Te Whatu Ora - Nelson Marlborough
(formerly known as Nelson Marlborough DHB)

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01960)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns a failure to action the necessary follow-up appointment at Te Whatu Ora — Nelson Marlborough (formerly known as Nelson Marlborough District Health Board (NMDHB)).[1] A man underwent surgery to remove a bladder tumour at Nelson Hospital. After the surgery, a postoperative plan was made for the man to have a follow-up consultation with the urologist in 2–3 weeks' time. However, administrative staff at NMDHB failed to action the man's appointment, and, as a result, he did not receive timely management of his care, and his histology results were not communicated to him.

2. Over a year later, the man presented to Nelson Hospital after experiencing discomfort and blood in his urine. During this consultation, it was discovered that NMDHB had failed to book the follow-up appointment after his surgery the previous year. The man underwent further investigations and was diagnosed with terminal bladder cancer. This may have been preventable had the man received timely follow-up and appropriate treatment postoperatively.

Findings

3. The Deputy Commissioner considered that NMDHB did not have in place robust systems to minimise the risk of errors in arranging important follow-up care in accordance with the New Zealand Health and Disability Services Standards. Accordingly, the Deputy Commissioner found NMDHB in breach of Right 4(1) of the Code.

4. The Deputy Commissioner also considered that the results of tumour biopsies was information that a reasonable consumer could expect to receive, and, accordingly, found NMDHB in breach of Right 6(1) of the Code.

Recommendations

5. The Deputy Commissioner recommended that NMDHB provide a written apology to the man for the failings identified in this report; outline the progress that has been made in implementing discharge summaries for all Day Stay Unit patients and the effectiveness of the stickers placed on the patient's chart; and monitor the new system implemented in relation to referrals created in the electronic system, and consider further changes to ensure that patients are informed of the need for a follow-up appointment.

6. The Deputy Commissioner will ask the Ministry of Health to seek confirmation from Health New Zealand of the activities and expected outcomes under the New Zealand Health Plan that will improve electronic booking systems and administrative processes to improve patient outcome by reducing multiple handling of information.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all 20 District Health Boards. Their functions and liabilities were merged into Te Whatu Ora — Health New Zealand. All references in this report to Nelson Marlborough District Health Board (NMDHB) now refer to Te Whatu Ora — Nelson Marlborough.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her father, Mr A, by Nelson Marlborough District Health Board (NMDHB). The following issue was identified for investigation:

- *Whether Nelson Marlborough District Health Board (NMDHB) provided Mr A with an appropriate standard of care in 2019 and 2020.*

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

9. The parties directly involved in the investigation were:

Mr A	Consumer
Ms B	Complainant/daughter
Nelson Marlborough DHB	Provider/district health board

10. Further information was received from:

Medical centre	Primary healthcare service
Dr C	Provider/general practitioner (GP)

11. Urologist Dr D is also mentioned in this report.

Information gathered during investigation

Introduction

12. This report concerns the delayed treatment of muscle-invasive bladder cancer.[2] Mr A was first diagnosed with a non-invasive bladder tumour[3] by urologist Dr D at Nelson Hospital in February 2019. After surgery in March 2019, Mr A did not receive the necessary follow-up with Dr D because administrative staff at NMDHB omitted to make an appointment. Over a year later, the bladder tumour progressed to become muscle-invasive metastatic disease, which may have been preventable had Mr A received timely follow-up and management after surgery.

[2] NMDHB's urology multidisciplinary meeting on 1 September 2020 reviewed Mr A's biopsy and classified the cancer as high-grade urothelial carcinoma in situ of the bladder. By the end of September 2020, this had metastasised and had become life-threatening.
[3] High-grade urothelial carcinoma.

Background

13. Mr A, aged in his early sixties at the time of these events, was an ex-smoker with a medical history that included bleeding in the brain,[4] hypertension, and migraines, for which he took medication.[5]

14. On 11 January 2019, Mr A presented to his general practitioner (GP) regarding blood in his urine[6] and other urinary symptoms.[7] The GP referred Mr A to NMDHB's outpatient urology service on 15 January 2019 and arranged for further testing, including urological imaging (CT-IVU) and urinary cell screening (urinary cytology). The cytology results were reported on 18 January 2019, and showed a high-grade non-invasive tumour on Mr A's bladder. The GP updated the urology service referral with the cytology results, noting that there was now a high suspicion of cancer.

15. On 7 February 2019, Mr A saw urologist Dr D at Nelson Hospital to discuss the cytology and CT-IVU results, and to make a management plan. Dr D documented discussing with Mr A that a tumour had been identified on the right-hand lateral bladder wall and was thought likely to be in the place where it had first formed (carcinoma in situ[8]). A further tumour was identified on the right-hand side in a bulging pouch (diverticulum) on the wall of the bladder.

16. On the same day, Mr A signed a consent form for transurethral resection[9] of the bladder tumour (TURBT[10]). The form recorded the respective risks discussed,[11] including the difficulty in managing the further tumour that had been identified in the bulging pouch on the bladder wall.

Bladder surgery at Nelson Hospital and follow-up appointment not actioned

17. On 13 March 2019, Dr D performed the TURBT on Mr A at Nelson Hospital. A catheter was inserted for urinary drainage, and samples of the tumours were taken and sent for histology (tissue analysis).

18. After the surgery had been completed, the following management plan was recorded for Mr A:

> "1. Discharge today if comfortable. TROC [trial removal of catheter] on Friday [15 March 2019]
>
> 2. Outpatient follow-up in 2–3 weeks to discuss histology with [Dr D]."

[4] A berry aneurysm (a bulge in a blood vessel) and subarachnoid haemorrhage (bleeding on the surface of the brain, usually as a result of pressure causing an artery wall to rupture).
[5] Cilazapril (used to treat high blood pressure and heart failure) and amitriptyline (used to treat migraine, tension headaches, depression, and low mood).
[6] Haematuria. Mr A had noticed this about a month previously but it had not caused him any pain.
[7] Urinating at night (nocturia) 1–2 times and struggling with urgency and frequency.
[8] A group of abnormal cells found only in the place where they first formed in the body.
[9] Resection is the process of surgically removing a tumour from an organ.
[10] A procedure to remove an early cancer in the bladder.
[11] These included bleeding, infection, perforation, and retention following surgery.

19. Dr D's plan for Mr A was recorded by the registrar who assisted him with the surgery. The plan was recorded both in the handwritten clinical notes of the operation and in a dictated note, on the day of the surgery. However, the dictated note was not typed and uploaded to the electronic record until 20 March 2019. NMDHB told HDC that at the time of events, the Day Stay Unit (DSU) did not complete discharge summaries for patients who were discharged on the same day.

20. Mr A told HDC that he was advised that he would be followed up by Nelson Hospital within a few weeks, but he did not receive a discharge summary or information about the surgery following the operation. A urology registrar spoke with Mr A prior to his discharge, but Mr A cannot recall the specific details of the conversation with the registrar.

21. NMDHB told HDC that despite the clear plan set out in Mr A's operation note following the resection surgery, the follow-up appointment with Dr D was never arranged. NMDHB stated that in March 2019, the normal process for the arrangement of outpatient appointments for patients was as follows:

1. The clinician places a patient label on the outside of the patient chart with the postoperative follow-up instructions written on the corner, or on a piece of note paper.
2. The administrative team in the DSU, generally the DSU ward clerk, instructs the urology secretaries via email to arrange for the follow-up appointment for the patient. The email is sent to "Urology Secretaries Inbox".
3. The urology secretary books the appointment in NMDHB's patient management system (SIPICS).
4. If there is no follow-up requested, the referral is closed and the patient is discharged from the SIPICS as there is no further action required.

22. In light of the complaint raised by Mr A, NMDHB conducted an internal investigation into why the follow-up appointment was not made after the TURBT surgery. It was initially unclear to NMDHB whether the DSU staff had failed to notify the urology secretary, or whether the urology secretary had failed to make the appointment.

23. After reviewing the email correspondence, NMDHB was not able to locate an email in the urology secretaries inbox for the outpatient appointment for Mr A. NMDHB told HDC that it was therefore reasonable to assume that the DSU staff did not send the appropriate email.

24. NMDHB further explained to HDC:

> "DSU clerks often review the notes to check if post-op follow-up instructions are recorded in the notes, however, because in this case the instructions were in the operation note (discharge summary), which was dictated and not yet typed and approved by the author (approval occurred 20 March 2019) there would have been no documentation to this effect in the clinical record."

25. NMDHB confirmed that the instructions for the postoperative follow-up were also documented in the handwritten procedure note by the urology registrar and added to Mr A's clinical file.

26. NMDHB gave HDC a copy of the handwritten note that was given to the urology secretary instructing administrative staff to book Mr A for the follow-up TROC consultation on 15 February 2019. However, NMDHB was unable to locate a copy of the patient label showing postoperative instructions for the follow-up appointment. NMDHB stated that its internal review also was unable to establish whether the handwritten procedure note was seen by administrative staff.

27. NMDHB told HDC that at the time of events, usually the urology secretary did a second check of the documentation prior to discharging the patient from the SIPICS system. However, in Mr A's case, the operation note had yet to be added to the system, and there was no discharge summary from the DSU.

Follow-up care provided in 2019

28. Mr A returned to Nelson Hospital on 15 March 2019 for the TROC appointment. The clinical notes document that the catheter was removed successfully and the trial without a catheter (trial of void)[12] was explained to Mr A. There is no record in the clinical notes of any discussion about a follow-up appointment in two to three weeks' time.

29. Mr A's histology was reported on 18 March 2019, and indicated that his bladder tumours were cancerous and were likely to grow rapidly and spread. NMDHB told HDC that Mr A's histology results were to be discussed at the follow-up appointment, but this did not occur.

30. Mr A told HDC that he was not told that he was to have a follow-up appointment with the consultant. However, he stated that he thought that the TROC was not the final appointment, and that he might need to be seen again for a follow-up, but he assumed that he would be contacted if necessary and would receive an appointment card as he had done in the past. Mr A said that because he did not receive an appointment card, he thought that everything must be "OK", as he had trust in the system.

12 April 2019 — GP review

31. Mr A saw Dr C on 12 April 2019 for a post-operation assessment. Dr C's consultation notes document that Mr A looked well, with his urination having "good flow but some second emptying 2–3 minutes later, no incontinence". The notes also document that Mr A was expected to see Dr D: "P[atient to] see specialist."

Re-presentation to GP in 2020 and subsequent escalation of care

32. On 30 April 2020, Mr A reported to the medical centre for noticeable blood in his urine, and "occasional discomfort" when urinating. Due to the COVID-19 lockdown, a telephone

[12] A trial of void determines whether the patient can pass urine normally when the catheter is removed.

consultation with his GP was arranged, and Mr A was asked to take a sample of his urine to the medical centre for further testing.

33. Mr A had a telephone consultation with Dr C on 1 May 2020. The consultation notes record that for several months Mr A had been experiencing recurring symptoms, including small amounts of blood in his urine, ongoing ache, and a sense that his bladder was not emptying completely. Mr A reported that despite these symptoms, he was feeling well and felt that his blood pressure had "normalised" after quitting his job. It was documented that as a result, he had decided to stop taking his blood pressure medication.

34. Dr C told HDC that following this consultation, a referral to the urologist was arranged.

35. On 21 May 2020, Mr A presented to Dr D's urology registrar at Nelson Hospital. The registrar acknowledged in the clinical notes that Mr A did not receive his follow-up appointment from March 2019. Specifically, it was documented:

> "Unfortunately, it sounds like [Mr A] was lost to follow up after his TURBT in March 2019. He was due for follow up 2–3 weeks after that operation but this never eventuated. This is particularly unfortunate in [Mr A's] case because he has high risk non-muscle invasive bladder cancer that may have been appropriate for BCG immunotherapy[13] as an adjunctive treatment to the TURBT. I have explained this to [Mr A] today, who was exceptionally understanding of this."

36. During the consultation, the registrar examined Mr A's bladder further with a cystoscope.[14] The examination showed extensive abnormalities of Mr A's bladder wall and prostatic urethra.[15] Mr A was booked for urgent TURBT re-resection surgery.

37. Mr A underwent further investigations and was diagnosed with high-grade muscle-invasive bladder cancer. He commenced chemotherapy in September 2020.

Further information

Mr A

38. Mr A and his family told HDC that in June 2021, after Mr A had his bladder removed, the cancer had advanced and spread to his lymph nodes. This was diagnosed as incurable and terminal.

NMDHB

39. NMDHB acknowledged that it had "clearly failed to deliver appropriate follow-up care to [Mr A] following his 13th March 2019 procedure in that [NMDHB] failed to make an outpatient appointment".

40. NMDHB told HDC that it sincerely apologises to Mr A and his whānau for the "harm and trauma" caused by the DHB's failure to provide appropriate and timely care. NMDHB stated:

[13] Treatment of the disease by activating or suppressing the immune system.
[14] A thin tube with a camera and light on the end.
[15] The part of the urethra that passes through the prostate.

> "We believe that had there been a discharge summary completed in DSU, prior to [Mr A] being discharged, then [Mr A] would have had written 'take home' record of the need for a follow-up appointment, the GP would have had a real time copy and knowledge of the same (rather than receipt of the Operation Note some days later) and there would have been additional clinical documentation indicating the follow-up requirements in the clinical notes. The Urology Secretary would then have been able to see the need for a follow up appointment in several places prior to closing SIPICS entry for that referral. NMH will move towards implementing discharge summaries for all DSU patients being discharged."

Serious Adverse Event Review

41. A Serious Adverse Event Review (SAER)[16] identified that the DSU ward clerk did not notify the urology secretary to book the follow-up appointment for Mr A. However, the appointment on 15 March 2019 for the removal of his catheter was booked with the instructions completed for the urology secretary.

42. The SAER also identified that the following factors contributed to the error:

- On the day, multiple changing staff, including a locum radiologist, provided care to Mr A, which meant that the "processes felt not tight enough".
- Mr A had assumed that the TROC appointment on 15 March 2019 was the final appointment, and he was not aware of the need to have further follow-up, hence he did not "chase" the appointment himself.[17]
- The GP failed to identify that the two- to three-week follow-up appointment had not been arranged.[18]

Dr D

43. Dr D told HDC that after the surgery was completed on 13 March 2019, the instruction to arrange a follow-up appointment was recorded by the registrar both in the immediate postoperative (handwritten) note and also in the dictated operation note.

44. Dr D stated:

> "I would expect that my follow-up appointments are scheduled according to the written order (in the immediate operative note or the clinic follow up order form) which is also

[16] A Serious Adverse Event Review is a review of an event that has led to significant additional treatment, been life threatening, or has led to unexpected death or a major loss of function for the patient. DHBs are required to review these events and report them to the Health Quality & Safety Commission.

[17] As set out above, Mr A told HDC that he never presumed that the TROC was the final appointment. Rather, he thought he might need to be seen again for a follow-up but expected to be contacted and to receive an appointment card as he had done in the past. Mr A stated that given that he never received an appointment card, he thought that everything must be OK, as he had trust in the system.

[18] HDC obtained in-house GP advice about the standard of care provided by this GP. The advice was that Mr A's GP's actions were reasonable, and the GP would not be expected to have in place processes to track completion of management plans that originated in secondary care (unless explicitly requested to do so). As a result, HDC took no further action in respect of this aspect of Mr A's care.

duplicated and requested in the dictated operative or procedure note. This was my expectation in March of 2019 and currently remains the expectation."

ACC

45. ACC accepted Mr A's claim for a treatment injury, as the delayed diagnosis prevented Mr A from receiving appropriate and timely immunotherapy treatment after the surgery in March 2019. Dr D explained to ACC that approximately 70% of patients will respond to immunotherapy and would need no further treatment.

46. In his report to ACC, Dr D stated that Mr A's treatment "has been compromised as a result of him being lost to follow-up", and he "has a much worse chance at survival even if he comes forward for cystectomy".

Responses to provisional decision

47. Mr A and Ms B were provided with an opportunity to comment on the relevant sections of the provisional opinion. Ms B told HDC that her father thought he would be followed up by the doctors only if he required further treatment, as he assumed "silence was good news and no need for further treatment".

48. Although it was documented that Mr A appeared to be "exceptionally understanding" of the missed follow-up appointment, Ms B told HDC that, in fact, her father felt "extremely disappointed and let down by the system". Ms B stated:

> "As you can imagine going from a 70% chance of needing no further treatment to a terminal diagnosis with a 2 year survival rate. This 'mishap' has cost my father many good years on his life and is completely reprehensible."

49. NMDHB was provided with an opportunity to comment on the provisional opinion, and it had no further comments.

Opinion: Nelson Marlborough District Health Board — breach

Background

Introduction

50. On 13 March 2019, Mr A underwent TURBT surgery at Nelson Hospital. Dr D performed the surgery with the assistance of a urology registrar. During the surgery, samples of bladder tumours were taken and sent for histology, and a catheter was inserted to drain the bladder.

51. After the surgery, Dr D made a postoperative plan to discharge Mr A on the same day if he felt comfortable. Dr D also planned for Mr A to re-present on 15 March 2019 for a TROC, and for Mr A to have a follow-up consultation with him in 2–3 weeks' time to discuss the histology of the tumour samples.

52. The postoperative plan was recorded by Dr D's registrar in two ways. The first was a handwritten clinical note on the day of the surgery. This record was contained in the body of Mr A's handwritten clinical notes. Secondly, the registrar dictated a note, also on 13 March 2019, but this was not typed and uploaded to the electronic record until 20 March 2019.

53. A follow-up appointment for the TROC was booked for 15 March 2019, and the histology review of Mr A's tumours was completed on 18 March 2019. The histology report showed that Mr A had high-grade papillary urothelial carcinoma — cancerous bladder tumours that grow quickly and are likely to spread. Mr A was not informed of the histology results at the time, as the plan was for Dr D to discuss the findings at the outpatient consultation planned for 2–3 weeks post-surgery. However, no appointment was made for this consultation and, accordingly, the histology results were not communicated to Mr A.

54. Mr A told HDC that he was never told that he was to have a follow-up appointment with Dr D post-surgery. Mr A said that whilst he thought he might need to be seen again, he had trust in the system, and thought that if he needed to be followed up, he would receive an appointment card as he had done in the past. As he received no such notice, he thought that everything must be OK.

55. Over a year later, on 21 May 2020, Mr A presented to a urology registrar at Nelson Hospital because he had been experiencing discomfort and had blood in his urine. During the consultation, it was discovered that no follow-up appointment with Dr D had been booked. Sadly, after further investigations, Mr A was diagnosed with high-grade muscle-invasive bladder cancer, which is now terminal.

DSU procedures at the time of events (March 2019)

56. The usual practice for booking postoperative outpatient urology appointments at the time of these events was for clinicians to place a patient label on the outside of the chart with postoperative follow-up instructions written on the corner or on a piece of note paper. The DSU administrative team would then email the urology secretaries at the "Urology Secretaries Inbox" with the postoperative instructions. The urology secretaries would then arrange for the appointment in the patient management system (SIPICS). If no follow-up was requested, then the referral would be closed and the patient would be discharged from the SIPICS. NMDHB stated that in addition to the above procedure, the DSU clerks often reviewed the patient's clinical notes to check whether postoperative follow-up instructions had been recorded in the notes.

How the error occurred

57. NMDHB told HDC that initially it was unclear whether the DSU ward clerk had failed to email the urology secretaries, or if the secretaries had failed to book the appointment. Upon further investigation, NMDHB could not locate an email in the secretaries' inbox requesting an appointment, and therefore NMDHB considers it reasonable to assume that the DSU staff did not send the appropriate email.

58. NMDHB told HDC that it was unable to establish whether the handwritten procedure note containing the follow-up plan was seen by the administrative staff. NMDHB was also unable to locate copy of the patient label showing postoperative instructions for the follow-up appointment with Dr D. The DHB further commented that at the time of these events, usually a second check was undertaken by the urology secretary prior to discharging a patient from the SIPICS system. However, in Mr A's case, as the electronic version of the operation note had yet to be added to the system, and because the DSU did not complete discharge summaries at the time of these events, there was no electronic documentation recording the postoperative instructions, with the consequence that Mr A was discharged without a follow-up appointment being made.

Failure to deliver appropriate follow-up care — breach

59. It is the responsibility of healthcare providers, such as NMDHB, to ensure that there are robust systems in place to minimise the risk of errors in arranging important follow-up care. Standard 3.3 of the New Zealand Health and Disability Services (CORE) Standards[19] states that each stage or service provision (assessment, planning, provision, evaluation, review, and exit) is to be provided within time frames that safely meet the needs of the consumer.

60. NMDHB has accepted that it "clearly failed" to deliver appropriate follow-up care to Mr A after his 13 March 2019 procedure by failing to make an outpatient appointment with Dr D. I agree and am critical that NMDHB's outpatient booking system was not sufficiently robust to ensure that Mr A received a follow-up appointment with Dr D within 2–3 weeks of his surgery. I note that Dr D's follow-up plan was recorded contemporaneously by handwritten clinical note, yet NMDHB's system was unable to identify this important information.

61. NMDHB told HDC that it believes that had a discharge summary been completed prior to Mr A being discharged, he would have had a "take home" record of the need for a follow-up appointment. The discharge summary also would have provided another place for the urology secretaries to identify the need for a follow-up appointment prior to closing off Mr A in its patient management system. NMDHB stated that it is in the process of implementing discharge summaries for all DSU patients.

62. I agree that a discharge summary would have assisted the relevant administrative staff to identify Dr D's follow-up instructions, as the summary would have provided a contemporaneous electronic record for staff to refer to. Had the urology service been in the practice of issuing discharge summaries at the time of these events, it is likely that the failure to book an appointment with Dr D would not have occurred.

63. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. NMDHB clearly failed to provide Mr A services with reasonable care and skill when its staff did not arrange a follow-up appointment with Dr D. Accordingly, I find that NMDHB breached Right 4(1) of the Code.

[19] NZS 8134:2008, see Appendix A.

Failure to inform Mr A of histology results — breach

64. I am also critical that Mr A was not notified about his histology results reported on 18 March 2019, which contained serious findings of fast-spreading cancerous tumours. Upon review of the evidence before me, including the fact that Dr D had made a clear contemporaneous plan to discuss the results, I consider that the failure to notify Mr A of the histology results was a systems failure. Had the follow-up appointment been booked by NMDHB's administrative staff, Mr A would have been informed of the results. That said, I remind Dr D of the importance of ensuring that he discusses histology results with his patients, particularly when significant clinical findings are reported.

65. Right 6(1) of the Code states that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including the results of tests and procedures. I consider that a reasonable consumer in Mr A's circumstances would expect to receive the results of his tumour biopsies. Accordingly, NMDHB's failure to ensure that Mr A was informed of these results constitutes a breach of Right 6(1).

Changes made at NMDHB

66. As a result of the events in this case, NMDHB made the following changes:

- Implemented a sticker for patient charts to convey Day Stay Discharge[20] information. The sticker has a tick box for noting if follow-up appointments are required, and a space for the date of the follow-up to be recorded. The sticker is completed by the clinician and fixed to the patient's chart. The DSU clerk then conveys the information by email to the secretarial inbox of the respective departments.
- Reviewed policies, procedures, and guidelines to ensure that they are adequate to prevent patients falling through the gaps. NMDHB confirmed that its policies, procedures, and guidelines have been updated to reflect the change in use of the new sticker.
- Began the process of implementing discharge summaries for all DSU patients.
- Implemented the "scOPe" software, which will allow clinicians to complete electronic operation notes that are automatically uploaded to the clinical record. This directly notifies the respective secretaries of the need for follow-up. NMDHB confirmed that the service upgrade was completed on 30 December 2021 with all services onboard.
- Ward clerks now check all DSU patients' notes for follow-up and then email the secretaries to ensure that follow-up is arranged.

[20] As opposed to overnight stay.

Recommendations

67. In light of the changes already made by NMDHB, I recommend that NMDHB:

a) Within three weeks of the date of this report, provide a written apology to Mr A for the failings identified in this report.

b) Outline the progress that has been made in implementing discharge summaries for all DSU patients and the effectiveness of the stickers placed on the patient's chart.

c) Monitor the new parts of the system that are automated, i.e., the scOPe system (where referrals are created in the patient portal and, when completed, are automatically sent to the requested service or department administrator to book the appointment) to test the efficiency.

d) Consider what further improvements could be made to its systems to ensure that patients are informed and understand that they will need to return for a follow-up appointment when this is the case.

68. NMDHB is to report back to HDC on the progress of recommendations b) to d) within six months of the date of this report.

Follow-up actions

69. A copy of this report with details identifying the parties removed, except Nelson Marlborough District Health Board and Nelson Hospital, will be sent to the Health Quality & Safety Commission, Te Aho o Te Kahu — Cancer Control Agency, and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

70. Further, I request that the Ministry of Health seek confirmation from Health New Zealand of the activities and expected outcomes under the New Zealand Health Plan that will improve electronic bookings systems and administrative processes to improve patient safety by reducing the multiple handling of information.

Appendix A: New Zealand Health and Disability CORE standards

Standard 3.3 of the Service Provisions Requirements (Ngā Whakaritenga Whakaratonga) of the NZS 8134.1.3:2008 states:[1]

"**Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

3.3.2 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.

3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

3.3.5 *The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.*

3.3.6 *The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.*

This shall include, but is not limited to;

(a) Consumer support group referrals;

(b) Education programmes;

(c) Consultation and liaison with community groups or relevant self-help groups."

[1] New Zealand Health and Disability Services (CORE) Standards (NZS 8134:2008). The Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 will come into effect on 28 February 2022 and supersede the NZS 8134:2008.