Continuity of services provided by DHB and radiology service
17HDC00163, 9 August 2019

District health board ~ Radiology service ~ Communication ~ Follow-up ~ Referral ~ Continuity of services ~ Right 4(5)

A 61-year-old woman was referred by her general practitioner (GP) to the emergency department (ED) of a public hospital, to investigate a possible pulmonary embolism (PE). A chest X-ray and CT scan were completed, and the ED consultant noted that there was no evidence of a PE, but the CT scan did show a "mass or mass-like area of consolidation in the right upper lobe". The CT report and the discharge summary recommended follow-up with a chest X-ray in six weeks' time.

There were a number of communication breakdowns from the district health board (DHB) to the woman and her GP, and the six-week follow-up did not occur. This led to a missed opportunity for additional investigations, and a probable delayed diagnosis of cancer. Further investigation led to a diagnosis of lung cancer with metastases.

Five and a half years later, the woman presented to her GP with a three-week history of upper respiratory symptoms, and was prescribed antibiotics. She returned to the GP two months later with intermittent right upper quadrant discomfort and heartburn. The GP referred her to the DHB's radiology service for a semi-urgent ultrasound (US) scan of the abdomen in relation to classic gall-bladder symptoms. The accepted timeframe for a semi-urgent US scan was within two to four weeks. The referral was waitlisted in May and outsourced by the DHB to a radiology service in June. The radiology service did not send an appointment letter to the woman until August, with an appointment date of October. The woman re-presented to her GP in September, and a private referral was made to another radiology service for a US scan of the abdomen. This was completed in September. The abdominal ultrasound was reported as normal.

Findings

The contract between the DHB and the radiology service did not include detail on the outsourced radiology services, and the DHB did not have systems in place to manage and monitor the outsourcing of US scans. There was a lack of communication from the DHB to the woman and her GP about the wait, and an unacceptable delay in the woman being sent an appointment for a semi-urgent referral. Accordingly, it was held that the DHB and the radiology service failed to ensure quality and continuity of services and, in doing so, breached Right 4(5).

Recommendations

It was recommended that the DHB (a) provide an update on the recommendations in its Serious Adverse Event Review Report; (b) provide an update on the outsourcing agreement with the radiology service; (c) audit 50 imaging referrals outsourced to the radiology service over the previous six months to ensure that systems are in place to manage expected timeframes; and (d) provide an apology to the woman's family.

It was recommended that the radiology service (a) provide an update on the outsourcing agreement with the DHB; (b) review its policies regarding orientation, training, support, and supervision of booking staff; (c) audit 50 imaging referrals outsourced to the radiology service by the DHB over the last six months to ensure that systems are in place to manage expected timeframes; and (d) provide an apology to the woman's family.