Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

CT scan results missed on discharge summary

21HDC00619

A report by Deputy Commissioner Carolyn Cooper has found a GP breached the Code of Health and Disability Services Consumers' Rights (the Code).

A woman in her sixties presented to ED at a public hospital following an injury. After an x-ray and CT scan, she was discharged with a primary diagnosis of soft tissue injury to her shoulder. The discharge summary did not include the results of the CT scan, because the formal report was not completed at the time of discharge.

The discharge summary was amended that day with a clinical note and two days later with the formal CT scan report, which noted an incidental finding of a 17cm mass in the woman's neck. The second amendment included a recommendation for the woman to be referred to ENT and to undergo an MRI. The original discharge summary, and the two amended versions, were sent to the woman's GP.

The CT scan finding was missed by the woman's GP who filed the third discharge summary without checking it, assuming it was a duplicate of the first two summaries which contained no significant changes.

The CT scan results were discovered over two years later, following a visit by the woman to an Accident and Emergency clinic. At that stage, the woman had surgery to remove the mass in her neck, which was found to be metastatic squamous cell carcinoma.

Ms Cooper considered the onus was on the GP to check the summaries for new information before filing them away. Failing to do this meant, "the findings were not actioned, and the woman's formal cancer diagnosis was delayed by over two and a half years," Ms Cooper said.

For failing to act on the CT scan findings and recommendations, Ms Cooper found the GP did not provide the woman with an appropriate standard of care. This breached of Right 4(1) of the Code.

Ms Cooper did not find the medical centre breached the Code and considered the error did not indicate a system issue. "In my view failure to act on the woman's scan results and recommendations of the public hospital was a human error and the responsibility of the GP alone."

However, Ms Cooper did note room for improvement to the medical centre's policy on the management of clinical correspondence and results. This was included in the report's recommendations.

The GP has made several changes to his practice since this event including:

- Personally apologising to the woman
- Informing his colleagues of the mistake to reduce the risk of a similar future event
- Meticulously reading all duplicate documents
- Closing his practice to new patients to allow more face-to-face patient time, and no longer seeing patients afterhours to ensure a better work–life balance

Ms Cooper acknowledged the GP's changes and also recommended that he:

- Undertake an audit of a random sample of 30 patient discharge summaries received by the medical centre, to confirm whether or not any recommendations and/or follow-up requests have been actioned.
- Complete a self-audit of his clinical records, using the Royal New Zealand College of General Practitioners clinical record review.

21 August 2023

Editor's notes

The full report of this case will be available on HDC's website. 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 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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