Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC01146)

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to a consumer by a medical centre.

3. In January 2019 the consumer attended a medical centre to arrange for a prostate specific antigen (PSA)[1] test. Abnormal results were received by the medical centre but inadvertently these were filed by an administrator at the medical centre rather than being sent through to the referring GP for follow-up. The abnormal results were picked up two years later and prostate cancer was diagnosed.

Background

4. On 14 January 2019 the consumer attended an appointment at the medical centre to discuss three clinical concerns. The consumer was seen by a locum general practitioner (GP).

5. At this appointment, the consumer requested a referral for a PSA test, as his brother had been diagnosed with prostate cancer. The locum recorded in the consumer's clinical records that he had no symptoms relating to prostate cancer, although '[his urine] stream was not as good as it was, but not bad'.

6. The locum also recorded that she had arranged for the consumer to check his results on the patient portal, ConnectMed.[2]

7. The consumer's original complaint stated that he did not have access to ConnectMed, and he had not discussed with the locum the expectation that he would access his own records.

8. The consumer's abnormal PSA results[3] (elevated to 8.0 micrograms/L) were sent through to the general medical centre inbox. However, inadvertently an administrative staff member at the medical centre filed the results instead of sending them through to the consumer's

[1] The test measures the level of PSA in the blood. PSA is a protein made by the prostate. Higher than normal levels can occur when there is a problem with the prostate, such as infection, enlarged prostate or prostate cancer.
[2] ConnectMed is a secure website that holds patient health information from their GP's system, including results, which patients can view when they have set up access to do so.
[3] Two PSA levels taken 6–12 weeks apart that are ≥4.0 micrograms/L for males aged 50–70 years. See: https://bpac.org.nz/2020/prostate.

Names have been removed (except the advisor) to protect privacy.

GP or locum for review. Therefore, the GP did not follow up with the consumer as would be expected.

9. The consumer said in his original complaint that he had assumed that everything was OK with the test results.

10. On 24 March 2021 the consumer attended an appointment with his usual GP to request a health check, including a PSA test. The GP checked the previous PSA test results and advised the consumer that they were abnormal and had been filed inadvertently without action. At this appointment, the GP arranged a repeat PSA test and scheduled an appointment for 31 March 2021 to discuss the result.

11. On 26 March 2021 the GP received the PSA result and contacted the consumer (via text) to tell him that his PSA test was still abnormal (elevated) and that they would discuss management at the appointment on 31 March 2021.

12. On 31 March 2021 the GP apologised for not having followed up the previous PSA result and made a referral to a urologist.

13. On 15 April 2021 the consumer attended an appointment with the urologist, who arranged for a biopsy. The biopsy report noted: 'Favourable Intermediate Risk Prostate Cancer.[4]'

14. On 24 May 2021 the urologist discussed the diagnosis and treatment options with the consumer and referred him to Radiation Oncology for treatment.

15. The consumer had a further appointment with the GP, who explained how the administrative error had occurred and apologised for the delay in diagnosis. Currently, the consumer is undergoing treatment.

Information gathered

Provider response to the complaint

16. The medical centre provided this Office with a chronological account of the incident (as detailed above) and an explanation of the outcome of an investigation it undertook when the delayed diagnosis was identified.

17. The medical centre explained that at the time the incident occurred, normal process was to advise the laboratory when a locum started work at the medical centre. This was to ensure that patient results would be sent to the locum's inbox. Despite this, in some instances a locum's results would be sent to the generic medical centre email address, which is what occurred with the consumer's PSA results from 2019. The generic email is managed by the administrative staff, who frequently review and distribute the results to the patient's GP or the locum who referred the patient for the tests.

[4] This means that the prostate cancer biopsied has a Gleason grade group of 1 or 2 and that half of the prostate biopsy samples showed cancer.

18. The medical centre explained that in the Medtech practice management software, the button 'OK', which distributes the records to the GP, is located next to the 'file' button, which files the results in the patient's records without an alert to the doctor or administrator. In the consumer's case, the administrator inadvertently pressed the 'file' button instead of the 'OK' button and filed the records. Therefore, nobody was aware that his PSA result was abnormal and that he required further tests.

19. Due to the lack of communication, the consumer assumed that no news was good news, and he did not look up his results on the patient portal or follow up with his GP.

20. The medical centre's results policy at the time of the incident was that patients would be contacted by their GP and advised of abnormal results. The medical centre's investigation confirmed that this process was followed once the consumer's PSA test from 2021 came back as abnormal.

21. The medical centre provided the consumer with open communication throughout the incident investigation and provided both verbal and written apologies with details of the actions implemented to reduce the likelihood of reoccurrence. This information was included in the medical centre's response to this Office.

In-house clinical advice — Dr David Maplesden

22. HDC's in-house clinical advisor, Dr Maplesden, provided the following advice in relation to the consumer's complaint and the medical centre's response and incident investigation:

- The medical centre's policies and procedures at the time of the event were consistent with current standards[5] as set by the Royal New Zealand College of General Practitioners.
- The decision to revise the policies and procedures following the complaint was appropriate to increase their robustness.
- As the consumer was asymptomatic at the time of his request for a PSA test in January 2019, the GP would not be expected to track this routinely.
- Dr Maplesden acknowledged how easy it is to push the 'OK' button instead of the 'file' button in Medtech.
- The medical centre's response indicates that the incident was taken seriously and that appropriate remedial measures were taken.
- The consumer's management once the filing error was noted was consistent with accepted practice, with prompt open disclosure and complaint management.

Responses to provisional opinion

23. The Practice Manager advised that the medical centre accepted my provisional decision and had no further comments. The consumer has not responded to the opportunity to comment on the provisional opinion.

[5] https://www.rnzcgp.org.nz/gpdocs/New-website/Advocacy/PB6-2016-Apr-Managing-patient-test-results.pdf.

Opinion: Medical centre — adverse comment

24. First, I acknowledge the distress caused to the consumer by the error in process at the medical centre and the two-year delay in his prostate cancer diagnosis.

25. The medical centre has taken the incident and complaint seriously and has learned from the case and put in place actions to mitigate the risk of a similar experience, as detailed below.

26. Regardless, the incident was significant, and the inadvertent misfiling of the consumer's PSA test result had a detrimental impact on his health care. I accept that the event was caused by an administrative error, but I am critical of the medical centre that such an event occurred in its system. I am also concerned that while the consumer's clinical notes state that he would log in to the patient portal to check his own results, he said that this was not discussed with him. Although the patient portal is a safety net that allows patients to be proactive partners in their health care, it does not absolve the provider's responsibility to communicate abnormal results to the patient. Further, the patient portal is useful as a safety net only if the patient knows how to use it.

27. Based on the medical centre's acknowledgement and acceptance of the error, and the changes it has made since this event, I have decided that the above adverse comment made against the medical centre is an appropriate course of action.

28. An anonymised copy of this decision will be published on the HDC website to remind Medtech users of the risk of misfiling test results and to ensure that patients are supported to use patient portals and feel comfortable speaking up when test results have not been received or followed up. I will also provide details of the incident and decision to Medtech to make it aware of the ease with which information can be misfiled.

Changes made by the medical centre

29. The following changes have been made at the medical centre since the events:

1. Staff have been reminded to be cognisant of the risk of errors such as this, and, if they have concerns that their practice environment (ie, multitasking/noise/workload) may pose a risk to their concentration and successful completion of tasks, to report this immediately.
2. Changes have been made to the way administrative staff on reception work, including the introduction of a period of 'undisturbed time' to undertake critical tasks such as redirecting results to the GP.
3. The results policy has been updated to mitigate the risk of this incident happening in the future. In particular, the policy now includes a requirement that all clinical staff, including locums, set a 'task' alert to follow up on blood test results that may have a significant impact for the patient. Detail of how results will be communicated or can be accessed via ConnectMed has been introduced into the policy, and all results now require comment by a GP before filing to show that they have been seen by a clinician.

4. Orientation processes (clinical and nonclinical) and documentation for new staff have been reviewed and improved where necessary to ensure that all staff are well informed of the policies and processes to which they will be subject.
5. In January 2020, the medical centre introduced 'daily huddles' for all clinical staff to enable communication of any concerns, queries, or changes in policy to be communicated openly, and to share any lessons gained from incidents and complaints.
6. Discussions have been had about how safety nets should be utilised wherever a potential risk has been identified.
7. Bi-annual email is sent to all ConnectMed users who have signed up, regardless of whether they have ever logged on, asking if they need any support, and, if so, providing the patient with appropriate contact details.
8. A clinical audit of all laboratory results requested by locum doctors was undertaken to ascertain whether there were other occasions on which abnormal results had been filed without clinical review or notification to the patient. The consumer's missed PSA result was the only occasion detected where a clinically significant result had not been followed up.

Follow-up actions

30. Given that the medical centre has provided a formal written apology to the consumer and made appropriate changes to its service since these events, I consider that no further recommendations are necessary.

31. A copy of this report with details identifying the parties removed, except the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

32. In addition, a copy of this report with details identifying the parties removed, except the advisor on this case, will be provided to Medtech to make it aware of the potential misfiling issue.