Wairarapa District Health Board

A Report by the

Acting Health and Disability Commissioner

Case 09HDC01040

Overview

On 2 September 2008, Mrs A (aged 79 years) presented at Wairarapa Hospital's Emergency Department (ED) with urinary retention. She was catheterised, referred to the community nursing service, and discharged home. The following day, she was referred to Wairarapa District Health Board's urology service by her general practitioner (GP). Mrs A returned to ED seven times in October, with retention or catheter problems. Further referrals were made to the urology service by the GP and ED. On 3 November 2008, Mrs A's friend, Mr B, made a formal complaint to Wairarapa District Health Board about the delay in arranging for her to be seen by a specialist.[1]

Mrs A was seen by a urologist on 11 November 2008. The main problem was identified as the in-dwelling catheter.[2] Arrangements were made for Mrs A to be taught intermittent self-catheterisation[3] and for follow-up in five months. Mrs A continued to have difficulties, and her follow-up appointment was brought forward to 2 December 2008. Following further tests, Mrs A was diagnosed with an aggressive and advanced bladder cancer. She had a course of palliative radiotherapy in January 2009 and was discharged to a private hospital the following month. Mr B received a response to his complaint on 20 March 2009. Mrs A died a short time later.

[1] Mrs A has two daughters, neither of whom lived locally. Her friends, Mr and Mrs B, were named as her "first *contacts*".
[2] A catheter left in place in the bladder and attached to a drainage bag to collect urine.
[3] Insertion and removal of a catheter in order to empty the bladder at regular intervals.

Complaint and investigation

On 13 March 2009, the Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to Mrs A by Wairarapa District Health Board.

An investigation was commenced on 3 September 2009. The following issues were identified for investigation:

- *The appropriateness of the care and adequacy of the information provided to Mrs A by Wairarapa District Health Board between June 2008 and March 2009, including the adequacy of the actions taken to ensure Mrs A received timely services following referrals for a specialist appointment.*

- *The adequacy of Wairarapa District Heath Board's response to the complaint made by Mr B on behalf of Mrs A.*

The parties directly involved in the investigation were:

Mrs A (dec)	Consumer
Mr B	Complainant/Friend
Mrs B	Friend
Wairarapa District Health Board	Provider
Urology Associates Limited	Provider
Dr C	Consultant urologist
Dr D	Consultant urologist
Dr E	Consultant urologist
Dr F	Consultant urologist
Dr G	General practitioner
Ms H	Urology nurse
Dr I	General practitioner
Ms K	Continence nurse specialist
Ms L	Daughter

Also mentioned in this report:

Dr N	House surgeon
Ms O	Urology nurse
Mrs M	Mrs A's friend
Hospital 2	Public hospital
Ms P	Community nurse
Ms Q	Community nurse
Ms R	Community nurse
Ms S	Continence clinical nurse specialist

Information was reviewed from: Wairarapa District Health Board and Urology Associates, Dr G, Mr B, Mrs B, Ms L and Mrs M.

Independent expert advice was obtained from urologist Dr Jonathan Masters (**Appendix 1**).

Information gathered during investigation

Urology services at Wairarapa District Health Board
Wairarapa District Health Board (Wairarapa DHB) serves a population of approximately 39,000[4] people. This is not large enough for the DHB to operate its own urology service. In April 2008, Wairarapa DHB contracted a Christchurch-based company, Urology Associates Ltd, to provide elective urological services. Urology Associates began providing these services from July 2008.

The arrangement between Wairarapa DHB and Urology Associates includes:

- Monthly visits to Wairarapa Hospital by a urologist from Urology Associates. These alternate between two-day visits and three-day visits, with surgery on one day and outpatient appointments on the other day(s).
- Two urology nurses at Wairarapa Hospital, employed by Urology Associates. The nurses are identified as the first point of contact if there is a problem with a urology patient or a new acute urological presentation.
- After-hours telephone service from a Urology Associates urologist.
- A different pathway for acute urological referrals, through the Board's general surgical service.
- An arrangement for urological emergencies requiring urgent surgery to be transferred to another public hospital.

Dr C, Dr E and Dr D work for Urology Associates. Urology Associates also has a Memorandum of Understanding with two doctors from another hospital, including Dr F, for the provision of services at Wairarapa Hospital.

Background
In April 2008, Mrs A (then aged 79 years) had a number of chronic health problems, but was quite active and independent. On 11 April, her GP referred her to the Wairarapa Hospital ED with lower abdominal pain. The GP suggested investigations to exclude cardiac disease, in view of her history of angina. The tests revealed no cause for concern. Mrs A was given pain relief and medication for constipation, and discharged home.

On 7 May 2008, GP Dr G referred Mrs A to the gastroenterology service at Wairarapa Hospital, noting a six-month history of increased fatigue, severe reflux and difficulty swallowing, weight loss and an increase in rectal bleeding.[5] Following an appointment

[4] www.wairarapa.dhb.org.nz/WDHB/AboutWDHB/FAQs.aspx

[5] Mrs A had a chronic history of small amounts of rectal bleeding.

at the gastroenterology clinic on 29 May, Mrs A was referred for a gastroscopy.[6] Dr G had also referred her to the medical service, for advice on further management with regard to the increased fatigue and a heart murmur. A consultant physician saw Mrs A on 16 June 2008, and considered her symptoms were compatible with a recurrence of fibromyalgia.

Between March and September 2008, Mrs A consulted Dr G in relation to urinary tract symptoms, and was treated for recurrent urinary tract infections.

First ED presentation and urology referral

On 2 September 2008, Mrs A contacted her GP practice, concerned that she was constipated and had been unable to pass urine since the previous morning. A practice nurse noted Dr G's intention to refer Mrs A to urology, as a mid-stream urine (MSU) test[7] was negative and her symptoms were recurring. Mrs A was advised to go to ED, which she did. She was seen by Dr N, who diagnosed urinary retention secondary to a partially treated urinary tract infection (UTI). Mrs A was catheterised, prescribed medication for the UTI and for constipation, discharged home, and advised to return if the retention recurred. Just before midnight, she returned to ED with further retention, and an in-dwelling catheter (IDC) was inserted. She was referred to the community nursing service for follow-up, and discharged home.[8]

On 3 September, Dr G referred Mrs A to the urology service. The referral noted a six-month history of intermittent urinary symptoms suggestive of UTIs, and the presence of *E.coli* some of the time. Dr G also noted that she had decided to start Mrs A on a prophylactic medication, but that she was concerned there was some other bladder pathology.

The urology referral from Dr G was received on 5 September, and acknowledged the same day with a letter from urology nurse Ms H. The letter stated that the referral had been triaged and that Mrs A had been placed on a semi-urgent waiting list for an outpatient appointment. Dr G was advised to contact urology nurses Ms H or Ms O if she had any questions.[9] Wairarapa DHB advised that its usual process on receipt of a referral is for a booking clerk to send an acknowledgement letter to the patient, advising that an appointment letter will follow. Appointment letters are usually sent two weeks prior to an appointment. It is not known whether Mrs A received an acknowledgement letter.

[6] A procedure using a flexible tube-like instrument with a camera (a scope) to examine the oesophagus, stomach and duodenum for abnormalities.

[7] A test to identify the presence of an infection.

[8] Mrs A's daughter, Ms L, and Mr and Mrs B, recall that Mrs A was first catheterised in July 2008. Ms L stated that when her mother stayed with her in early July, she had a catheter in situ. However, the records from ED, the community nursing service, the urology service and the GP practice consistently show that Mrs A was first catheterised on 2 September.

[9] Enrolled Nurse (EN) Ms H and Registered Nurse (RN) Ms O were the urology nurses employed by Urology Associates but based at Wairarapa Hospital.

Wairarapa DHB provided two copies of the referral from Dr G (**Appendix 2**). One shows that it was triaged on 25 September as urgent, and the triage stamp indicates that requests were made for a renal ultrasound, MSU and urine cytology.[10] There was a question mark beside the box for cystoscopy.[11] The second copy shows that the referral was triaged on 25 September as semi-urgent. The boxes for renal ultrasound, MSU and cytology were ticked, but there were also lines through the requests for the ultrasound and cytology.

Wairarapa DHB's response to HDC included information from consultant urologists Dr C and Dr E, of Urology Associates. In the initial response, Dr C noted that the referral for Mrs A was triaged as urgent, and that appropriate investigations of MSU, cytology and an ultrasound were ordered. Dr C stated that Mrs A was "seen two months later in clinic, which is appropriate for an urgent triage". Wairarapa DHB subsequently advised that on the basis of the information in the referral, the correct triaging category was semi-urgent. It stated that the referral was re-triaged accordingly by Urology Associates, and that Mrs A was scheduled for an appointment in December 2008. It did not explain what prompted the re-triaging.

Wairarapa DHB's Urology GP Referral Triage Guidelines state that the aim is for urgent referrals to be seen within one month, semi-urgent within three months, and routine within twelve months (but preferably within six months).

On 9 September, Dr G left a telephone message for Dr N in relation to further management of Mrs A, but did not hear back.

Community nursing, further visits to ED and further urology referrals
A community nurse visited Mrs A at home the day after her first visit to ED, as requested. The community nurse fitted a day bag to the catheter and provided catheter education, including written information. Mrs A was seen again by community nurses five times during September. On 25 September, it was noted that Mrs A was competently changing her day bag and that she should be reviewed again in two weeks. On 8 October, the community nurse called at Mrs A's home twice and phoned once, but she was not at home.

On 10 October, Mrs A had an episode of haematuria.[12] She saw GP Dr I, who referred her to ED. Dr I noted in the clinical record that day that Mrs A was "awaiting urology department appt, recently received letter that would be over 5 months". At ED, the IDC was changed, blood and urine specimens taken, and antibiotics prescribed, and Mrs A was advised to return if the catheter blocked. It was noted that she was awaiting a urology appointment. Mrs A returned to ED twice on 11 October and again on 12 October, with further haematuria and/or a blocked IDC. At the second visit on

[10] Checking for abnormal cells.

[11] Examination of the bladder and urethra using a scope.

[12] Blood in the urine.

11 October, it was noted that Mrs A would ask her GP to expedite the urology referral.[13]

On 13 October, Mrs A saw Dr G, who contacted ED. It was agreed that the catheter might be irritating the bladder wall and that they should try removing it. The practice nurse removed the catheter that morning. At about 10pm that night, Mrs A presented at ED with urinary retention. An IDC was reinserted and a referral sent to the community nurses (CNs), requesting follow-up the next day. An urgent referral was also sent to the urology service, stating that Mrs A had previously been referred and that her issues were ongoing. It was noted that she had presented to ED four times in three days with urinary issues, that she had had many issues with her IDC including frank (visible) haematuria and blocking, that she had developed retention six weeks earlier, and that she had not yet received an appointment. This referral was received the following day.

A re-referral was also sent to the urology service by Dr G on 15 October, noting recent events and asking for the referral to be expedited. This was received on 17 October. On 19 October, Mrs A had further haematuria and presented again at ED. On 20 October, Dr G phoned the outpatients department and was advised that Mrs A was on a priority list to be seen in November. There were further CN visits on 16, 23 and 30 October, and 6 November.

On 30 October, Dr I saw Mrs A, noting that she was quite distressed with continued pain from the catheter and further haematuria. Dr I referred Mrs A back to ED for an IDC change. She also sent a referral to the urology department at Hospital 2, in an effort to get an earlier appointment there.

On 3 November, Dr G was advised by Hospital 2 that the referral should be re-directed to EN Ms H at Wairarapa Hospital. Dr G spoke with EN Ms H, who said that she had the referral and would try to get Mrs A a clinic appointment on 11 or 12 November.[14] Dr G also noted that EN Ms H hoped Mrs A did not need scoping (a cystoscopy) as this could not currently be done because of a sterilisation process problem. Dr G enquired about the possibility of a private appointment, but was advised that Mrs A could not be seen until the following Wednesday (12 November) anyway, and that there was no availability at Hospital 2 until the following year.

Complaint to DHB

On 3 November, Mrs A's friend, Mr B, wrote a letter of complaint to Wairarapa DHB, on her behalf. He noted that she had now been offered a urology appointment for the following week, but expressed his concerns about the delay. Mr B noted that Wairarapa DHB should respond directly to Mrs A if there were privacy issues. On 11

[13] Mrs A's friend, Mrs M, took her to ED on two occasions because of catheter problems. Mrs M could not recall the exact dates, although she thought these visits were some time in September.

[14] It is not clear which referral EN Ms H was referring to, as Wairarapa DHB stated in its response that it has no record of receiving Dr I's referral.

November, the Acting Quality Assistant acknowledged receipt of the complaint and advised that it would be investigated.

Appointment with Dr C
On 11 November, Mrs A was seen by consultant urologist Dr C. Mrs A's friend, Mrs B, was also present.

Dr C advised HDC that at that appointment, she had the first referral from Dr G, which referred to altered urinary symptoms and recurrent urinary tract infections, but not to haematuria. She did not have Dr G's second referral, the referral from ED, Dr I's referral, or the ED notes. Dr C was therefore not aware that Mrs A had a catheter in place or that she had been to ED, until she told her. Dr C explained that there were no ultrasound results because the appointment had been brought forward. Wairarapa DHB subsequently advised that their radiology department had no record of an ultrasound request. There were no cytology results.

Dr C's main recollection of the appointment was how disgruntled Mrs A was with the catheter, and how uncomfortable it was. Dr C's focus was therefore on looking at options for removing the catheter, in order to make Mrs A more comfortable. Dr C explained that she did not perform a physical examination, as Mrs A had had at least three or four recent examinations at ED when the IDC had been unblocked or changed. At this time, it was not possible to perform flexible cystoscopies during clinics. Dr C noted that the most common cause of urinary retention in elderly females is an atonic bladder,[15] and that this is more common with diabetes, which Mrs A had. Dr C considered that this was the most likely diagnosis, noting that no abnormality had been found during previous catheter insertions.

The decision was therefore made for Mrs A to be taught intermittent self-catheterisation, so that she did not need a permanent catheter. Dr C's intention was to perform a flexible cystoscopy five months later, during her next scheduled visit to the Wairarapa. Dr C recalls that Mrs A expressed a preference for having this procedure done by a female doctor, and there was no indication that it needed to be done more urgently. Mrs B recalls Mrs A expressing her preference for a female doctor only after Dr C had indicated her intention to follow up five months later. Mrs B advised HDC that Mrs A was not given the choice of having the cystoscopy performed sooner. In a letter to Dr G, Dr C noted that the cystoscopy could be brought forward if Mrs A had ongoing problems with haematuria once she was doing intermittent self-catheterisations, or if she could not do these for some reason.

13 November–1 December 2008
On 13 November, continence clinical nurse specialist (CNS) Ms K visited Mrs A to remove the indwelling catheter and to teach her intermittent self-catheterisation. CNS Ms K noted that there was some haematuria present and that Dr C was aware of this. Mrs A was to attempt the procedure later that afternoon. CNS Ms K phoned later that

[15] An atonic bladder is a dilated bladder. It sometimes occurs as a result of another health issue that impairs the ability of the nerves in the bladder to relay signals to the brain. It can also develop as a result of some form of obstruction.

day, and Mrs A said she had catheterised herself twice with a small return. CNS Ms K informed the CN on duty that evening that she might be called if a problem arose.

Just after 10pm, Mrs A re-presented at ED with urinary retention, and an IDC was reinserted. It was noted that Mrs A was to be seen by a CN the following day, that this might involve a repeat attempt to remove the catheter and further education in self-catheterisation, and that Mrs A knew to return to ED if the IDC blocked again.

On 14 November, it was decided that the IDC should be left in for a further week before trying again with the self-catheterisation process. Mrs A was seen by a CN on 15 November. CNS Ms K reviewed her on 17 November, noting that EN Ms H was to contact Dr C in relation to Mrs A's difficulty with self-catheterising and the recent haematuria. There was a further CN visit on 18 November.

On 24 November, CN Ms P visited Mrs A to remove the catheter, at the request of CNS Ms K. Later that morning CNS Ms K visited Mrs A for another self-catheterisation education session. Mrs A's first attempt was successful, but a second attempt later that afternoon was not. CN Ms Q visited at 7.15pm. She noted that Mrs A had tried to catheterise four times since 1pm, but had been unsuccessful. CN Ms Q was also unable to perform the catheterisation. She noted that Mrs A was feeling very sore and uncomfortable, and it was agreed that she should go to ED. CN Ms Q noted that Mrs B would be with her at ED. At ED the nursing staff attempted catheterisation but were unsuccessful.

The ED note indicates that Mrs A's bladder was distended and her urethra was extremely tender and stinging. An ultrasound confirmed a full bladder. A catheter was reinserted by Dr N, who noted "some initial resistance overcome". Mrs B was present at ED and reported that the attempt by Dr N was painful for Mrs A. Mrs A returned home.

On 25 or 26 November, Mr B phoned EN Ms H to ask when Mrs A would be seen again by a urologist.[16] EN Ms H spoke to urologist Dr D, who noted that Mrs A had been unable to perform intermittent self-catheterisation and was again suffering retention. Dr D said that her appointment for a renal ultrasound and flexible cystoscopy would be brought forward, but that if flexible cystoscopy was not possible because of haematuria, she should be placed on the next general anaesthetic rigid cystoscopy list. EN Ms H noted that Mrs A and Mr B were happy with this. Dr I spoke to Mrs A and noted that she had a follow-up urology appointment for 2 December.

On 27 November, Mrs A's daughter, Ms L, phoned CNS Ms K to ask about the possibility of respite care for her mother, as soreness from the catheter was making her reluctant to mobilise. CNS Ms K undertook to follow this up. CN Ms R visited Mrs A that day, noting her relief that she now had a urologist appointment. However,

[16] Mr B stated that this call was made on 25 November. Notes from Urology Associates indicate it was on 26 November.

she was "upset at how [CNs] 'did some damage' when trying to insert the IDC" on 24 November. The following day, Mrs A was admitted to a facility for ten days' respite care.

On 28 November, CNS Ms K wrote to Dr C, outlining the events of the previous fortnight. She described the efforts to teach Mrs A self-catheterisation, the difficulties experienced, the further visits to ED, and the respite care arrangements.

Appointment with Dr F
On 2 December, Mrs A had an ultrasound and was seen by urologist Dr F.[17] She was accompanied by Ms L. Dr F performed a flexible cystoscopy. In a follow-up letter to Dr I, Dr F stated that the "striking finding is on bimanual examination where it is apparent there is a thickened, enlarged swelling affecting the anterior vaginal wall and base of the bladder region". Dr F noted the need to exclude a malignancy. He arranged for further tests, including blood and urine tests, CT scans of the chest, abdomen and pelvis, and a cystoscopy/ examination under anaesthetic and biopsy.

Diagnosis and treatment
Mrs A was admitted to Hospital 2 and had a bladder biopsy on 8 December. The investigations confirmed invasive transitional cell carcinoma of the bladder, which was extensive throughout the pelvic floor. Surgery was not possible. Mrs A was referred for palliative radiotherapy to provide symptom control, and discharged home.

On 31 December, Mrs A had a further visit to Wairarapa Hospital ED, because of rectal bleeding. On 6 January 2009, she had a follow-up urology appointment with Dr D. Dr D noted that Dr F was due to see Mrs A again the following week to discuss further management. It was noted in Wairarapa DHB's response that notes from the multi-disciplinary team meeting at Hospital 2 were not available for this review.

Early in the New Year, Mrs A had a further period of respite care before commencing radiotherapy treatment at Hospital 2 on 15 January 2009. Her admission at Hospital 2 was complicated by haematuria and vaginal bleeding, anaemia, and a urinary tract infection.

Wairarapa Hospital, 12–20 February 2009
On 12 February 2009, Mrs A was transferred from Hospital 2 to Wairarapa Hospital. Later that day, she was seen by a social worker who noted that Mrs A's goal was to return home following discharge. The clinical notes over the next few days indicate that Mrs A's condition was fluctuating, and that she continued to need quite a lot of assistance. There is a reference in the nursing notes on 14 February to her daughter expressing concerns about how Mrs A would manage on discharge. On 14 February, Ms L emailed the hospital to request a meeting to discuss her mother's care. She also noted her understanding that her mother was to have a period of rehabilitation, and her concerns about the possibility of another attempt to remove the catheter.

[17] Dr F is a [Hospital 2-based] urologist providing services at Wairarapa Hospital through a memorandum of understanding with Urology Associates.

At 8.30am on 16 February, Ms L and Mrs B arrived at the ward, understanding that a meeting had been arranged to discuss the discharge plan. There is no record of a meeting having been arranged, although the previous afternoon a registered nurse had noted: "Daughter would like to be here for Dr's round in mane." When no one had arrived by 11am, Ms L and Mrs B followed up with nursing staff. An admission and discharge nurse came to speak with them, and provisional arrangements were made for a family meeting the following day. Later that day, house officer reviewed Mrs A. He discussed several issues, including the diagnosis and prognosis, the in-dwelling catheter, swallowing, and discharge planning.

A family meeting was held on 17 February. This was attended by Mrs A, Ms L, Mrs B, the social worker, palliative care CNS Ms S, a physiotherapist, a consultant surgeon, and a registered nurse.[18]

Notes show that the issues of concern were whether Mrs A was to receive rehabilitation or palliative care, whether the IDC would be removed and subsequent care in relation to this, difficulty with phlegm in the throat, and "where to from here?".

It was confirmed that Mrs A was under the palliative care service. The IDC was to be left in place, with only a urologist deciding whether removal was appropriate and, if so, what the plan of care would be if reinsertion was required. It was noted that there was no immediate answer in relation to the throat issue, as reduced motility in the oesophagus had been longstanding. It was agreed that Mrs A would need palliative care in a community facility.

Later that day, urologist Dr E reviewed Mrs A and, on his advice, the catheter was removed the following morning.

At 6.30pm on 18 February, RN Ms O noted that Dr E had seen Mrs A, and that she did not yet want the IDC replaced. It was noted that this was to be reviewed the following morning and, if it was going to be reinserted, it would need to be done by Dr E before he returned to Christchurch in the afternoon. On 19 February, the nursing note stated that Mrs A appeared resigned to having the IDC replaced, but that she was understandably nervous about this. Dr E reinserted the IDC that afternoon.

Discharge to a private hospital and palliative care

On 19 February, Mrs A and her daughters met with CNS Ms S on the ward. Mrs A consented to the palliative care service, and an initial assessment was completed. CNS Ms S notified the GP practice of Mrs A's planned admission to a private hospital the following day, and provided copies of the assessment and other relevant documentation to the private hospital.

[18] Mrs A was originally referred to the palliative care service by her GP practice on 15 January, when she commenced radiotherapy at Hospital 2. The service was advised that she would be away for nine weeks. On 11 February, the service was advised that Mrs A was being transferred back to Wairarapa Hospital the following day, and contact was made with the ward.

On 20 February, Mrs A was discharged to the private hospital.

Notes from the palliative care service show that the team maintained regular contact with Mrs A and staff at the private hospital, either by phone or in person, over the following five weeks. This was generally every two to three days, depending on Mrs A's symptoms. The notes indicate regular review of care needs including medication, pain control, bowels, skin integrity, appetite, and mobility. Four weeks later, CNS Ms S phoned Ms L and, later that day, spoke with Ms L and Mrs A's other daughter at the private hospital. Ms L and her sister had been taking turns to stay with their mother overnight, and spoke about their experience in trying to support their mother at this difficult time.

A few days later, a doctor from the palliative care service reviewed Mrs A, noting that her condition was steadily deteriorating and she was now very frail. Mrs A died later that night.

Post bereavement follow-up
CNS Ms S spoke to Ms L the following day. On 6 April, an RN from the palliative care service phoned Mrs B, who expressed her disappointment with the service. Messages were left for Mrs A's daughters. On 8 April, the RN spoke to Ms L.

On 9 April, CNS Ms S had another discussion with Mrs B about her concerns in relation to the palliative care service. CNS Ms S noted that she explained the palliative care input provided to Mrs A, and that she had been in touch with Mrs A's daughters while they were in town, rather than with Mrs B.

Complaint response
On 20 March 2009, Mr B received a response (dated 16 March 2009) to his complaint, from the perioperative and inpatient unit manager. The letter included an apology for the delay in responding and confirmation that the complaint had been investigated. She outlined how Dr G's initial referral had been responded to, stating:

> "An initial referral was received for [Mrs A] on 3rd September and noted to be urgent, but needed subsequent clinical tests to confirm diagnosis. These were duly undertaken and [Mrs A] was booked to be followed up by [Dr C] in November 2008. [Dr C] made the comment in her commentary post clinic that she appeared pleased with how [Mrs A] was managing and that she would follow her up in five months time.
>
> [Mrs A] appeared happy with the clinic visit and she was asked to contact the Hospital if there [were] any further problems.
>
> She did contact the Hospital and the patient was referred to [Dr D] at Urology Associates in Christchurch. Further instructions for ultrasound and for her to be seen in clinic in December were made. A cystoscopy was performed and [Mrs A] was then placed on the urgent waiting list for surgery at [Hospital 2] the following week. This is consistent with resources and priority that can be managed within the Wairarapa as we do not have a dedicated urologist on site."

The perioperative and inpatient unit manager apologised on behalf of the hospital for the delays that may have occurred in terms of Mrs A's care, but said that every effort was made to accommodate her needs and care. The letter concluded by thanking Mr B for "taking the time to write and offering us the chance to review and improve the quality of our services".

Wairarapa DHB subsequently advised HDC that the complaint had been mislaid. Following a review of all complaints in March 2009, it was discovered that a response had not been sent to Mr B. The complaint was resent to the relevant departments on 11 March, and the response was sent to Mr B on 16 March.

Additional information from Urology Associates and Wairarapa DHB

Prior to the start of a formal investigation, preliminary advice was obtained from an independent expert, urologist Dr Jonathan Masters (see **Appendix 1**). Dr Masters reviewed the care provided to Mrs A and raised some concerns about the arrangements for the provision of urological services to patients in the Wairarapa. Wairarapa DHB was asked to respond to these concerns. The response was provided by Dr E, on behalf of Urology Associates Ltd (see **Appendix 3)**.

In summary, Dr E contests the numbers of first and follow-up appointments needed each year put forward by Dr Masters. Dr E concludes that from a numbers perspective, there can be no argument that the monthly visit from Urology Associates is sufficient to service the needs of the Wairarapa. He also states that the frequency of the clinics is also adequate and appropriate, given that the clinics are for elective urological services and there is a different pathway for patients who need to be seen more urgently.

Dr E addresses the question raised by Dr Masters in relation to the accessibility of the urology service for GPs and other health services. He outlines the way in which the referrals for Mrs A were dealt with, noting that the urology service was made aware of the problem of retention only on 14 October, and that Mrs A was seen 25 days later on 11 November. However, Dr E states that while Urology Associates had communicated clearly with general surgeons about how to contact the urologists, it had "perhaps been remiss in pro-actively contacting the Emergency Department with the same information". He notes that the urology service needs to communicate more clearly with ED and GPs about the mechanisms for getting urgent cases seen and managed.

Dr E discusses the provision of services by more than one provider. He considers that the model of providers from two centres with specialty nursing backup is ideal for the Wairarapa, and that the co-operative venture has considerably enhanced the urology service provided.

He concludes:

> "[W]hile the model for delivery of urological care to the WDHB is sound and appropriate, it has been highlighted through this unfortunate case that the

> communication of pathways for discussion with urologists has not been well presented to the Emergency Department. Urology Associates will be talking to members of the Emergency Department and establishing clear protocols for future communication around problematic urological patients and conditions, Furthermore, another formal communication to the general practitioners in the Wairarapa will be undertaken in an attempt to improve direct access to urologists and the urology nurses for advice."

In addition, Wairarapa DHB states that in March 2008, prior to the involvement of Urology Associates, a "mega clinic" was undertaken with operation sessions performed over a weekend to deal with the backlog of clinical activity. Consequently, in the early clinics conducted by Urology Associates, there were a disproportionate number of follow-up appointments and also a large number of patients with bladder cancer who were overdue for flexible cystoscopy. This limited the number of new patients able to be seen in the early clinics.

Changes

Wairarapa DHB has advised that the following changes have been made as a result of what happened to Mrs A, and as part of its philosophy of continuous improvement:

Referral triaging

- All urology referrals are now triaged within seven days of being received at Wairarapa DHB, by the nurse employed by Urology Associates. The referral is date stamped on receipt, and the date of triaging is recorded.
- All referral letters are faxed to Urology Associates to be scanned into its electronic system.
- Once the referral has been scanned by Urology Associates, a letter is sent to the GP advising that the referral has been received.
- Complex referrals are sent to Urology Associates for triaging.

Information sharing

- A clear protocol outlining pathways into the urology service has been established for the ED.
- Letters from the urology service are stored in Wairarapa DHB's clinical information system.
- Correspondence from GPs and other DHBs addressed to the urology service is scanned into Urology Associates' electronic record, and a hard copy is filed with the Wairarapa DHB notes.
- All correspondence for patients receiving assessment or treatment at Hospital 2 is sent to both Wairarapa Hospital and Urology Associates.
- An electronic referral system commenced in March 2010 and will be introduced gradually for all Wairarapa GP practices. Referrals will be received at a single point of entry, and GPs will receive immediate acknowledgement of receipt. Phase 2 of the e-referral system will enable:
  - clinicians to review and triage referrals electronically;
  - updates to be sent to GPs throughout the referral assessment process;

- clinicians to send advice back to GPs for those referrals submitted by the GP "for advice only";
- electronic tracking and reporting of referrals.

Arranging tests

- All tests are now requested when referrals are triaged, request forms are hand delivered to the Laboratory and Imaging Department, and receipt of the request is signed for.
- There has been an investment in new equipment for urological care, including a new ultrasound machine and a 50% increase in equipment for flexible cystoscopies. There is now a greater capacity for procedures to be performed in the outpatients setting.

Handling complaints

- The urology nurses have had further education in relation to acknowledging and resolving complaints.
- A new Director for Quality, Safety and Risk has been appointed. (At the time of these events there had been no dedicated quality and risk manager in position for four years.)
- There is now a dedicated Quality Co-ordinator, whose portfolio includes complaints management.
- There are new policies and processes for dealing with complaints, including an electronic complaint management system to replace the previous paper-based system.

Wairarapa DHB and Urology Associates also note that since the introduction of the new urology service, waiting times have decreased and all patients are now seen within the time frames set out by the Ministry of Health. Over the past two years, there has been an increase of up to 40% for both new patients being seen in urology clinics and patients undergoing urological operations.

Opinion: Breach — Wairarapa District Health Board

Introduction

District health boards have a responsibility to ensure access to specialist services, irrespective of whether they provide the services themselves or contract a third party to do so. It is commendable that Wairarapa DHB had taken action to improve the provision of urology services, by setting up the arrangement with Urology Associates Ltd. Obviously there may be teething problems when a new service commences. However, this does not excuse poor service. Health services are constantly changing to meet new demands, and as new ways are found to meet those demands more effectively and efficiently. Providers need to ensure that the services they provide, including during periods of change and transition, are of an acceptable standard.

Mrs A had a right to services provided with reasonable care and skill, and a right to co-operation among providers to ensure quality and continuity of services.[19] In my view, the service provided by Wairarapa DHB was not consistent with these rights. In particular, the processes for triaging the urology referrals, arranging necessary tests, and ensuring relevant information was available to those who needed it, did not work as they should have.

Wairarapa DHB was required to facilitate the fair, simple, speedy, and efficient resolution of the complaint made by Mr B.[20] There was an unacceptable delay in responding to the complaint. I would be less critical of this if the response reflected a genuine and thorough review of the events. It did not. The response contained factual inaccuracies, and summarised the service provided to Mrs A in a way that suggested a much more straightforward course of events than actually occurred.

Initial referral

Mr and Mrs B, and Ms L, recall that Mrs A was first catheterised in ED in July 2008. In his preliminary advice, Dr Masters noted that this was an important distinction because had she been in retention from July, he would regard the provision of care as "grossly inadequate". However, the records from ED, the community nursing service, the urology service, and the GP practice consistently show that Mrs A was first catheterised on 2 September, and I accept that this was the case.

Triaging referral and scheduling appointment

Mrs A presented at Wairarapa Hospital's ED with urinary retention on 2 September 2008. The following day, she was referred to the urology service by her GP. The referral was received on 5 September, but it is difficult to determine clearly what happened next. Annotations on the referral itself show that it was not triaged until 25 September, when it was triaged once as urgent and then as semi-urgent. In its response, Wairarapa DHB stated that the referral was triaged on 25 September, and that it was then sent to Urology Associates, where it was re-triaged, correctly, as semi-urgent. It is not clear what prompted Urology Associates to re-triage the referral. However, a letter had been sent to Mrs A's GP on the day the referral was received, noting that it had been triaged and prioritised as semi-urgent.

If the referral was triaged on the day it was received, it is not clear who knew this aside from EN Ms H and Dr G. If — as Wairarapa DHB itself suggests — the referral was not triaged until 25 September, the delay of 20 days from receipt to triaging is excessive. According to Wairarapa DHB's Urology GP Referral Triage Guidelines, the aim is for patients to wait no longer than one month for an appointment if the referral is urgent. As Dr Masters points out, if the referral had been urgent, nearly three weeks had elapsed before it even reached triaging.

[19] Right 4(1) — Every consumer has the right to have services provided with reasonable care and skill. Right 4(5) — Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

[20] Right 10(3) — Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

Wairarapa DHB advised that Mrs A was initially scheduled to be seen by a urologist during the December clinic. She did not receive an appointment letter for this, as these are not sent out until a fortnight prior to an appointment. The letter to Dr G acknowledging receipt of the referral did not indicate how long Mrs A would have to wait for an appointment. Dr I noted, on 13 and 30 October respectively, that Mrs A did not yet have an appointment. However, Mrs A apparently received a letter early in October, advising that her appointment would be over five months away.

The second referral, from ED, was sent to the urology service on 13 October and received the next day. It was noted that Mrs A had presented at ED for the fourth time in three days, and that she had many issues with her IDC including frank haematuria and blocking. It was noted that Mrs A had been referred previously, but asked that the triage be checked as she had not yet received an appointment. The referral was marked urgent. There is no evidence of this referral having been triaged, or any other action taken in response to the referral.

The third referral, from Dr G, was sent on 15 October and received on 17 October. Dr G explained that Mrs A now had a catheter, but had had several episodes of haematuria and catheter blockages. Dr G also noted the four presentations to ED over the previous weekend. Again, there is no evidence of this referral having been triaged or any other action taken.

On 20 October, Dr G was told that Mrs A was on a priority list to be seen in November, although it does not appear that an appointment had actually been scheduled. On 30 October, Dr I was so concerned about the delay she endeavoured to get Mrs A an appointment at Hospital 2. On 3 November, Dr G was advised that this was not possible. Dr G then spoke to EN Ms H, who said she would try to schedule an appointment for 11 or 12 November, which she did.

This is all very muddled. In Wairarapa DHB's first response, Dr C noted simply that the referral was triaged as urgent and that Mrs A was seen two months later, which is "appropriate for an urgent triage". The Urology GP Referral Triage Guidelines in fact show that the target time frame for urgent referrals is no longer than one month. Dr C's account also conflicts with information subsequently provided by the Board, that the referral had been re-triaged by Urology Associates as semi-urgent.

Dr C also notes that the second and third referrals were received after the monthly clinic (in October) and "hence she was placed in the very next clinic in November". Dr E stated that the 11 November appointment was arranged in response to the second referral from Dr G. While it is true that Mrs A's appointment, apparently scheduled for December, was brought forward, I can see no evidence that this occurred in response to the referrals of 14 and 15 October, or that it occurred before 3 November, when Dr G spoke to EN Ms H. On that date, EN Ms H told Dr G that she would try to get Mrs A into clinic on 11 or 12 November. This would not have been necessary if Mrs A had already been scheduled. It is accepted that Wairarapa DHB may not have received the referral Dr I sent to Hospital 2, as by that stage Dr G was following up by phone.

Mrs A attended ED *seven* times in October, with urinary retention or catheter problems. Urology Associates and Wairarapa DHB have acknowledged that more needed to be done to ensure that GPs and ED were aware of the mechanisms for getting urgent cases seen and managed.

Arranging appropriate tests
When the first referral was triaged on 25 September, it was noted on the referral form that Mrs A needed a renal ultrasound, MSU, and urine cytology. When the referral was re-triaged as semi-urgent, it appears that the ultrasound and cytology requests were cancelled. It is clear from Dr C's initial response that she considered all of these tests were necessary.

Dr C stated that when she saw Mrs A on 11 November, ultrasound results were not available because the appointment had been brought forward. However, Wairarapa DHB subsequently stated that radiology had no record of the request. There is no evidence that an ultrasound was requested when the first referral was triaged. If the request had not been made or was lost, presumably there would have been no ultrasound even if the appointment had not been brought forward. In other words, it is not clear that the failure to arrange the ultrasound had anything to do with the rescheduling of Mrs A's appointment.

It is not clear whether the question mark beside cystoscopy on the triage stamp indicated uncertainty about the need for Mrs A to have the procedure, or about the ability of the service to perform cystoscopies during outpatient clinics.

I have been provided with no information to show that when Mrs A's 11 November appointment was confirmed on 3 November, arrangements were made for her to have the necessary tests prior to the appointment. The time frame may have been too short to arrange the ultrasound, but the MSU and cytology could have been arranged. As Dr Masters notes, in this particular case the cytology might have been extremely useful.

Again, there is a lack of clarity and the information provided is contradictory. It would appear that either the tests were not requested when they should have been or, in the case of the ultrasound and cytology, requested and then cancelled when they should not have been. It was Wairarapa DHB's responsibility to ensure there was an effective system for arranging tests needed prior to specialist appointments.

Information and communication
When Dr C saw Mrs A on 11 November, she had a copy of Dr G's first referral. She did not have Dr G's second referral, the ED referral, or any of the notes from ED. Dr C says that she cannot explain this.

I agree with Dr Masters that it was inexcusable that important documents, letters and notes were not available when Mrs A came to the clinic. This was a serious systems failure. Mrs A was able to provide some information in relation to her multiple ED presentations. However, as Dr Masters states:

> "Had the ultrasound scan, the urine cytology, and the ED and subsequent referrals been available to [Dr C] in the outpatients [clinic] on November 11, I have no doubt the consultation would have had a very different emphasis and outcome."

Although Dr Masters does not believe that intervention in September and October, as opposed to December and January, would have changed the outcome for Mrs A, he notes that it may have reduced her suffering a little. I agree.

In addition, when Dr D saw Mrs A on 6 January 2009, he did not have access to information from the multi-disciplinary meeting at Hospital 2.

Urology Associates began its service in the Wairarapa in July 2008. Dr Masters finds evidence that a good deal of thought went into setting up the service, and he considers the number of surgical interventions to be more than adequate. However, he also notes that the vulnerability of the model is during the days that urologists are not physically there. As he states: "Whilst the plan on paper is admirable, this case illustrates that delivery is critically dependent on all stakeholders knowing when and how to convey important information to each other." The process for ensuring that the urologists from Urology Associates had access to necessary information was not adequate. In this case, information needed to be shared between Wairarapa Hospital (including outpatients and ED), Hospital 2, Urology Associates, Mrs A, and her GP.

Wairarapa DHB and Urology Associates have recognised the importance of this, and the need to take further action to minimise the risk of such lapses occurring again.

Treatment provided following diagnosis
I note Dr Masters' opinion that once the cystoscopy and vaginal examination were performed on 2 December, Mrs A's plan and treatment proceeded remarkably quickly.

Complaint response
Mr B submitted a written complaint to Wairarapa DHB on, or shortly after, 3 November 2008. The main reason for his complaint was the delay in arranging for Mrs A to be seen by a urologist, despite the efforts of two GPs and ED staff. He noted that he was submitting this on behalf of Mrs A, but that Wairarapa DHB should respond directly to her if there were privacy issues. Receipt of the complaint was acknowledged within a reasonable timeframe, in a letter dated 11 November.

However, Mr B did not then hear anything further about the complaint for four and a half months. The response was received five days before Mrs A died. This is poor. Providers should inform complainants about the progress of their complaints at regular intervals.

Furthermore, I have concerns about the quality of the response. I note the following in particular:

- The letter to Mr B states that following receipt of the initial referral, clinical tests were needed to confirm the diagnosis, that these were duly undertaken, and that

Mrs A was then booked for an appointment with Dr C. As outlined above, this is inaccurate. It suggests a complaint investigation that was anything but thorough.

- The letter states: "[Dr C] made the comment in her commentary post clinic that she appeared pleased with how [Mrs A] was managing and that she would follow up in five months time." Dr C wrote in her letter to Dr G that Mrs A was finding the catheter uncomfortable at times and was troubled by its blocking. In her response to HDC, Dr C recalled that her main memory of their conversation was how disgruntled Mrs A was with the catheter, and how uncomfortable it was. This does not fit well with Dr C simply being pleased with how Mrs A was managing.
- The letter states that following the clinic visit (11 November) Mrs A was asked to contact the hospital if there were further problems, that she did this, and that she was referred to Dr D at Urology Associates. This is an abbreviated account that, again, does not accurately reflect what occurred. It omits to mention the two further late night visits to ED, the continuing difficulties Mrs A was clearly having with self-catheterisation (known to community nursing staff), and the calls needed on her behalf to expedite the second appointment.

The letter includes an apology for the delay in responding, but no explanation as to why this occurred. There was also an apology for the delays that may have occurred in relation to Mrs A's care. However, in the context of the above, I find the final sentence, thanking Mr B for offering Wairarapa DHB the chance to review and improve the quality of its services, insincere and trite. It is hardly surprising that Mr B, with the agreement of Mrs A and her family, chose to pursue his complaint through HDC.

In my experience, most complaints are made because consumers and their representatives want to know that where a service has been deficient, improvements are made so that other patients do not experience the same problems.[21] Handled with due care and consideration, complaints can provide opportunities for learning and improvement. Handled badly, they can inflame a situation and increase mistrust. Dealing with complaints effectively and meaningfully is an essential part of providing a quality health care service.

Summary

Wairarapa DHB's systems for ensuring timely access to specialist urology care were not adequate. There were deficiencies in relation to referral triaging, arranging appointments and necessary tests, and ensuring providers had access to relevant information when needed. This represented a lack of reasonable care and co-operation and, accordingly, a breach of Rights 4(1) and 4(5).

[21] Bismark, M., Dauer, E., Paterson, R. and Studdert, D. (2006), "Accountability sought by patients following adverse events from medical care: the New Zealand experience", *Canadian Medical Association Journal*, 175 .

Wairarapa DHB's response to Mr B's complaint took four and a half months, and did not reflect a fair investigation of his concerns. This was a breach of Right 10(3).

Other comment

Community nursing
Mr B also noted concerns about the service provided by the community nurses, in particular repeated efforts made by one nurse to catheterise Mrs A, in a way that caused her intense pain. Mr B queried why the difficulty with catheterising had not raised suspicions of a more complex problem. The records suggest that it was CN Ms Q's efforts to insert the catheter on 24 November that Mrs A found especially painful. I do not think it is possible to establish with any certainty what happened on this occasion. However, I note that when CN Ms Q saw Mrs A, several other CNs, and CNS Ms K, had already seen her. The previous week, CNS Ms K had spoken to EN Ms H about the difficulty Mrs A was having with self-catheterisation, haematuria, and clots. On the day in question, Mrs A had had the IDC removed in the morning, and an education session with CNS Ms K, followed by several attempts at self-catheterisation. The cumulative effect of multiple attempts would certainly not have helped.

Discharge planning and palliative care
Mr B also considers that there was unhelpfulness and passive obstruction in relation to palliative care.

The records show that following transfer to Wairarapa Hospital, Mrs A expressed both her wish to return home, and her understandable concerns about whether she could manage this. It is difficult to comment further on the discharge planning process without Mrs A's own account. I am concerned that it was only at the request of Ms L and Mrs B, that a meeting was arranged to discuss the discharge arrangements. It appears there was a lack of clear communication between staff, Mrs B and Mrs A's daughters at this time.

Mrs A was referred to the palliative care service by her GP. The service commenced, with Mrs A's consent, when she returned to Wairarapa Hospital in mid-February. CNS Ms S visited Mrs A on the ward and was involved in the discharge planning process.

Following Mrs A's discharge to the private hospital, records show that staff from the palliative care service maintained regular contact with Mrs A, staff at the private hospital, and other health professionals. They had some contact with Mrs A's daughters. Progress notes indicate that the team responded promptly and appropriately to Mrs A's changing care needs. When CNS Ms S spoke to Mrs B about her concerns, she noted that Mrs B may not have been aware of the level of input provided by the service. Again, this emphasises the importance of clear communication, including a

shared understanding about the arrangements for maintaining contact with family members and patient representatives.

Adverse comment — Urology Associates Ltd

As noted above, it was Wairarapa DHB's responsibility to ensure that its population had access to specialist urology services. It had contracted Urology Associates to provide elective services. The arrangement with Urology Associates includes provision for after-hours telephone access to a urologist, and for the general surgical service to deal with acute urology referrals. Dr E, on behalf of Urology Associates, submits that the service itself is adequate and appropriate, but accepts that Mrs A's experience highlighted the need for better communication in relation to how the service is accessed. It is certainly unfortunate that this was not recognised sooner.

Some effort had been made to introduce the new service, with an invitation to GPs and senior medical staff from Wairarapa DHB to attend a presentation by Urology Associates. Clearly, this was not sufficient. Pathways for access need to be known by relevant parties, in this case other health professionals. Urology Associates has acknowledged this, and taken steps to ensure ED staff and GPs are better informed about the mechanisms for getting patients seen and managed. I note Dr Masters' advice that since there may be frequent turnover of staff in ED, there needs to be a process for ensuring new ED staff are familiar with the urology service and how it is accessed.

Response to provisional opinion

Wairarapa DHB accepts that Mrs A's rights were breached. It has provided written apologies to Mrs A's friends, Mr B and Mrs B, and to her daughters. The Chief Executive has offered to meet with them to apologise in person.

The actions taken by Wairarapa DHB and Urology Associates in response to these events and this investigation, as outlined on pages 13–14, are noted. The steps taken to improve the service are commendable.

Follow-up actions

- A copy of this report with details identifying the parties removed, except Wairarapa District Health Board, Urology Associates Ltd, and the expert who advised on this case, will be sent to the Director-General of Health, all district health boards, and the Quality Improvement Committee,[22] and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[22] Soon to be replaced by the Quality and Safety Commission.

Appendix 1 — Independent urology advice to Commissioner

The following expert urology advice was obtained from urologist Dr Jonathan Masters:

Preliminary advice:
14 JUL 2009
Complaint: [Mrs A] Wairarapa District Health Board
Your ref: 09HDC01040

My name is Jonathan Grenville Masters, Medical Council Number […]. I have been asked to comment on the information available as to whether there are concerns about the care provided by WDHB which require formal investigation in this case. The patient is not known to me and I am unaware of any possible conflicts of interest.

Background
[Mrs A] was a 79-year-old woman at the time of presentation, with a number of significant comorbidities. Nevertheless she was living independently. I can not establish from the medical records available that she had presented in urinary retention in July 2008, as stated in the summary. The first episode of retention was 2 September 2008 when she was catheterized in the Emergency Department. She was referred to the urology outpatients clinic by her GP on 3 September 2008. That letter does not mention urinary retention but change in symptoms for 6 months. It was graded as "urgent" on 25 September 2008 and an US, MSU, and urine cytology requested. In addition there is a "?" in the booking sheet for a flexible cystoscopy. The GP letter states: "I am now concerned that there is some other bladder pathology". The urine analysis of 28 August was not "normal" as stated in the GP letter because there was persistent microscopic haematuria.

There was microscopic haematuria at the time of the catheterisation and soon after, several episodes of macroscopic haematuria. She represented again on 3 September 2008, 10 October 2008, 11 October 2008, 12 October 2008, 13 October 2008, 19 October 2008, 13 November 2008, and 24 November 2008, all to the Emergency Department with blocked catheters, or urinary retention. She was referred by the Emergency Department to Urology services for the second time on 13 October, and she was referred by her GP for the second time on 15 October. She was referred for the third time by her GP on 30 October 2008, this time both to the urologists at [Hospital 2] and again to the urology service provided at Wairarapa. A formal complaint was made on 30 October 2008 on her behalf by [Mr B]. She was seen by the visiting urologist on 11 November 2008. This appointment had been brought forward 1 month, according to the visiting urologist. It is not clear during this consultation that the 4 subsequent referrals were available to the visiting urologist. A diagnosis of retention secondary to diabetes was made. The frank haematuria was noted and it was felt adequate to investigate this in 5 months, or sooner if there were problems. [Mrs A] was to learn ISC. There is no record of a physical examination at this consultation, and there is no record of the urine cytology that had been requested being done or being looked at during this consultation. She was unable to manage

ISC, had ongoing haematuria and eventually had a flexible cystoscopy and vaginal examination on 2 December 2008, both of which were abnormal. She was booked for a CT scan and a general anaesthetic cystoscopy and biopsy on 9 December 2008. Histology confirmed muscle invasive Transitional Cell Carcinoma of the bladder with invasion of the vagina. She was discussed at a uro-oncology multi disciplinary meeting at [Hospital 2] on 19 December, and a decision was made to offer palliative radiotherapy only. Despite this treatment, her decline was rapid and there were concerns raised about the appropriateness of trying to discharge her home in February 2009. This was apparently the patient's wish but it was highly unlikely that she would have coped, and she was discharged to [the private hospital]. She died [a short time later].

Observations

1) Wairarapa is a DHB that serves a population of 38 000 only. This is not a sufficiently large enough population to employ an independent urology service. In addition urology is becoming increasingly sub specialized and so Wairarapa will need to buy in urology services. Nevertheless Wairarapa has a duty of care to its population to provide adequate urology care. Currently this is provided both by Urology Associates on a monthly basis and also some cover from [Hospital 2]. With that size population a reasonable estimate is that there is requirement for 100–150 new patients a year and 200–300 follow-ups a year.

2) This lady presented with advanced bladder cancer. It is unlikely that earlier diagnosis or treatment would have changed her prognosis. It is, however, possible that earlier intervention and management may have alleviated some of the obvious problems that she suffered through September, October, November and December 2008.

3) As soon as the flexible cystoscopy and vaginal examination had been performed on 2 December 2008, this lady had her plan and treatment remarkably quickly.

Areas Of Concern

I would like to highlight the following areas of this lady's care to the Commissioner.

1) Provision of care for this lady seems at best confusing. Numerous referral letters were written on her behalf. The GP felt compelled to write to both Urology Associates at the Wairarapa clinic and also to the urologists at [Hospital 2] as she was unhappy with the wait. With clinics only being provided once a month it would seem inevitable that future patients who are urgent but never unwell enough to be acute, will face exactly the same problem as this lady and her GPs and the Emergency Department faced. Namely that a 2-month wait (which had been brought forward 1 month) will be the norm. Two months for an urgent referral is probably at the upper limit of what would be regarded as acceptable. Do the GPs know this is how long the patients will wait? It is not clear that any of the subsequent referral letters that made quite clear this lady's distress were ever seen or acted upon by the visiting urologists. Again in January 2009 she was seen by a visiting urologist

from Urology Associates and in that consultation it does not appear that the decision made by the multi disciplinary meeting [at Hospital 2] in December 2009 was known to him. I am concerned as to how well the provision of urology services by different providers serves the population of Wairarapa and whether clinics being available only once a month is an adequate service. I am concerned as to how easy it is for GPs and other health professionals to seek urology advice and expedite appointments where necessary.

2) Appropriate tests were requested at the time the referral was processed, namely urine cytology and an US scan, and given her symptoms and persistent microscopic haematuria, also a cystoscopy. There is no mention of the cytology result at the time of the consultation and I can not find a record. Whilst in many cases urine cytology may not be helpful, in this particular case it may have been extremely useful. Despite the referral being urgent, an US scan was not available and eventually took place 3 months after the original referral. Again had this been available sooner, more urgent intervention may have taken place. At the consultation it would have been helpful to record the physical examination. Urinary retention is unusual in women, even diabetic women, and physical examination may have helped to establish a cause. It is not clear to me why a flexible cystoscopy was originally planned for 5 months in a lady who obviously had unexplained frank haematuria. (Was this decision based on resource constraints or clinical judgement?) It is true that this was brought forward appropriately when she was obviously struggling.

Conclusions

I do not think that any different management would have altered this particular lady's prognosis but possibly some of her suffering. As far as I can establish she did not present in urinary retention in July 2008 but in September 2008. This is an important distinction because had she been in urinary retention from July 2008 I would regard the provision of care as grossly inadequate. I feel that a 2-month delay for an urgent referral is really at the upper limit of acceptability. On reviewing this case I am concerned about the provision and co-ordination of care that patients with urological problems can expect in the Wairarapa given that 2 different providers are involved, and the ease with which GPs can access the service if the original situation deteriorates. Provided that the Commissioner can establish that this is not a problem, her care would otherwise seem satisfactory.

Yours truly,
Jonathan Masters
Consultant Urologist
BA BMBCh MD FRCS(Urol) FRACS

Additional advice from Dr Masters:

1) Please comment generally on the standard of care provided to [Mrs A] in relation to urology services between September 2008 and March 2009
Provision of urology services in Wairarapa was altered in April 2008, with Urology Associates providing elective urological care, and advice with regard to all acute problems by being available by phone to discuss patients with consultant colleagues and by providing 2 urology nurses to see all inpatient urology patients daily. In the documentation provided to me, by inference this would appear to be a significant improvement on what appeared to be an ad hoc service prior to this. In general I would regard the level of care once this lady was seen by the urology services as being satisfactory and within the norm for New Zealand.

2a) The response to the referrals to Wairarapa DHB's urology service to include the triaging of the referrals
The referral received and acted on by Urology Associates was a letter referring an elderly diabetic lady with recurrent infections and symptoms. This letter appears to have been triaged twice on 25 September 2008; once it was triaged as urgent and then a separate copy of the same letter has been triaged as semi urgent. It took 20 days from receipt of the letter to triaging of the letter. Thus if the time frame for an urgent referral is 4 weeks as per the guidelines, most of 3 weeks has been used to get to the point of triaging.

Appropriate investigations were requested when the letter was triaged but as far as I can ascertain the urine cytology was never done and the ultrasound request was lost.

Further referrals from ED and from the GP were apparently not available at the time of the clinic appointment. Had the Ultrasound scan, the urine cytology and the ED and subsequent referrals been available to [Dr C] in the outpatients on 11 November, I have no doubt the consultation would have a very different emphasis and outcome. Whether it was the letter from [Mr B] or the promptings of the nursing staff, Urology Associates to their credit, were able to respond very rapidly for this lady to be seen for a flexible cystoscopy in December 2008.

2b) Communication between Wairarapa Hospital Emergency Department and the urology service
It does not appear that there was any direct verbal communication between the emergency department who were de facto the primary caregivers for her catheter and its problems, and Urology Associates. This is despite the fact that the contract with Urology Associates makes this possible through an on-call phone number. Given the frequency of attendances for [Mrs A] after 3 September 2008, this may have been helpful. This arrangement was only established in April 2008 and such phone access may still have been novel. This is clearly an area of communication that needs to be iterated and then reiterated on a regular basis as staff in the emergency department may turn over quite frequently.

2c) [Dr C's] consultation with [Mrs A] on 11 November 2008 and the treatment plan

From the referral letter, [Dr C] was expecting to manage one problem and found she was coping with a very different one, including the fact that a catheter was in place. [Dr C] did not perform a physical examination. The emphasis was first to be rid of the catheter which is reasonable and then to investigate the cause of the retention and haematuria. Many elderly patients can manage self catheterization surprisingly well and live much improved lives without a permanent catheter and so this was a reasonable plan. Again had all the information been available at this consultation, the urgency of determining the cause would have been different. The desire to provide a woman doctor for [Mrs A] meant a flexible cystoscopy was scheduled for 5 months. In retrospect, the clinical need was much more acute than this and when this became apparent [Mrs A] was seen promptly in December, as had been suggested by [Dr C] in her letter of 11 November.

3) Please comment on the model used by Wairarapa DHB to deliver urological care

I believe that in terms of numbers of outpatients slots Wairarapa DHB through their contract with Urology Associates are providing a very good urology service. It is clear that a good deal of thought has gone into the set up of the service and I expect the number of surgical interventions is more than adequate. Where this particular model is vulnerable is during the 25 days of each month that urologists are not physically there. Whilst the plan on paper is admirable, this case illustrates that delivery is critically dependent on all stakeholders knowing when and how to convey important information to each other. In this case communication between Urology Associates, the GPs involved, the ED, and the urologists [at Hospital 2] could all have been better at times.

4) Please comment on the changes outlined by Wairarapa DHB in light of these events

I believe that Urology Associates have understood that good communication is vital. Talks to the GPs and ED are important, and are planned or have been undertaken. However these will need to be regularly repeated or updated as personnel change and protocols are forgotten. It is now possible to perform "walk in" flexible cystoscopies. This was not the case when [Mrs A] was seen. This is a significant improvement and to be commended. Had it been available and utilised for [Mrs A], diagnosis of her underlying cancer and its treatment could have been expedited.

It is not excusable that important documents, letters and notes were not apparently available when this lady came to clinic. Requests for X-rays should not be lost and tests correctly asked for should be carried out. These are systems issues and I hope that sections 7 and 8 in the letter of [the CEO] on behalf of Wairarapa DHB have adequately addressed these.

5) If not included above are there any specific changes you wish to make to your preliminary advice

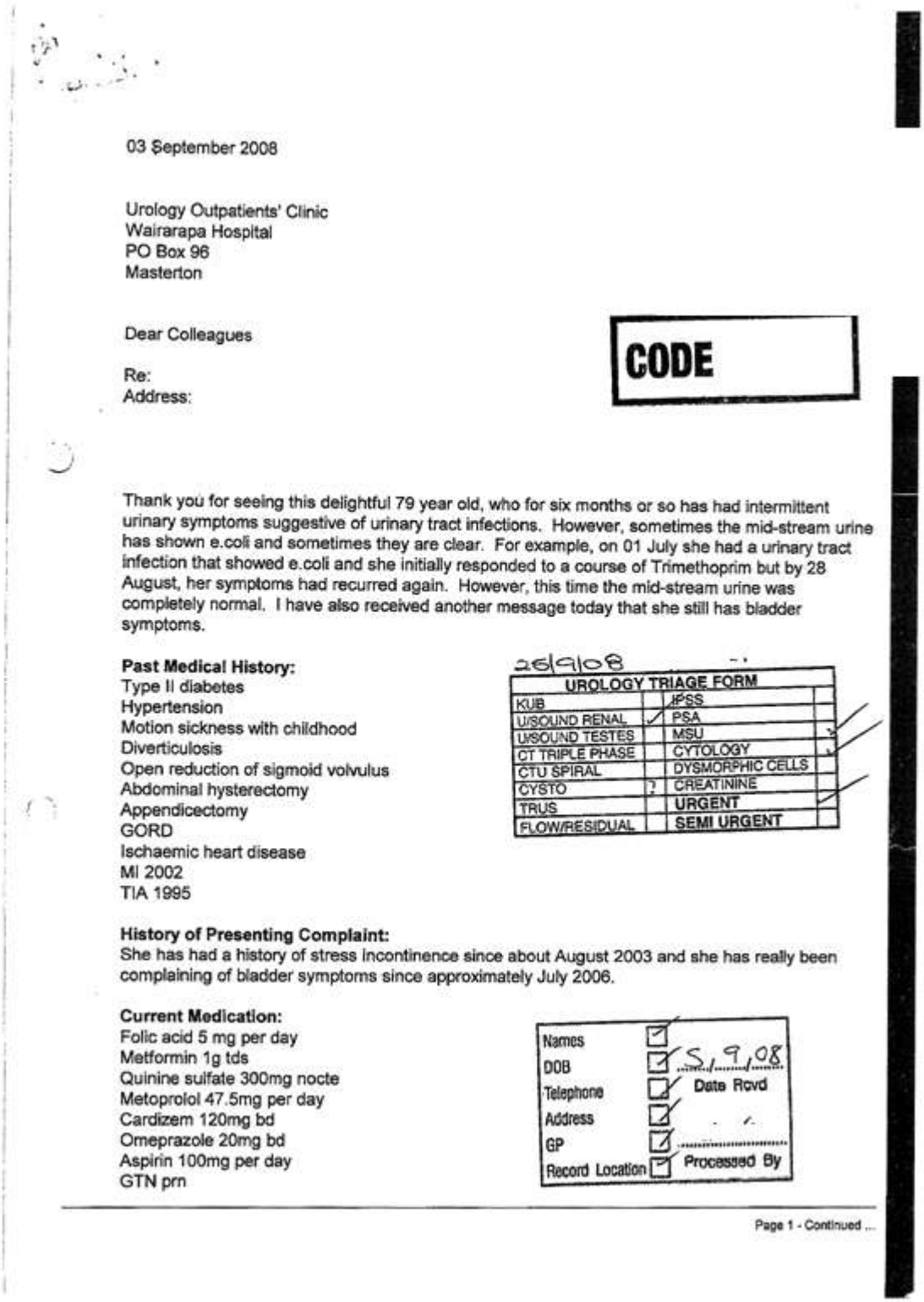
No. Ultimately this lady had an aggressive and incurable cancer. I do not believe earlier intervention in the time frame available (Sept/Oct 2008 compared with Dec08/Jan09) would have changed the outcome. It may have reduced her suffering a little.

6) Are there any other aspects of the care provided by Wairarapa DHB that you consider warrant additional comment?
I note there remains a discrepancy between [Mr and Mrs B's] contention that a catheter was placed in June/July 2008, and the medical records that note a catheter first being placed in September 2008. It is true a catheter was placed in September and so she did not have a catheter in in September.

Yours truly,

Jonathan Masters
Consultant Urologist
BA BMBCh MD FRCS(Urol) FRACS

Appendix 2 — Triaged referrals



03 September 2008

Urology Outpatients' Clinic
Wairarapa Hospital
PO Box 96
Masterton

Dear Colleagues

CODE

Re:
Address:

Thank you for seeing this delightful 79 year old, who for six months or so has had intermittent urinary symptoms suggestive of urinary tract infections. However, sometimes the mid-stream urine has shown e.coli and sometimes they are clear. For example, on 01 July she had a urinary tract infection that showed e.coli and she initially responded to a course of Trimethoprim but by 28 August, her symptoms had recurred again. However, this time the mid-stream urine was completely normal. I have also received another message today that she still has bladder symptoms.

Past Medical History:
Type II diabetes
Hypertension
Motion sickness with childhood
Diverticulosis
Open reduction of sigmoid volvulus
Abdominal hysterectomy
Appendicectomy
GORD
Ischaemic heart disease
MI 2002
TIA 1995

26/9/08

UROLOGY TRIAGE FORM			
KUB		IPSS	
U/SOUND RENAL	✓	PSA	
U/SOUND TESTES		MSU	✓
CT TRIPLE PHASE		CYTOLOGY	✓
CTU SPIRAL		DYSMORPHIC CELLS	
CYSTO	?	CREATININE	
TRUS		URGENT	✓
FLOW/RESIDUAL		SEMI URGENT	

History of Presenting Complaint:
She has had a history of stress incontinence since about August 2003 and she has really been complaining of bladder symptoms since approximately July 2006.

Current Medication:
Folic acid 5 mg per day
Metformin 1g tds
Quinine sulfate 300mg nocte
Metoprolol 47.5mg per day
Cardizem 120mg bd
Omeprazole 20mg bd
Aspirin 100mg per day
GTN prn

Names	☑	
DOB	☑	5.9.08
Telephone	☑	Date Rcvd
Address	☑	
GP	☑	
Record Location	☑	Processed By

Page 1 - Continued ...

Names have been removed (except Wairarapa DHB, Urology Associates Ltd, and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

24- 9-08; 9:47AM;

03 September 2008

Urology Outpatients' Clinic
Wairarapa Hospital
PO Box 96
Masterton

CODE

Dear Colleagues

Re:
Address:

Thank you for seeing this delightful 79 year old, who for abt months or so has had intermittent urinary symptoms suggestive of urinary tract infections. However, sometimes the mid-stream urine has shown e.coli and sometimes they are clear. For example, on 01 July she had a urinary tract infection that showed e.coli and she initially responded to a course of Trimethoprim but by 28 August, her symptoms had recurred again. However, this time the mid-stream urine was completely normal. I have also received another message today that she still has bladder symptoms.

Past Medical History:
Type II diabetes
Hypertension
Motion sickness with childhood
Diverticulosis
Open reduction of sigmoid volvulus
Abdominal hysterectomy
Appendicectomy
GORD
Ischaemic heart disease
MI 2002
TIA 1995

2/9/08.

UROLOGY TRIAGE FORM	
KUB	IPSS
ULTRASOUND RENAL	PSA
U/SOUND TESTES	MSU
CT TRIPLE PHASE	CYTOLOGY
CTU SPIRAL	DYSMORPHIC CELLS
CYSTO ?	CREATININE
TRUS	URGENT
FLOWRESIDUAL	STAT/ URGENT

Nurse clinic for residual

History of Presenting Complaint:
She has had a history of stress incontinence since about August 2003 and she has really been complaining of bladder symptoms since approximately July 2006.

Current Medication:
Folic acid 5 mg per day
Metformin 1g tds
Quinine sulfate 300mg nocte
Metoprolol 47.5mg per day
Cardizem 120mg bd
Omeprazole 20mg bd
Aspirin 100mg per day
GTN prn

Names	☑	
DOB	☑	5.9.08
Telephone	☑	Date Rcvd
Address	☑	
GP	☑	
Record Location	☑	Processed By

Page 1 - Continued ...

Appendix 3 — Response from Dr E on behalf of Urology Associates. Limited to Dr Masters' preliminary advice.

Dr Masters observes in his report that the Wairarapa serves a DHB with a population of 38,000 only. He notes that this is not a sufficiently large population to employ a urologist within the DHB. He also comments that with this size population a reasonable estimate is that there would be a requirement for 100–150 new patients (FSAs) and 200–300 follow-ups a year. We would contest these numbers. There has been considerable experience gained by Urology Associates through a similar arrangement with [another] District Health Board. With this experience, we have observed that approximately 270 FSAs are required in a population of this size. This differs from the estimates of FSAs estimated by Dr Masters, in that there is no significant private Urological service within a DHB such as the Wairarapa and therefore the numbers coming through the public sector would also include those that might be serviced privately in a centre with a dedicated urologist. It is also our contention that many areas of New Zealand are, in fact, under-served in terms of their ability to put through FSAs (new patients). Further, Dr Masters anticipates that 200–300 follow-ups a year should be seen. This would be a new patient follow-up ratio of 1:2. This would mean that two follow-ups would be seen for each new patient. Even in Christchurch, a centre with a complex tertiary referral basis and case mix, the number of new patients seen for each follow up is only 1:1.97. In the Wairarapa over the previous 12 months this ratio has been around 1.4 follow-ups for each new patient seen, which we believe appropriate for a DHB of this size. As we have experienced [at a similar sized DHB], the monthly visits are sufficient to deal with the workload. These visits alternate between a two-day visit and a three-day visit. On the two-day visit there is a day of operating followed by a day of clinic and on the three-day visit there is a day of clinic followed by a day of operating followed by a day of clinic. By utilising this matrix of outpatient visits, the numbers of FSAs being served is 70% greater than that which Dr Masters had suggested would be the requirement for a population of this size. Therefore, there can be no argument about the ability for this monthly visit to service the needs of the population from a numbers perspective.

The second concern that Dr Masters has over the provision of monthly clinics is whether these are frequent enough to service the population of Wairarapa in a timely manner. It must be emphasised that the contract between Urology Associates and the WDHB is for elective urological services. For acute urological referrals there is a clear pathway that has been communicated to the General Surgeons [attachment provided] and sits within the contract that Urology Associates has with the Wairarapa District Health Board Attachment [attachment provided]. This pathway is that urgent and acute problems that are felt not to be able to wait for the next clinic or that need admitting can be discussed directly with the urologists. Their cell phone numbers have been provided. The acute service provision lies with the General Surgical Department in communication with the urologists. On the 16th September 2008 I personally addressed the Clinical Society Meeting, introduced the Urology Service and outlined the acute pathway. All GPs and senior WDHB medical staff were invited to this meeting [attachment provided]. In addition to this clear pathway for dealing with acute problems, Urology Associates employs two part time nurses in the WDHB who

are available to help with any urological problems. Both these nurses have ready access to UA urologists at any time. It is our contention therefore that monthly clinics are adequate and appropriate for the provision of elective urological services to the WDHB, and that there is a clear pathway for more urgent problems.

The third concern that Dr Masters has expressed is that of the adequacy of accessibility to services for GPs and other health services. In order to address this concern, an in depth look at the details of this case are required. The first contact with the Urology Department was from the general practitioner and this is in a referral letter dated 3 September 2008 [attachment provided]. It was received on 5 September 2008 and triaged on the 25th September. This letter specifically states the problem to be intermittent urinary tract symptoms suggestive of urinary tract infections and that this had been a chronic problem since July 2006. It is noted, however, that on 2 September 2008 [Mrs A] was seen 0940 in the Emergency Department having not passed urine since 1900 the previous night [attachment provided]. A diagnosis was made of retention secondary to a partially treated urinary tract infection. She was also noted to have a tendency towards constipation and her catheter was removed following drainage of the urine. She re-presented later the same day [attachment provided], again in retention. The indwelling catheter was replaced and left in "until her bowels had been sorted". It was noted at that time that she "has a urology consult pending". It is assumed therefore that although the consultation was written on 3 September, [Mrs A] had presumably consulted her general practitioner prior to that event. The GP letter was triaged urgent (according to our protocol, with recurrent urinary tract infections, this should have been triaged semi-urgent) and the appropriate tests including a renal ultrasound, MSU and cytology were arranged. She re-presented four times over the dates of 10, 11, 12 October, [attachment provided] with problems with haematuria and blocking catheter. On 14 October it was noted in the Emergency notes that she was "awaiting urology review — is in system but haven't got appointment". It should be noted that on this last attendance on 13 October a PV speculum examination was performed which showed "no obvious cystocele or rectocele". At that time a referral was sent from the Emergency Department to Urology, [attachment provided] outlining that she had been in retention six weeks ago, she tended to constipation and that she has had a number of issues with the IDC including haematuria and blockage. The number of presentations to Emergency was not stated. The consultation concludes "just wanting to let you know that her issues are ongoing so that her triage can be checked as she has not yet received an appointment". The second, and from our records, the only other referral from her general practitioner arrived on 15 October 2008 [attachment provided]. This letter emphasises she had had a number of presentations to ED with haematuria and blockage of the catheter, but also that it was felt that her retention was secondary to constipation. It was requested that her urology appointment be expedited, and accordingly she was booked into the next clinic, just over three weeks later.

In examining these details, it is clear that the urological service was only aware of the problem of retention on the 14th October, and that [Mrs A] was seen 25 days later on the 11th November. If the problem had been communicated earlier to urology, she could have been seen as early as the September clinic. Whilst there exist clear

pathways for dealing with urgent problems, these are through the general surgeons, who were not contacted in this case. It is apparent that Urology need to communicate more clearly to the Emergency Department and to the GPs the mechanisms of getting urgent cases seen and managed. We would therefore contend that there is adequate access to Urological services, but feel that the communication of how to access these services needs to be better communicated.

Dr Masters also raises the issue of his concern "as to how well the provision of a urology service by different providers serves the population of Wairarapa". It should be noted that prior to the arrival of Urology Associates there were providers from both [Hospital 2] and [a hospital in a main centre]. There was no communication between these providers of any sort and no co-operative or comprehensive service. Urology Associates has considerable experience of running services in DHBs of the size of Wairarapa. It was felt important to have the [Hospital 2] urologists involved in this service, as this is the natural point of referral (both traditionally and geographically) for Emergency and urgent cases that cannot be dealt with in the Wairarapa. There has been considerable communication between the [Hospital 2] urologists and Urology Associates and each year the specific issues are discussed at a face-to-face meeting. There is also considerable phone traffic in between meetings. All complications and complaints are discussed at the Urology Associates business meeting, and any specific issues communicated back to the [Hospital 2] urologists. [Mrs A's] case was discussed in this manner once we became aware of the complaint. Thus, although in an ideal world there would be a single provider, the model of providers from two centres with specialty nursing backup is, we believe, the ideal model for the Wairarapa. Rather than weakening the urology service provided to the WDHB, we believe this co-operative venture has enhanced it considerably. It is however concerning that the information from the multi-disciplinary meeting [at Hospital 2] was not available to the visiting urologist in January 2009 and we have discussed this with the [Hospital 2] urologists. In future copies of all correspondence relating to a Wairarapa patient [at Hospital 2] will be forwarded directly to Urology Associates for placement in the Urology Associates notes, as well to the WDHB for placement in the Wairarapa clinical records.

In summary, while the model for delivery of urological care to the WDHB is sound and appropriate, it has been highlighted through this unfortunate case that the communication of pathways for discussion with urologists has not been well presented to the Emergency Department. Urology Associates will be talking to members of the Emergency Department and establishing clear protocols for future communication around problematic urological patients and conditions. Furthermore, another formal communication to the general practitioners in the Wairarapa will be undertaken in an attempt to improve direct access to urologists and the urology nurses for advice.