Management of cardiology referral between DHBs
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District health board ~ Public hospital ~ Cardiologist ~ Respiratory physician ~ Angiography ~ Urgent referral ~ Triage ~ Communication between DHBs ~ Communication between doctors ~ Communication with patient ~ Data transmission ~ Systems ~ Rights 4(1), 4(5), 6(1)(c)

A man was referred to DHB 1's cardiology department for an angiography, by his respiratory physician at DHB 2. The respiratory physician telephoned DHB 1 and then faxed his referral letter to DHB 1, attaching a copy of the man's exercise tolerance test (ETT) results. The referral needed to be assessed to determine whether it was an urgent, semi-urgent, or routine priority.

The information contained in the man's ETT results was significant, and warranted an urgent priority or immediate admission to hospital. However, the triaging cardiologist at DHB 1 was unable to decipher the ETT results as they were too faint to read. Neither the triaging cardiologist nor the staff at DHB 1 followed up a legible copy of the ETT results. The man was given a "semi-urgent" grading based on the information contained in the referral letter. The man was subsequently offered appointment dates in August 2009 or September 2009. Sadly, the man died of a heart attack prior to the first of those appointments.

It was found that DHB 1's systems failed in three important areas: staff did not obtain sufficient information to determine whether it was necessary to refer the respiratory physician's call to the on-call registrar or consultant, did not seek a legible copy of the ETT results, and did not appropriately acknowledge the referral. As a result, DHB 1 did not provide the man with services with reasonable care and skill and breached Right 4(1) of the Code.

In addition, DHB 1 did not communicate effectively with DHB 2 and breached Right 4(5) of the Code. DHB 1 also failed to provide the man with adequate information about his referral and breached Right 6(1)(c) of the Code.

Adverse comment was made about DHB 2's failure to ensure that the referral had been received and was being actioned.

Adverse comment was also made about the triaging cardiologist's failure to ensure that a legible copy of the ETT results was obtained and reviewed. He was not found to have breached the Code owing to mitigating factors present in the case, in particular the failures of DHB 1 as noted above.