Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

System failed to support clinicians in timely follow-up of MRI results
20HDC00167

The Health and Disability Commissioner Morag McDowell has found Southern District Health Board (now Te Whatu Ora Southern) breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to support clinicians to follow up critical MRI results showing metastatic disease (cancer) for a discharged patient.

The patient, a woman in her seventies, was admitted to hospital after presenting with leg and back pain. She had raised inflammatory markers and a history of cancer. In hospital she had an MRI scan which, due to the shortage of radiologists, was outsourced.

Provisional findings, based on informal readings of the scan, identified 'no sinister cause' for the woman's presentation and she was discharged with a diagnosis of sciatica. However, a formal report, made available several days later, noted probable metastatic disease and recommended further evaluation.

No further action was taken by staff on the formal report for nearly two weeks – until an Emergency Department (ED) doctor contacted the woman's GP practice to alert them to the results. The woman was then referred to urgent oncology. She entered palliative care shortly after and subsequently passed away.

Ms McDowell found SDHB breached Right 4(1) of the Code for failing to provide woman with an appropriate standard of care.

"SDHB's system failed to support its clinicians adequately to follow up the woman's MRI report in a timely manner and there was an unnecessary delay in the woman receiving the follow-up care she required," said Ms McDowell.

"The delay could have been even longer were it not for the fortunate actions of a clinician who did not have direct responsibility for the woman's care but noticed that her MRI report had not been actioned and took appropriate steps to ensure this was addressed."

Ms McDowell also found SDHB breached Right 4(2) for failing to adhere to the Medical Council of New Zealand documentation standards.

"The standard of clinical documentation during the woman's admission at the public hospital was inadequate and omitted important details regarding her care," she said.

Ms McDowell also made an adverse comment in relation to an orthopaedic surgeon, who was the clinician responsible for reviewing the findings of the MRI report and arranging the required follow-up.

Ms McDowell extended her condolences to the family.

Since this event, Te Whatu Ora has made several changes, including:

- Installing a new Radiology Information System across its services. This means diagnostic scan reports are now automatically distributed to clinicians on the electronic system upon receipt and no longer require manual authorisation.
- Working on improving the standard of medical documentation and electronic discharge summaries.
- Undertaking a substantial review of Electronic Acceptance Policy for acknowledgement of results for radiology investigations.

Ms McDowell recommended that Te Whatu Ora:

- Provide a written apology to the woman's family.
- Conduct an audit of 500 radiology results to confirm they were acknowledged by the responsible clinicians within acceptable timeframes.
- Inform HDC on actions aimed at resolving issues concerning lack of scheduled time for clinicians to carry out clinical non-contact duties (such as reviewing of imaging reports).
- Consider how its electronic system can be improved to better support clinicians to review clinical results that require follow-up.

July 10, 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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