Management of incidental finding of rectal lymph nodes
17HDC00316, 15 June 2018

District health board ~ Emergency department ~ General surgery ~ Electronic sign-off ~ Right 4(1)

A 72-year-old man presented to the Emergency Department (ED) of a public hospital after falling approximately three metres. He sustained injuries to his left hip and left side of his chest. A senior ED consultant ordered an urgent CT scan of the chest, abdomen, and pelvis. The man was then transferred to the surgical ward and was seen by a consultant surgeon.

The following day, full reporting of the CT scan was entered into the information technology (IT) system at the hospital. The final report noted numerous enlarged meso-rectal lymph nodes and suggested endoscopic examination to rule out a rectal tumour. Several days later, the man was discharged from hospital. However, the final CT scan report was not sighted until eight months after discharge, when further investigation was initiated. The man was diagnosed with Stage IIIa squamous cell carcinoma of the anus, and underwent chemo-radiotherapy treatment and surgery.

At the time of these events, the IT system did not allow for electronic sign-off of test results. There was no alert system to notify a doctor that a result had arrived, nor was there a doctor-specific list of results to review, which meant doctors could not look up all the results of tests or procedures they had ordered that day apart from proactively on an individual patient basis. A further complicating factor in this case was that where the care of a patient is transferred to another medical team the responsibility of following up test results is also transferred to that team. The hospital acknowledged that this was a significant weakness in its system and, until this could be improved, there was no protection from recurrence.

Findings

The district health board had a weak IT system that did not allow for electronic sign-off, and it did not have a clear, effective, and formalised system in place for the reporting and following up of test results. The district health board did not provide services to the man with reasonable care and skill, and breached Right 4(1).

Recommendations

It was recommended that district health board:

a) Provide a written apology to the man.

b) Update HDC on the progress and effectiveness of its IT system upgrade, including the development of policies and procedures with respect to electronic sign-off of test results and radiology reports.

c) Advise whether "sticky notes" (a rough tool to assist clinicians to proceed with treatment and to answer immediate clinical questions) are still being used under the new IT system, and what measures have been taken to ensure that they are used as a preliminary reporting tool only, and that the final reports are also reviewed.

d) Audit the management of test results ordered in ED where patients have been transferred to another ward.

e) Take steps to ensure that discharge summaries accurately reflect available final diagnostic reports, and report back to HDC on the steps that have been taken.

f) Develop policies and procedures on the management of test results and radiology reports.