28 November 2016 ([Dr A]) and reads: *needs better pain relief dysmenorrhea, req hormones review.* Prescriptions were provided for [Ms B's] regular medications plus Naproxen. Blood tests performed later that day showed FSH and LH levels were elevated and oestradiol level reduced consistent with menopause.

(x) On 8 December 2016 practice nurse [RN C] recorded: *P/c with [Ms B] advised re Bt results look like post menopausal, Pv bleeding has settled. I will check with [Dr A] re results and call [Ms B] back as needed.*

Management Notes: Do results confirm post menopausal ? see my notes Thanks [RN C] menopausal pattern but she's still having periods!

It is not possible for me to determine whether [RN C] rang [Ms B] back after discussing the results with [Dr A], or what the management plan was to be if [Ms B] continued to bleed despite blood tests indicating menopause.

(xi) [Ms B] saw [a locum GP] at [the medical centre] on 18 January 2017. His notes include: *[Ms B] feels that the fibroid and pain associated are getting better. Now she is concerned about pain in her groin, and pain in her R buttock. 5 weeks. She has no radiation of pain, no back pain. Sore at night time as well. Tender ischial tuberosity — trouble sitting at times.*

She is having irreg periods, last a few days, some bright bleeding to start — not really like her usual periods. Bowels alternating diarrhoea and constipation. Nulliparous. Menarche age 11.

On exam

Weight 51 — not changed

Tender over R ischial tuberosity, also tender in R groin just lateral to femoral artery on deep palpation.

Has a rocky low abdominal mass — note scan was done around March 2016 — 43mm mass in uterus, possibly a fibroid.

Doesn't feel like a fibroid now.

Needs urgent gynae referral.

I explained to [Ms B] that I was worried about this mass.

An urgent gynaecology referral was made leading to [Ms B's] diagnosis of advanced endometrial cancer as noted in section 2.

7. Comments

(i) [Ms B] presented a history initially consistent with dysfunctional uterine bleeding and perimenopause although her precise menstrual pattern is difficult to determine from the available documentation. She had no 'alarm' symptoms of iron deficiency anemia or unexplained weight loss when reviewed in December 2015 (or in the following 12 months). While a pelvic examination and cervical smear (if not up to date with screening) might normally be expected as part of the initial workup of DUB, [Ms B] had never been sexually active which obviated the requirement for a smear, and I think it was reasonable to defer a pelvic or speculum examination under the circumstances and instead opt for immediate ultrasound referral. There were adequate clinical details

on the ultrasound form. I think the ultrasound report was sufficiently explicit in the recommendation that the identified intrauterine mass required urgent further investigation even if it might have been consistent with a fibroid.

(ii) The failure by [Dr A], as the person who ordered the investigation and who had been charged with undertaking the recommended further management, to ensure the mass was further investigated in a timely fashion must be regarded as a severe departure from expected standards of care even if was an unintended oversight. However, it is somewhat difficult to determine the reasons for the apparent failure of a seemingly robust practice policy on following up of investigation results. [RN C] has indicated she undertook a preliminary discussion of the scan results with [Ms B] and was then to discuss recommended management with [Dr A]. [Dr A] has no recall of ever seeing the result or undertaking any discussion regarding the results, and there is no note from either provider regarding a structured management plan or what clinical advice was provided to [Ms B]. There is an implication that [Ms B] was advised to make an appointment with [Dr A] and declined to do so, but there is no record of such discussion. If [Ms B] was given appropriate information (that she had a uterine mass that might be sinister and the radiologist had recommended urgent further investigation of the mass) and made an informed decision not to proceed with further investigation, this would be a significant mitigating factor. However, there is no indication from [Ms B] that this was the case and the clinical documentation does not support such a scenario. In summary, the management of [Ms B's] ultrasound scan result was poor, but I am unable to determine whether this was primarily a result of human error (GP and/or practice nurse) or poor processes. The practice might be asked to undertake a more detailed internal review of the processes undertaken in this case (particularly around 'tasking' of the GP) and to report back to the Commissioner on their findings and any remedial actions undertaken.

(iii) There were subsequently missed opportunities to recognize that [Ms B] was overdue for the recommended further investigation of her uterine mass. The result was evidently not adequately 'tracked' once there had been a discussion with [Ms B]. Tracking of the result should perhaps have been continued until the recommended further investigations were initiated rather than just following notification of the result, or a separate 'task' initiated and tracked to ensure the recommendations were followed up. Had [Ms B] been informed she had a possibly suspicious uterine mass that required further investigation, it might be expected she would enquire about the testing when no appointments had been received within a few weeks. However, if she had been informed only that she had a likely fibroid, she may have found this sufficiently reassuring not to enquire further or to report ongoing symptoms. The information provided to her in April 2016 is critical but not recorded. Practice nurse [RN C] recorded [Ms B's] current gynaecological symptoms in a telephone call on 7 November 2016 (including some PV spotting and *pain/related to fibroid*) but [Dr A] evidently did not review this note when [Ms B] reported a 'dysmenorrhea' symptom to him, and requested hormone tests, in an appointment three weeks later. Furthermore, on 8 December 2016 [Dr A] noted some discordance between [Ms B's] hormone tests (suggestive of menopause) but the fact she was *still having periods.* While a diagnosis of advanced endometrial cancer made at this point is unlikely to have altered [Ms B's] prognosis or subsequent clinical course, I am moderately critical of the apparent failure

by [Dr A] to review the preceding notes which might have prompted him to review [Ms B's] previous ultrasound report."

Dr Maplesden provided the following further advice:

"1. I have reviewed the additional response received from [the medical centre].

(i) Further documentation has been provided in relation to the practice process for handling of clinical correspondence. This includes a formal deputizing process and makes redundant the comment in my original advice relating to apparent lack of such a process (section 5(v)). The process has now been strengthened further to include monitoring of locum in-boxes for an extended period following departure of the locum.

(ii) There has been an extensive internal review of the issues raised by [Ms B's] complaint but the practice is still unable to explain how [Ms B's] scan result was apparently filed without [Dr A] reviewing it, or how a task was deleted before it was completed (see below). Some measures are outlined which should increase the robustness of the task management process in relation to handling of clinical results.

(iii) I have made an assumption with these and previous comments on [the medical centre's] results handling processes that nursing staff are notifying patients of abnormal results only once those results have been reviewed by the GP. I would be concerned if such results were being discussed with patients before they were reviewed by the GP.

(iv) I think the relevant processes [the medical centre] had in place at the time of the events in question were consistent with accepted practice.

2. Further response from [Dr A]

(i) The task sent by [RN C] to [Dr A] on 18 April 2016 was deleted on 20 April 2016. The practice cannot confirm who removed the task or why although as with any PMS, accidental deletion can occur if the wrong key is inadvertently pressed. [Dr A] does not recall seeing the message which read:

P/c with [Ms B] re USS test results, advised re mass seen ?fibroid. Heavy bleeding has stopped, still some red PV spotting in the daytime and PV fluid loss overnight orange/brown in colour. Task [Dr A] re ?further investigation as per USS comment. Can you call [Ms B] and discuss as needed. Thanks [RN C].

So this is a situation whereby [Dr A] (who ordered the ultrasound scan) does not recall ever seeing [Ms B's] abnormal ultrasound result although it was filed in her notes from his inbox on 17 March 2016, and he is unable to recall seeing the task sent to him by [RN C] regarding the result, that task being sent on 18 April 2016 and deleted on 20 March 2016. This is a very unsatisfactory situation and whatever the underlying cause of these sequential errors, I remain of the view it represents a severe departure from expected standards of care and had a profound effect on [Ms B's] subsequent management.

3. I remain of the view that [Dr A] did not adequately review [Ms B's] notes at subsequent consultations, and this led to missed opportunities to recognize earlier the

need to review her ultrasound report and consider urgent gynaecology assessment. I remain moderately critical of this situation. I do not believe a brief review of the previous two or three consultation notes, which are usually readily visible in the patient's PMS, is a particularly onerous or time consuming task but has some importance in facilitating continuity of care. It might have led to proactive enquiry regarding [Ms B's] gynaecological symptoms even if the next consultation was for unrelated issues. The task note referred to above was written in the clinical notes as were subsequent references by the practice nurse to [Ms B's] ongoing bleeding symptoms (7 November 2016). On 8 December 2016 [Dr A] responded to [RN C's] request for advice regarding [Ms B's] recent blood tests results by noting they were consistent with menopause (which they were) '*but she's still having periods'.* While noting [RN C] had recorded [Ms B's] '*pv bleeding has settled'*, [Dr A's] comment I think should have triggered recognition that such bleeding was abnormal or at least required prompt review and referral if it recurred, leaving aside the issue of the overlooked scan result.

4. Some comment is made regarding [Ms B's] reluctance to attend for review of her gynaecological symptoms but it must be acknowledged that her decisions were made with the reasonable assumption (by her) that her scan result was not particularly concerning."

Appendix B: In-house nursing advice to the Commissioner

The following expert advice was obtained from RN Vivienne Josephs:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided by [RN C] of [the medical centre]. In preparing the advice on this case, to the best of my knowledge, I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **Documents reviewed**
I have reviewed the information on file: complaint from [Ms B]; response from [RN C]; clinical notes from [the medical centre]; expert opinion from Dr Maplesden, response from [the medical centre]; and conversation notes between [HDC] and [Ms B].

3. **Complaint and background**
[Ms B's] complaint concerns a delayed follow up by [the medical centre] on a 4.3cm uterine mass found on pelvic ultrasound performed on 17 March 2016. The report suggested a fibroid but advised consideration of other pathologies and recommended an urgent gynaecological review. This report was downloaded to the patient's file and to [Dr A's] (GP) inbox following the scan but was not seen by the GP. On 18 April 2016, [Ms B] contacted [RN C] to obtain the results of the scan and was told there was a mass, likely a fibroid but a gynaecological review was recommended. A task message for follow up was sent by [RN C] to [Dr A] on 18 April 2016 but the task was deleted on 20 April 2016 and was not seen by [Dr A]. The follow up gynaecological review did not occur and on 27 January 2017, [Ms B] was diagnosed with Stage IV metastatic endometrial cancer.

4. **Advice requested**
I have been asked to review the information on file and advise whether [RN C's] actions on 18 April 2016, 7 November 2016 and 8 December 2016 in relation to [Ms B], met accepted standard in terms of follow up. It was noted that there are different accounts of events between the two parties. I have been asked to provide advice in the alternative.

5. **Actions of 18 April 2016, 7 November 2016 and 8 December 2016**

18th April 2016

[RN C]
On 18 April 2016, [RN C] received a call from [Ms B] to obtain her ultrasound result from her scan performed on 17 March 2017. [RN C] documented that she advised [Ms B] that a mass had been seen and it was ? fibroid. A task message was sent by [RN C] to [Dr A] stating what information she had given [Ms B] and queried whether there would be further investigation as requested in the ultrasound report.

[Ms B]
[Ms B] states she saw [Dr A] in late 2015 for heavy irregular vaginal bleeding during which blood tests and a pelvic ultrasound were ordered. At this initial December appointment, [Ms B] was told by [Dr A] that he would call her with the result of the scan. The ultrasound was performed on 17 March 2016. She did not hear back from the practice and so called for her results on 18 April 2016.

According to [Ms B's] handwritten notes on 18 April 2016, [Ms B] phoned the practice for the results and spoke with [RN C]. [Ms B's] notes state that she was told about a 43mm round mass in her uterus, that it was possibly a fibroid and that other tests had been recommended. A referral to a gynaecologist has been requested but that nothing has been done. She was told that *[Dr A] had seen the results.* She was told that [RN C] would *doublecheck with him* ([Dr A]) *in case missed something*. In [Ms B's] verbal account with [HDC], [Ms B] recalls being told by the practice nurse that 'I'm sure he's seen all this', and that it could be a fibroid and that she ([RN C]) will go back and ask.

Nursing Advice
Both [Ms B] and [RN C] acknowledge that the presence of the uterine mass found on the ultrasound was conveyed to [Ms B] on 18 April 2016 and that there was a need for a gynaecological review. It is not documented in the clinical notes if it was conveyed to [Ms B] that the scan report requested an urgent gynaecological review.

[RN C] recognised that the request for that review had not occurred and had sent a task message to [Dr A] which served to both inform him of the advice she had given [Ms B] and as a reminder of the gynaecological review that was requested in the report. This would be accepted standard of practice. However, there was no confirmation in the clinical notes following this entry that [RN C] had spoken with [Dr A] or had followed up with a phone call and an update to [Ms B]. I am critical of this lack of documentation which would confirm that those conversations had taken place.

[Dr A] in his response states that most communication of results in his practice is done through the practice nurse. It is not clear if there is usually a discussion between the GP and nurse prior to conveying results to patients or afterwards. In this case, [Dr A] denies any conversation with [RN C] in April 2016 regarding the result.

[Ms B's] account of the conversation describes her uncertainty about whether [Dr A] had been aware of the ultrasound result and the assumption conveyed to her by [RN C] that he had seen it. [Ms B] does state that [RN C] said she would double-check with [Dr A] and get back to her by the end of the week if there were any concerns. This was then left for [Dr A] to contact [Ms B].

In [the medical centre's] practice policy 'Management of Test Results', it's not clear if the practice nurses also receive a copy or are alerted to the arrival of a patient's radiological results. [Ms B] states that she was told at her GP visit in December 2015 that she would be contacted with the results of her scan. She

contacted [the medical centre] one month after her scan in March 2016 as she had not heard back.

I do question the emphasis that appears to have been communicated in regards to the mass being a fibroid (stated in the report as may *represent a submucosal fibroid* which could have detracted from the consideration of other pathologies. [Dr A's] response states that he was advised by [RN C] in January 2017 that she had told [Ms B] in April 2016 of a mass ? fibroid and that further investigation is recommended '*subsequent discussion to be on the basis of a presumed fibroid and not the potential for other pathology*'. This comment needs clarification.

It is also not clear whether the 'urgency' of the review, as stated in the report, was conveyed to either [Dr A] or [Ms B]. It is also not clear whether both the scan result and the task message were lost from the practice system. If both had been lost and the task message had been followed up by a discussion with [Dr A], it would have prompted a review and follow up.

7th November 2016

[RN C]

On 7 November 2016, [RN C] received a phone call from [Ms B] requesting a form for her usual blood tests. Clinical notes document that the vaginal bleeding was mostly settled except for some PV spotting. [RN C] noted that [Ms B] was still getting pain and [RN C] queried whether it was related to the fibroid. Notes state that [Ms B] wanted to get the blood tests done and then pluck *up enough courage to come back and see [Dr A]*. [RN C], in her response, stated that she advised [Ms B] to make an appointment to see her GP but she declined. She cannot recall additional details apart from those documented in the clinical notes.

Nursing Advice

There is no reference to [Ms B's] scan result or of any follow up gynaecological review being discussed with [Ms B] or any documentation of the same. [Ms B's] ongoing pain was presumed to be due to the assumed fibroid without reference to possible *'other pathologies'* suggested in the scan result. [RN C] states she did advise [Ms B] to see the GP which is standard practice, but it is not documented why the advice to make an appointment to see her GP was declined by [Ms B]. There is also no documentation that the task message sent to [Dr A] documented in the visit in April had been reviewed.

In this scenario, I am critical of the fact that there was no documentation of any discussion regarding follow up from the scan result with either [Ms B] or [Dr A]. I am also critical of the documented assumption of the diagnosis of a fibroid being the cause of [Ms B's] ongoing pain without documented discussion with [Dr A] regarding this.

[Ms B]

[Ms B] told HDC that on 7 November 2016, she had phoned the practice requesting a form for blood tests and also mentioned that she was able to feel the uterine mass and that she had a bright yellow discharge. She states that she was told that these signs were not concerning and that the symptoms could be attributed

to the fibroid. [Ms B] states she was told that the nurse would speak to the GP again. In [Ms B's] discussion with HDC, [Ms B] could not recall being advised to see the GP and also said they were joking and laughing with her about fibroids. She stated she was in a lot of pain and that she needed courage to see the GP again as she felt he hadn't done anything for her. [Ms B] stated that the nurses knew about the bleeding and different coloured discharge but said she was told it was normal and *'nothing out of the ordinary for fibroids and menopause'*.

[Ms B] states that she made many calls to the practice and said that the nurse she spoke to (it is not clear which nurse) dismissed her concerns and did not call her back. She also states that the results of blood tests were not conveyed to her despite several calls. A nurse promised to ring back but this did not occur. [Dr A] states in his response to Dr Maplesden that he ([Dr A]) advises patients to contact the practice nurse a few days after the scan had been done to get the result.

Nursing Advice
In this scenario, there appears to be poor communication between the practice and [Ms B] regarding returning [Ms B's] calls and addressing her concerns. There is no documentation in the clinical notes of these calls. The mention by [Ms B] of being able to feel a palpable mass, a change in vaginal discharge and ongoing pain would raise a red flag for an urgent GP review. If [Ms B] was not advised to see her GP and her symptoms were recognised as being *'nothing out of the ordinary for fibroids and menopause'* without a clinical review, this would be a significant departure from an acceptable standard of practice[1].

8th December 2016

[RN C]
On 8 December, [RN C] documents that she had a phone call discussion with [Ms B] and advised her that the blood test results (bloods taken on 28 November 2016 following a visit to the GP) appear post menopausal, noted that her vaginal bleeding had settled and stated that she would check the results with [Dr A] and then call [Ms B] back if needed. It's not stated in the clinical notes if [Ms B] was called back or if she needed a return call. [RN C] had informed [Dr A] as the clinical notes state his confirmation of a menopausal pattern with an accompanying exclamation mark in the clinical note that she is still having periods. [RN C's] later response stated that she had consulted [Dr A] to confirm the meaning of the blood test results and as far as she can recall, did call back [Ms B].

Nursing Advice:
If [RN C] had informed the GP, documented in the clinical notes and returned [Ms B's] call after discussion with the GP, then the acceptable standard of care would have been met.

[Ms B]
There is no account from [Ms B] for this date.

[1] New Zealand Nursing Council Code of Conduct http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct. Accessed 20 January 2018

6. Summary of Clinical Advice

There are two differing accounts from [Ms B] and [RN C] regarding the post scan follow up on 18th April 2016, 7 November 2016 and 8 December 2016. Clinical advice has been given above.

I am critical of:

(i) The lack of documentation in the clinical notes regarding conversations between [RN C], the GP and [Ms B] regarding follow up of the results of the scan, the progress of the gynaecological review and the symptoms described by [Ms B] of changing vaginal discharge and ongoing pain. There is also no documentation that there was any enquiry from [Ms B] on either 7 November or 8 December as to the progress of the gynaecological referral.

(ii) The focus on a 'fibroid' as being the reason for ongoing symptoms without further clinical review. [RN C] states she had encouraged [Ms B] to see her GP but [Ms B] had declined.

[RN C's] response is very brief. It might be helpful to ask [RN C] for further details and clarification regarding the conversations between herself and [Dr A] and the conversations between [RN C] and with [Ms B] on the days specified above.

Addendum

Since the advice provided above, I have now seen a full statement by [RN C] regarding the conversations and actions on 18 April 2016, 7 November 2016 and 8 December 2016. There is no change to the above advice.

With the benefit of hindsight, [RN C] could have been prompted by [Ms B's] call and reference to the pain and continued pv spotting to follow up on the progress of the recommended gynaecological review from the 17 March scan and the tasked message sent to [Dr A]. However, not doing so would not be considered a departure from accepted practice.

Vivienne Josephs (RN, PG Cert Adv. Nsg)
Nursing Advisor
Health and Disability Commissioner
Auckland"

The following further advice was obtained from RN Josephs:

"I have reviewed [RN C's] response to my clinical advice dated 1 February 2018.

I accept her statements/explanations that:

She saw that the results had been removed from [Dr A's] electronic in-tray on 13 April 2016 indicating that he would have had to see them to be able to remove them. [RN C's] task message advising [Dr A] of [Ms B's] call and the questioning of the need for further investigation, met her obligation.

Nurses at [the medical centre] do not routinely check results so [RN C] did not have access to the result prior to [Ms B's] call on the 18 April 2016. [RN C] provided clarification of the process in which scan results are received at [the medical centre]. It would appear that the two ways that results can be accessed for review is firstly when the results come to the GP's inbox and secondly when the patient calls to ask for their results.

[RN C] envisaged her task message asking [Dr A] to call [Ms B] would be followed up.

If further investigations are required where serious pathologies need to be ruled out, it is best done between doctor and patient. In contrast, [Dr A's] response states that most communication of results is done through the practice nurse. I agree with [RN C] that this result should have been discussed between Dr and patient following [RN C's] task message and not nurse and patient and that [RN C's] task message was sufficient to meet her obligation.

[RN C] did not query that [Ms B's] pain was due to her possible fibroid. She explains that the *'? Fibroid'* in the clinical notes refers to [Ms B] querying with [RN C] whether the pain was due to the fibroid. However, the assumption still exists that a possible fibroid is the cause of the pain.

Following the conversation with [Ms B] on 8 December 2016 regarding the results of her blood tests showing [Ms B] to be post menopausal, [RN C] fulfilled her professional obligation by informing [Dr A]. His surprise at the finding, documented in the clinical notes, could have prompted [RN C] to further discuss the implications of that finding, but the responsibility for follow up was with [Dr A].

I remain critical that:

on the 7 November 2016, [RN C] did not ask if [Ms B] if she had heard back from [Dr A] regarding a follow up gynaecological appointment or checked in the previous clinical note to see if [Dr A] had made an entry regarding any follow up action to [RN C's] earlier task message. [RN C] states she wasn't prompted to review [Ms B's] earlier clinical notes, but I would suggest that given [Ms B's] complaint of vaginal bleeding and pain, that she should have done so.

I do note, however, that she has now included in her practice that she will follow up any urgent or potentially serious task messages sent to doctors with a verbal conversation to clarify that they have received and actioned the message.

The remainder of [RN C's] response relates to [Ms B's] account of events rather than a response to my earlier clinical advice.

Viv Josephs, RN, BHSc, PGCert (Nursing)
Nursing Advisor
Health and Disability Commissioner"