Health New Zealand | Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral

Nurse Practitioner, NP B

Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC01999)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by Health New Zealand|Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral (Health NZ MidCentral)) and a nurse practitioner at a medical centre. This case highlights the importance of robust and transparent systems for managing and tracking referrals to ensure timely patient care.

2. The woman was referred to Health NZ MidCentral for investigation of rectal bleeding to rule out malignancy, and an appointment was anticipated within six to eight weeks. The referral did not document whether an internal digital rectal examination (DRE) was undertaken. An error with the internal referral at Health NZ MidCentral meant that the referral was not actioned, and this resulted in a delay.

3. Seven weeks after the referral, the referring nurse practitioner contacted Health NZ MidCentral and was assured that the referral was progressing; however, this was incorrect. The nurse practitioner made a second referral to Health NZ MidCentral 13 weeks after the first referral. However, the second referral did not convey urgency in terms of the original delay and in respect of the ongoing symptoms. The woman received her colonoscopy 18 weeks after her first referral and was diagnosed with rectal cancer.

Findings

4. The Deputy Commissioner considered that Health NZ MidCentral did not have robust processes in place for managing referrals and for identifying when referrals were not progressing. The Deputy Commissioner found Health NZ in breach of Right 4(1) of the Code.

5. The Deputy Commissioner also found Health NZ in breach of Right 4(5) of the Code by not providing the nurse practitioner with accurate information about the stalled referral, which resulted in further delay.

6. The Deputy Commissioner criticised the nurse practitioner's failure to document DRE findings at the time of the referral and commented that ideally providers should indicate the urgency of a referral.

Recommendations

7. The Deputy Commissioner recommended that Health NZ MidCentral provide an apology and report back to HDC on the implementation of the e-referral and triage system approved to replace the paper-based referral process; consider developing a live auditing system (while waiting for the electronic system to be implemented); and consider opportunities to document all calls to the booking office regarding referral progress to identify and escalate concerns from providers and consumers. Health NZ MidCentral was also asked to provide a progress update to HDC on the working group established to look at the referral and prioritisation procedure and the transfer of a referral between specialties; and to consider whether it would be appropriate to review and localise Community HealthPathways information relating to referrals from primary to secondary care.

8. The Deputy Commissioner recommended that the nurse practitioner review current information regarding the referral of patients with features suggestive of bowel cancer, lead a peer group discussion on this topic, and report back to HDC with a reflection.

9. The Deputy Commissioner recommended that the medical centre consider the process for identifying urgent tasks for follow-up and whether these could be undertaken by a resource staff member rather than waiting for a particular staff member to return to work.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Mr A about Mrs A's referral for a colonoscopy[1] by Health New Zealand|Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral[2] (Health NZ MidCentral). The investigation was extended to include the nurse practitioner at the medical centre. The following issues were identified for investigation:

- *Whether Health NZ MidCentral provided Mrs A with an appropriate standard of care between 18 June 2020 and 28 October 2020 (inclusive).*
- *Whether Nurse Practitioner B provided Mrs A with an appropriate standard of care between 15 June 2020 and 28 October 2020 (inclusive).*
- *Whether the medical centre provided Mrs A with an appropriate standard of care between 15 June 2020 and 28 October 2020 (inclusive).*

11. This report is the opinion of Deputy Commissioner Deborah James and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr A	Complainant
Health NZ MidCentral	Group provider
Nurse Practitioner (NP) B	Provider
Medical centre	Provider

13. Gastroenterologist Dr C is also mentioned in the report.

[1] An examination of the inside of the large intestine (the colon, rectum, and anus).
[2] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand (now Health NZ). All references to MidCentral District Health Board in this report now refer to Health NZ MidCentral.

14. In-house clinical advice was obtained from general practitioner (GP) Dr David Maplesden (Appendix A). Independent clinical advice was obtained from NP Rosemary Minto (Appendix B).

Information gathered during investigation

Background

15. Mrs A attended a medical centre on 15 June 2020 with bowel changes and was referred to Health NZ MidCentral on 18 June 2020 for further investigation to rule out malignancy. Regrettably, due to issues processing the referral, Mrs A was not seen for a colonoscopy until 28 October 2020 (132 days after the referral was received), when she was diagnosed with adenocarcinoma.[3]

Brief sequence of referral progress

15 June 2020	Mrs A was assessed by NP B at the medical centre.
18 June 2020	NP B received Mrs A's test results and spoke with her. Referral sent to General Surgery to rule out malignancy: — Health NZ MidCentral sent automated acknowledgment that referral was received. General Surgery triaged and redirected the referral to the Gastroenterology Department.
2–3 July 2020	Referral triaged by Gastroenterology in a non-contact/virtual clinic: — Internal referral letter dictated to General Surgery requested for Mrs A to be seen in the General Surgery Clinic with rectal outlet symptoms. — Letter inadvertently sent to the wrong clinician for review and signing, and no action was taken.
23 July 2020	Health NZ MidCentral closed the referral of 18 June 2020 as a 'non-contact closure'.
31 July 2020 (approx.)	Mrs A contacted Health NZ MidCentral booking office and was told she had been referred back to her GP. Mrs A contacted the medical centre on 31 July 2020.
10 August 2020	NP B contacted Health NZ MidCentral booking office and was told that the referral was still in the system, waiting to be seen.
7 September 2020	NP B sent a second referral to General Surgery.

[3] A type of cancer that starts in the mucus-producing glands.

14 September 2020	Referral triaged by Gastroenterology as semi-urgent and placed on endoscopy list. Mrs A was contacted for an appointment.
23 October 2020	Colonoscopy procedure performed.

Appointment 15 June 2020

16. On 15 June 2020, Mrs A (who was aged in her late forties at the time) attended the medical centre with a three-month history of occasional abdominal pain and rectal bleeding. She was seen by NP B, who documented that Mrs A was experiencing a change in bowel habit, bleeding when passing a motion, and rectal pain/discomfort. Mrs A had a medical history of epilepsy,[4] cervical dysplasia,[5] pelvic organ prolapse surgery in 2008 and 2016, and depression. At the 15 June 2020 appointment, '[n]o obvious external haemorrhoids[6]' were noted.

17. Blood tests and faecal occult blood (FOB) testing[7] were arranged. NP B stated that FOB tests were standard practice for patients who presented with overt rectal bleeding, and these tests were ordered to confirm the bleeding described by Mrs A.

18. The medical centre told HDC that NP B explained that a physical examination of the abdomen and inspection for haemorrhoids would be indicated for a consumer presenting with rectal bleeding and a change in bowel habit. It was documented that Mrs A had slight abdominal tenderness, and that a visual rectal inspection did not identify any obvious external haemorrhoids.

19. NP B told HDC that a digital rectal examination (DRE)[8] would be performed as part of her standard assessment of someone with Mrs A's symptoms. However, a DRE and discussion of family history is not documented in the clinical notes or in the referral.

First referral 18 June 2020

20. Mrs A's test results were returned on 17 June 2020. She was contacted by NP B on 18 June 2020 to discuss her blood and FOB test results, and to gain consent for a referral to secondary care for investigation. Following this discussion, NP B made a referral to Health NZ MidCentral Surgical Outpatients on 18 June 2020, requesting an appointment for Mrs A 'who presents with a history of altered bowel habit, blood noticed when passing stool and low ferritin to rule out malignancy'.

21. No urgency was specified for the referral, but NP B told HDC that the referral requested review of the possibility of malignancy. The referral contained information about Mrs A's

[4] A brain disorder characterised by repeated seizures.
[5] Abnormal or pre-cancerous cells in and around a woman's cervix.
[6] Swollen, enlarged veins around the anus and lower rectum.
[7] A test to check for the presence of blood in the faeces.
[8] A digital rectal examination (DRE) is an examination of the rectum (back passage) in which the health provider feels for lumps, swelling or bleeding inside the patient's rectum using a gloved finger.

medical history, relevant notes, and investigation findings, including red flags of altered bowel habit and rectal bleeding, to enable Health NZ MidCentral to identify the level of urgency. However, the referral did not contain details about any DRE having been undertaken. The medical centre said that it had been informed that Health NZ MidCentral would make its own clinical assessment regarding the priority of a referral.

22. In response to the provisional opinion, NP B told HDC that Health NZ MidCentral acknowledged receipt of the referral of 18 June 2020, and she did not hear any further from it, which was consistent with her experience with other referrals.

23. Mr and Mrs A told HDC that they were informed by NP B that Mrs A would be seen by the hospital within six weeks. NP B noted that there were no written guidelines on how long a referral would take, and that delays occurred often, but it was her expectation that Mrs A would be seen within six to eight weeks. A task was generated automatically for the practice to follow up on the referral in a fortnight.

24. Two weeks later, on 29 June 2020, NP B texted Mrs A to advise that the referral had been sent and to ask whether she would like to attend a follow-up appointment that day. NP B told HDC that Mrs A declined the appointment at that stage and informed the practice that she was still waiting to hear from Health NZ MidCentral.

Health NZ MidCentral management of first referral

General Surgery

25. Health NZ MidCentral told HDC that the referral was received electronically by the Central Referrals Office on 18 June 2020, and that Mrs A's GP received an automated email acknowledging receipt of the referral.

26. The referral was addressed to the General Surgery Department and triaged by a surgeon who considered that Mrs A might need a colonoscopy and redirected the referral to the Gastroenterology Department on Friday 26 June 2020.

Gastroenterology

27. The Gastroenterology response to the referral was to provide non-contact advice. Health NZ MidCentral explained that '[a]dvice given constitutes a non-contact or virtual appointment', and in this case the advice given was a referral back to the General Surgery team.

28. Gastroenterologist Dr C reviewed the referral on 2 July 2020 and noted that the referral information 'sounded like outlet bleeding[9]', which required a surgical opinion. Dr C dictated an internal referral letter for Mrs A to be assessed for 'rectal outlet symptoms' and noted that she could be referred back to the Gastroenterology Department if there was any suggestion of pathology further up her colon.

[9] The presence of bright red blood during or after passing a bowel motion.

29. Health NZ MidCentral told HDC that consumers who have 'per rectum bleeding'[10] and are assessed as low probability of bowel cancer, such as people with outlet-type bleeding and those who are younger, are referred to the General Surgery team. Health NZ MidCentral conducted a Root Cause Analysis[11] investigation into the delay in Mrs A's care, which concluded that based on the information available to the gastroenterologist, the decision to triage to General Surgery was appropriate.

30. Dr C told HDC that referrals from primary care may be transferred to a different specialty by either writing on the paper referral and passing it on, or by dictating a letter to the other specialty explaining why it is considered that the referral would be best managed by the other specialty. Dr C noted that both referral transfer processes contain some risk that an error may occur, but he considered an internal letter to be preferable when the reason for the transfer needed to be made clear. He said that in this case, his dictated letter acted as an internal referral, and the original referral was closed because having two referrals open for the same patient event is problematic.

31. Dr C's internal referral letter dictation was received by a medical secretary for transcription, with a request for copies to be sent to the General Surgery Clinic, Mrs A, her GP, and the referring clinician, NP B. The letter was typed on 3 July 2020, and was intended to be emailed back to Dr C for signing. However, erroneously it was emailed to a different clinician in the Gastroenterology Department. The receiving clinician inadvertently marked the email as read and did not take any further action on it.

32. NP B's referral for Mrs A was closed on 23 July 2020 following transcription of the non-contact letter. However, Mrs A and NP B were not informed of the referral outcome during the time Dr C's transcribed letter remained unactioned in another clinician's email inbox.

Referral follow-up

33. Mr A told HDC that Mrs A contacted Palmerston North Hospital by telephone regarding her referral, and 'was told [she] had been referred back to her [doctor]'. She telephoned the medical centre on Friday 31 July 2020 to raise concerns about progress of the referral. This contact is documented in the medical centre's clinical record as:

> 'P[atien]t concerned by phone contact she had with [Palmerston North Hospital] — was told that the referral sent by [NP B] was a "non-closure contact [sic]". Wants to know what happens now and if she is going to get a colonoscopy. Symptoms persist unchanged.'

34. A task was generated for NP B to follow up on the referral, and Mrs A was given advice to contact the medical centre if her condition became worse.

35. NP B worked at the medical centre only on Mondays. She told HDC that the task system is inappropriate for urgent clinical matters, as tasks do not generate an automatic notification.

[10] Bleeding from the anus or rectum.
[11] The process of investigating the root causes of problems to identify appropriate solutions.

She said that she had a full day[12] seeing patients on Monday 3 August 2020 and cannot recall whether she checked her tasks in the practice's computer system that day. She attended to Mrs A's task on Monday 10 August 2020 when she was next at the medical centre. NP B documented her telephone contact with the bookings clerk at Health NZ MidCentral on 10 August 2020 and noted her understanding that Mrs A was 'still in the system awaiting to be seen'.

36. Health NZ MidCentral told HDC that it has no referral activity on record for Mrs A during this time, and it cannot comment on NP B's contact with the booking office.

37. The medical centre told HDC that NP B was assured that Mrs A could expect to be contacted within a fortnight, and NP B felt reassured that this was a reasonable time frame. Mrs A was informed of this, and a plan was documented in the medical centre notes for a further consultation on 7 September 2020 to check on the referral progress, and to send a further letter to Health NZ MidCentral if there had been no response regarding a specialist appointment.

Second referral 7 September

38. On 7 September 2020, NP B returned from annual leave and spoke with Mrs A. NP B documented that Mrs A was still experiencing symptoms and had not received any information about a Surgical Outpatients appointment. No physical assessment is recorded as having occurred at this appointment but repeat blood tests were arranged by NP B. Mrs A was contacted about the blood test results, which showed that she had a low iron level.

39. NP B sent a second referral to Surgical Outpatients dated 7 September 2020 noting that this was a second referral, and that Mrs A was continuing to experience bleeding and a change in bowel habit and had commenced Floradix (an iron tonic) because of increasing lethargy and tiredness. The referral contained investigation results and clinical notes, including information about the first referral on 18 June 2020 and Mrs A's telephone follow-up with Palmerston North Hospital and the medical centre on 31 July 2020 and the follow-up telephone call to the booking office. No urgency was specified in the referral.

Health NZ MidCentral management of second referral

40. The second referral was addressed to Surgical Outpatients on 7 September 2020 and was received electronically by the Central Referrals Office on the same day. On 14 September 2020, the referral was triaged by a gastroenterologist/endoscopist as 'semi urgent (soon)'. Referrals for a colonoscopy triaged as semi-urgent are to be seen within six weeks.[13]

41. Health NZ MidCentral advised that semi-urgent colonoscopies are booked 6–7 weeks in advance to ensure that consumers have adequate notice and have received instructions and preparation prior to the procedure. This also allows the service to maximise the available

[12] In response to the provisional opinion, NP B told HDC that she had '14 patient appointments booked that day and saw a total of 21 patients. [She] also attended to other clinical work, meetings and other tasks.'

[13] The Ministry of Health's 'Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography' 2019 (discussed in more detail below) stipulates that if a patient meets the referral criteria, semi-urgent referrals are to be seen within a six-week timeframe.

capacity within the specialty. Health NZ MidCentral told HDC that Mrs A would have received a telephone call after the second referral, as this was triaged and booked within a week, and no acknowledgment letter is sent when booking short time frames.

42. Health NZ MidCentral told HDC that there was no progression of Mrs A's first referral until the second referral was received. Dr C's dictated letter was sent to General Surgery on 30 September 2020 (which was 12 weeks after the first referral was received, and 3 weeks after the second referral was received) and triaged as semi-urgent on 30 September 2020. However, by this stage the second referral had been triaged and Mrs A was already on the list for a colonoscopy.

43. The medical centre told HDC that on 30 September 2020, the medical centre received Dr C's letter about the first referral, and this letter was dated 3 July 2020.

Colonoscopy

44. Mrs A's colonoscopy took place at Palmerston North Hospital on 28 October 2020. This was seven weeks after the second referral of 7 September 2020, and 18 weeks after the first referral on 18 June 2020. Prior to the colonoscopy procedure, the surgeon performed a DRE and could feel a mass approximately 5cm from the anal verge. Mrs A was later diagnosed with rectal cancer.

Referral timeframes

45. In accordance with the 'Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography[14]' (2019), the **two-week** referral criteria includes:

- Known or suspected CRC[15] (on imaging, or palpable, or visible on rectal examination), for preoperative procedure to rule out synchronous pathology
- Unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin below the local reference range)
- Altered bowel habit (looser and/or more frequent) six weeks' duration plus unexplained rectal bleeding (benign anal causes treated or excluded) aged 50 years or older.

46. The **six-week** referral category includes:

- Altered bowel habit (looser and/or more frequent) > six weeks' duration, aged ≥50 years
- Altered bowel habit (looser and/or more frequent) > six weeks' duration plus unexplained rectal bleeding (benign anal causes[16] treated or excluded), aged 40–50 years

[14] A radiological examination of the large intestine.
[15] Colorectal cancer.
[16] The 'Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography' (2019) defines 'benign anal causes' as 'haemorrhoids, anal fissure, anal fistula, inflammatory bowel disease, radiation proctitis, and mucosal or full thickness rectal prolapse' and states: 'If no benign anal cause is identified or bleeding continues after the treatment of these, benign causes can be excluded.'

- Unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥50 years
- Unexplained iron deficiency anaemia (haemoglobin below local reference range) (see Comments for Services section items 1 and 2)
- New Zealand Guidelines Group (NZGG) Category 2 family history plus one or more of altered bowel habit (looser and/or more frequent) > six weeks' duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥40 years
- NZGG Category 3 family history plus one or more of altered bowel habit (looser and/or more frequent) > six weeks' duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥25 years
- Suspected/assessment inflammatory bowel disease (consider FSA)
- Imaging reveals polyp >5 mm.

Health NZ MidCentral referral processes

47. Health NZ MidCentral told HDC that the Gastroenterology triage system is mainly paper based with referrals passed from central processing to Gastroenterology administration, then forwarded to the responsible consultant and then back to Gastroenterology administration. Within this process there is potential for referrals to be misplaced, and it may be difficult to identify where a step did not occur as it ought.

48. At the time of the error with Mrs A's referral there was no reporting of draft letter wait times that would have identified referral letters that had not been finalised in a timely manner. However, since this event, a report of all draft letter wait times has been run, and a report is run from the electronic patient administration system (WebPAS) to identify electronic referrals that have been waiting for more than three weeks to be triaged.[17] The Gastroenterology Department told HDC that it is 'extremely keen' to move to an electronic triaging system.

Further information

Health NZ MidCentral

49. Health NZ MidCentral acknowledged that Mrs A's internal referral letter to General Surgery was inadvertently emailed to another clinician, and this caused a delay in Mrs A receiving an appointment. Health NZ MidCentral told HDC:

> '[Health NZ MidCentral] unreservedly apologises for the delay for [Mrs A] to receive treatment. We understand that this will add significant distress to what is already a distressing and anxious time for the family.'

[17] This report will not identify delays with referrals that have not been entered into WebPAS.

Health NZ MidCentral Root Cause Analysis

50. Health NZ MidCentral undertook a Root Cause Analysis into the delay in Mrs A's care, with an initial severity assessment code (SAC) rating of 2.[18] The Root Cause Analysis identified the following causal factors as having contributed to the delay in Mrs A's diagnosis:

- No DRE had been documented on Mrs A's first referral. There was a concern that this assessment may have informed the triage decision between Gastroenterology and Surgical Outpatients;
- The referral letter was sent from the referring gastroenterologist to another gastroenterologist by email; and
- The receiving gastroenterologist did not pick up that he had been sent a referral in error.

51. The Root Cause Analysis identified human error as the cause for the referral being misdirected. In 2021, the Chief Medical Officer and the Clinical Lead of Gastroenterology met to discuss ways to improve the workload for Gastroenterology senior medical officers. The incident also highlighted risks inherent in the paper referral process in place, and the use of email for keeping track of correspondence.

52. Health NZ MidCentral told HDC that it shared a synopsis of the Root Cause Analysis with the medical centre and THINK Hauora — HealthPathways[19] for discussion with their clinical teams.

Medical centre

53. The medical centre noted that a DRE would not have mitigated the referral being mismanaged by secondary care. The medical centre considers that the referral 'red flagged' the need to rule out malignancy and contained sufficient information to be prioritised as a six-week wait. The medical centre also noted that the HealthPathways information about referrals for patients with colorectal symptoms was not specific to the MidCentral area at that time, and referral pathways were reliant on the knowledge of primary care and their communication with secondary care.

54. The medical centre considers that it should be able to rely on secondary care having robust processes for managing referrals. The medical centre noted the difficulty of predicting wait times for semi-urgent and routine referrals, and it considers that it is impractical for primary care to track each referral to secondary care after the referral has been received to ensure that administrative errors have not occurred. Mrs A was given safety-netting advice on the approximate wait time, and this enabled her to follow up on the referral when this timeframe was exceeded.

[18] An SAC 2 rating relates to incidents that result in permanent major or temporary severe loss of function not related to the natural course of the illness or that differ from the immediate expected outcome of the care management — this can be sensory, motor, physiological, psychological or intellectual.

[19] HealthPathways improves and standardises primary care management through best-practice and localised pathways. The community health pathway for rectal bleeding in the MidCentral and Whanganui districts had yet to be fully developed at time of events.

NP B

55. NP B noted that she made the referral in accordance with the Map of Medicine framework for referral that was current in 2020.

56. NP B acknowledged that her referrals did not record a discussion of family history or documentation of completion of a DRE, which would be part of her standard assessment. She told HDC that she is disappointed that Mrs A's referral was delayed due to Health NZ MidCentral's internal error. NP B said that as a result of Mrs A's experience, she has reflected on ways to make time for completion of administrative tasks and documentation and ensures that DREs are completed and documented when required for patients with colorectal symptoms.

Responses to provisional opinion

Health NZ MidCentral

57. Health NZ MidCentral was provided with an opportunity to comment on the provisional opinion. Health NZ MidCentral told HDC that clinical staff had no further comment to make.

58. Health NZ MidCentral told HDC that it is continuing to progress the implementation of the electronic referral and triage process.

Medical centre

59. The medical centre was provided with an opportunity to comment on the provisional opinion, and it advised that it had no further comments.

NP B

60. In response to the provisional opinion, NP B clarified that she was confident that she would have undertaken a DRE 'as standard practice in the course of [her] assessment of someone with [Mrs A's] symptoms'. She told HDC that she cannot recall why the DRE and discussion of Mrs A's family history was not documented in the clinical notes, and explained to HDC that this oversight may have been caused by her busy workload at that time.

61. NP B said that she returned from leave on 7 September 2020, and this was her earliest opportunity to follow up with Mrs A. NP B stated that she immediately arranged blood tests and made a further referral to Health NZ MidCentral, which noted explicitly that this was a second referral. She told HDC that she 'acted as promptly as [she] could have in the circumstances', and she considers it unfair that HDC has concluded that her actions lacked urgency.

62. NP B told HDC:

> '[I]n my experience, health practitioners are entitled to rely on the accuracy of information supplied by other health providers. To this end, I relied on the information from the bookings clerk [at Health NZ MidCentral on 10 August 2020] to the effect that [Mrs A's] referral was in progress. Had I been given different information (for example, had the bookings clerk informed me of the internal error within [Health NZ MidCentral] which delayed the processing of [Mrs A's] referral) I would have taken any steps

necessary to ensure it was progressed immediately. However, I do not have visibility of [Health NZ MidCentral's] internal processes.'

63. NP B said that prior to 2022, reviews of acknowledgement of referrals from Health NZ MidCentral were carried out by the practice's administration staff. The process was updated in 2022 so that administration staff were tasked with following up referrals to check whether the patient had been seen, or to chase the referral. NP B noted that the efficacy of this process relies on the correct information being supplied by Health NZ MidCentral booking staff.

Mr A

64. Mr A was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and he reiterated his understanding of the delays in his wife's referral.

Opinion: Preliminary matters

65. Consumers have the right to co-ordination among providers to ensure quality and continuity of services, and I am concerned that this was not Mrs A's experience. Several documentation and communication lapses in Mrs A's referral management occurred between departments at Health NZ MidCentral, and between primary and secondary care. I acknowledge that in any human endeavour, mistakes may happen, but I am concerned that several opportunities to identify and correct the error were missed.

66. This case highlights the importance of providers having a robust referral management system with adequate safeguards to identify and expedite missed or inappropriately triaged referrals.

Opinion: Health New Zealand — breach

67. Mrs A was referred to Health NZ MidCentral with a three-month history of bowel changes and rectal bleeding, and investigation was requested to rule out malignancy. I have identified several individual and systems factors that contributed to errors in progressing Mrs A's referral, and the consequent delay in her receiving care.

68. In the first instance, I note that three human errors contributed to the delay in progressing the referral — Dr C's transcribed letter was emailed to the wrong clinician; the clinician marked the email as read without taking any corrective action; and when the referrer rang the booking office regarding the progress of the referral, she did not receive the information needed to initiate immediate action.

69. The referral management process was complex, with numerous transition points for referrals between services, and a mixed paper and electronic referral system. At the time of Mrs A's referral, there was no monitoring and reporting of draft letter wait times to ensure that internal referral letters were finalised in a timely manner. As such, there was no awareness that Dr C's letter to General Surgery remained unactioned. Health NZ MidCentral's process for paper-based referrals carried the risk of a document being overlooked, and it was not possible to create electronic reports to monitor the progress of paper referrals that had not been entered into WebPAS.

70. A referral process that relies on human accuracy has inherent fallibilities, and a previous case issued by this Office[20] highlights the importance of systems safeguards to identify errors when they occur. In that decision, the Commissioner reinforced 'the importance of having a robust referral system in place, supported by adequate policies and procedures that allow for prompt identification when a referral has not been actioned'. Yet in Mrs A's case, when a referrer queried the progress of a referral, it appears that this did not raise a concern that the referral might have been lost in the system.

71. At the time of NP B's telephone call to Palmerston North Hospital on 10 August 2020, seven weeks had passed without the outcome of Mrs A's referral having been communicated to Mrs A or NP B. Due to a lack of documentation provided by Health NZ MidCentral, I am unclear where the booking office sourced information about Mrs A's referral progress during the telephone call with NP B, and whether this information was accurate. I note that Health NZ MidCentral told HDC that NP B's original referral was closed on 23 July 2020 following non-contact advice being given, and Dr C's referral letter to General Surgery had not been sent. In light of this, I consider that the information provided to NP B that Mrs A was 'waiting to be seen' was unreliable, and, as a result, NP B did not take further steps to ensure that Mrs A would be seen or re-referred if the referral had been declined. The medical centre noted that NP B felt reassured that Mrs A would be sent a letter within two weeks.

72. Health NZ MidCentral has no record of having received calls from Mrs A and NP B. However, given the contemporaneous nature of the general practice records, I consider it more likely than not that Mrs A and NP B made the follow-up telephone calls.

73. I am critical that Health NZ MidCentral's referral system was not sufficiently robust to prevent and detect errors. In particular, I am concerned about the quality of information provided by Health NZ MidCentral when NP B contacted the booking office about a referral that was not progressing as expected, and that Health NZ MidCentral did not have in place a process to document such contact and the action taken in response to a referrer's concerns, or a patient's concerns.

74. I am reassured that Health NZ MidCentral's Board has approved the implementation of an e-referral and triage system to replace the manual systems currently in place.

[20] See Opinion 19HDC02393 (6 September 2021).

Referral timeframes

75. Due to the administrative errors with the referral, and the missed opportunities for identification and correction of the errors, Mrs A experienced an 18-week wait between her first referral on 18 June 2020 and the colonoscopy on 28 October 2020. When Dr C's internal referral letter was reviewed by the surgeon on 30 September 2020 it was triaged as semi-urgent, and the expectation was that a patient with this category of referral would be seen for a colonoscopy within six weeks.[21] Mrs A's 18-week waiting time was significantly outside the Ministry of Health 'Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography' (2019) timeframes.

Conclusion

76. I consider that overall, Health NZ MidCentral did not have robust processes in place for managing referrals and identifying when referrals were not progressing as they ought to be. As a result of errors causing delays with Mrs A's referral, she did not receive timely or appropriate services. Accordingly, I find that Health NZ MidCentral breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[22]

77. I am also concerned that when NP B contacted Health NZ MidCentral to discuss Mrs A's referral, she was not provided with the information needed to identify concerns with the referral's progress and take appropriate steps. Mrs A had a right to co-operation between her healthcare providers to ensure that she received continuity of services. Accordingly, I find Health NZ MidCentral to have breached Right 4(5) of the Code.[23]

Other comment

78. Health NZ MidCentral noted that triaging referrals is high risk, as clinicians rely on primary care providing all the information required for referrals to be triaged appropriately, and its Root Cause Analysis identified the lack of a documented DRE on the referral documentation as a significant factor in the decisions made about the referral. Health NZ MidCentral considers that the addition of this information may have led the triaging gastroenterologist to prioritise a colonoscopy within the Gastroenterology Department rather than transfer the referral to General Surgery.

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[21] See paragraphs 46-46.
[22] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[23] Right 4(5) of the Code states: 'Every consumer has the right to co-operation among providers to ensure quality and continuity of services.'

Opinion: NP B — adverse comment

79. In considering whether an appropriate standard of care was provided in the process of referring Mrs A to Health NZ MidCentral, I sought in-house clinical advice from GP Dr David Maplesden, and independent clinical advice from NP Rosemary Minto.

80. At the outset, I note that Dr Maplesden considers that the information provided to Health NZ MidCentral at the first referral was sufficient for it to assign a six-week wait for a colonoscopy, and both my advisors are of the view that the reason for the delay lies with Health NZ MidCentral's administration of the referral. I accept their advice. However, I consider that a well-coordinated referral process requires the co-operation and smooth transfer of information between primary and secondary care providers, and for this reason I have also considered the primary care actions and response to Mrs A's referral management.

Documentation — adverse comment

81. Dr Maplesden considers that the first referral by the nurse practitioner was adequate, but he noted some departures from best practice regarding the lack of inclusion of the family history and the potential red flag of unintended weight loss. He advised that abdominal palpation and inspection were undertaken, but he 'would be mildly to moderately critical if a DRE was not undertaken' as part of the assessment in question. He also advised that he would be 'mildly to moderately critical of the standard of clinical documentation if a DRE was performed and the result not documented, even if the result was negative'.

82. NP Minto, a nurse practitioner peer of NP B, considers that Mrs A's initial consultation with NP B was deficient because a DRE was not documented. NP Minto noted that when Mrs A attended the practice on 7 September 2020 there was a further opportunity to undertake a DRE. NP Minto advised that not undertaking a DRE was a departure from accepted practice and the Ministry of Health clinical advice, to a moderate to severe degree. She said that if the DRE was performed but not documented, this would be a moderate departure from the required standard of documentation.

83. The medical centre and NP B acknowledged that the findings from a DRE were not documented in the clinical notes or on the referral. In response to the provisional opinion, NP B expressed confidence that she would have undertaken a DRE as standard practice for someone with Mrs A's symptoms, and she cannot recall why this was not documented in the notes. Mrs A has not commented on this aspect of her care.

84. In my view, noting that there is documentation that NP B performed a physical examination of Mrs A on 15 June 2020, which included abdominal palpation and an inspection for external haemorrhoids, and taking into account NP B's statement above that she would have undertaken a DRE as standard practice in the course of assessing Mrs A's symptoms, I find it more likely than not that a DRE was performed at the appointment on 15 June 2020.

85. Both clinical advisors in this case agree that if a DRE was performed but not recorded, this would be a departure from the expected standard of documentation. I accept this advice and I am critical that the findings of Mrs A's DRE were not documented on the referral.

86. I acknowledge NP B's response to HDC that her workload may have contributed to the lapse in documenting the DRE. However, I note that other aspects of Mrs A's assessment, such as abdominal palpation and external examination for haemorrhoids, were documented in the first referral. In light of the importance of DRE findings to referral timeframes and triaging for colonoscopy, and the degree of effort required to document this additional finding in the referral, I do not consider NP B's workload to have been a mitigating factor in these circumstances.

87. Regarding Mrs A's second referral, I acknowledge NP Minto's advice that there was a missed opportunity to undertake a further DRE when Mrs A attended the medical centre on 7 September 2020 to discuss her continuing symptoms and referral progress. Dr Maplesden advised that as Mrs A's 'symptoms remained unchanged there was no apparent need to re-examine her', although he noted that with the benefit of hindsight, DRE findings at that time may have increased Mrs A's priority for review.

88. I note that 7 September 2020 was NP B's first day back at work, and that while NP B spoke with Mrs A about her referral and her ongoing symptoms, this conversation was not in the context of a scheduled appointment. I acknowledge that in retrospect a further DRE at the time of Mrs A's second referral may have been instructive, but I note Dr Maplesden's advice that there was no apparent need to re-examine her at that stage. Therefore, I am not critical that a further DRE was not performed on 7 September 2020.

Referral tracking — educational comment

89. I acknowledge that NP B set a task to follow up the first referral in two weeks' time and was sent an electronic confirmation that the referral had been received by Health NZ MidCentral. NP B also communicated to Mrs A her expectation of a six- to eight-week timeframe for an appointment and followed up with a Health NZ MidCentral booking clerk when this timeframe elapsed (between seven to eight weeks).

90. Dr Maplesden advised that secondary care waiting times may not be consistent with Ministry of Health targets, and this can create difficulty for referring clinicians in predicting the likely wait for a procedure and when concerns should be raised. He considers that it was reasonable for NP B to wait until the outside range of the anticipated timeframe for a colonoscopy was reached (eight weeks) before contacting Health NZ MidCentral herself. Noting that NP B was assured by the bookings clerk that Mrs A was in the system and could expect to be contacted within the next two weeks, Dr Maplesden considered it reasonable management for NP B to make a further referral to the surgical service on 7 September 2020 when told by Mrs A that no appointment had been received.

91. NP Minto was critical of delays in NP B's follow-up of the first referral after Mrs A raised concerns on 31 July 2020 following her telephone call to the hospital. I note that NP B

worked part-time at the medical centre, and this contributed to her not contacting the booking office until 10 August 2020. Following her contact with the booking office, NP B understood that Mrs A was waiting to be seen, and the plan was to wait for a further two weeks and then to send another letter. However, as NP Minto noted, no action was initiated by NP B until she saw Mrs A on 7 September 2020 (four weeks after contact with the booking office). NP Minto considers that this delay was inappropriate and a moderate departure from the expected standard of care.

92. In response to the provisional opinion, NP B told HDC that she was on annual leave for the three weeks between 10 August and 7 September 2020, and that she followed up with Mrs A on 7 September 2020, which was her first day back at work. NP B further noted that she relied on information from the booking clerk that the referral was in progress. NP B told HDC that if she had been aware that the first referral had been misplaced by Health NZ MidCentral, she would have taken steps to make the second referral before going on leave on 10 August 2020.

93. In light of the further information provided by NP B regarding her leave from work, and the reliance she placed on the information given to her by the Health NZ MidCentral booking office, I am not critical that NP B did not make the second referral until she returned to work on 7 September 2020. However, in the circumstances where the purpose of Mrs A's referral was to 'rule out malignancy', the referral had exceeded seven weeks of the anticipated six- to eight-week waiting time, and the plan was to follow up two weeks after NP B's telephone call with the booking office, I consider that it may have been helpful for NP B to have asked a colleague to monitor the referral progress while she was on three weeks' leave.

94. Regarding tracking of Mrs A's second referral, I note that there is no reference to the medical centre undertaking additional tracking or having contact with Mrs A between the time of her second referral on 7 September 2020 and the colonoscopy on 28 October 2020. Dr Maplesden advised:

> 'While I think it was reasonable of [NP B] to assume the DHB would reassess [Mrs A's] priority with respect to the delays to date, and to undertake the colonoscopy within two weeks as she had apparently been led to believe, I am mildly critical there was no further enquiry after two weeks (or apparently no instruction to [Mrs A] to report if she had not had the procedure within two weeks) to ensure the by now significantly delayed procedure (noting particularly persistence of the suspicious symptoms) was undertaken in a timely manner.'

95. I accept the medical centre's comments that general practices do not have the resources to track each referral until patients have been seen. However, I am mindful that Mrs A's referral was for investigation to 'rule out a malignancy'. I consider that even though it may not be possible to track all referrals, referrals for patients with a suspicion of cancer ought to be distinguished from other requests and followed up promptly.

96. I am critical that Mrs A's referral was not tracked more closely in light of her continuing symptoms and accumulating delays. However, I acknowledge that NP B's two referrals and

telephone contact with the booking clerk can be regarded as mitigating factors, as can her period of leave, and that the delay in Mrs A's referral was primarily a result of secondary care rather than primary care issues.

Referral urgency — educational comment

97. NP Minto advised that the clinical documentation does not convey whether the urgency of Mrs A's referral was discussed with her, or made explicit in the referrals to Health NZ MidCentral, particularly the urgency surrounding the delay of the first referral.

98. NP B told HDC that Mrs A was informed that a specialist appointment would take six to eight weeks. Mr A told HDC that Mrs A expected that she would be seen within six weeks, and she followed up with providers when this timeframe was exceeded. While I am critical that the advice given to Mrs A was not documented in the clinical record, I consider it more likely than not that Mrs A received information about the urgency of her symptoms.

99. Regarding communication of Mrs A's referral urgency to Health NZ MidCentral, NP Minto considers that the first referral of 18 June 2020 contained sufficient information about Mrs A's symptoms to raise 'red flags'. However, the referral does not contain information about the urgency for Mrs A to be seen, and there is no documentation about the urgency of the referral having been discussed with the booking office on 10 August 2020, or in the second referral of 7 September 2020. NP Minto advised:

> '[T]here should have been more urgency indicated in the advice provided to [Health NZ MidCentral] regarding the prolonged wait after the first referral, particularly given the ongoing symptoms and the delay in the secondary care review which departs from expected care (6–8 weeks). Whilst this may have occurred there is no documentation indicating this. In my opinion this would be considered a moderate departure from standard care.'

100. The medical centre told HDC that Health NZ MidCentral makes its own decisions about the priority of a referral, and there is no guarantee that secondary care will accept the general practice assessment regarding the level of urgency.

101. Referrals are completed by both nurse practitioners and general practitioners, and I would expect both professional groups to complete the process to the same standard. Regarding the second referral of 7 September 2020, Dr Maplesden noted that blood test results taken at that time 'did not raise a need to increase the priority of the referral'. Further, he noted that the second referral contained information about the first referral and contact with the booking office, and he considers it reasonable that NP B would assume that Health NZ MidCentral would take previous delays into account when prioritising the referral.

102. Both advisors concur that as the delay in Mrs A's referral lengthened, there was a corresponding escalation in the level of urgency for her to be seen.

103. I consider that co-operation among providers entails both the referrer conveying urgency where appropriate, and secondary care taking into account the concerns of primary care

when triaging referrals. Beyond the point where anticipated timeframes were exceeded, it would have been appropriate for NP B to express urgency regarding the time elapsed since the first referral of 18 June 2020 (anticipated appointment within eight weeks) and the time elapsed since the contact with the booking office of 10 August 2020 (anticipated letter within two weeks).

104. While I am mindful that referrals are triaged by the receiving agency, I remind NP B of the importance of clear communication between providers. Ideally, Mrs A's referrals, in particular the second referral, should have signalled the urgency more strongly in light of the anticipated timeframes having been exceeded.

Opinion: Medical centre — no breach

105. Regarding the referral tracking process, Dr Maplesden considers that the relevant policies provided by the medical centre appear 'fit for purpose and consistent with similar policies [he has] viewed from other practices'. I have no criticism of the medical centre's role in Mrs A's referral management.

106. I have considered the medical centre's comments regarding the impracticality of tracking referrals until a patient is seen. While I appreciate that general practices should be able to rely on the administrative processes of secondary care, this case demonstrates that there is always an opportunity for inadvertent error, which may have significant implications for consumers.

107. I appreciate the resource constraints on primary health care and the impracticality of tracking each referral that has been received by secondary care, but I consider that resource utilisation needs to be considered in the context of the patient's clinical circumstances. While in general it may be acceptable to track a referral only until it has been acknowledged as accepted, where there is a suspicion that the patient may have cancer, this places a greater onus on primary care to track a referral, particularly in circumstances where the patient becomes increasingly unwell and the referral is not progressing as expected.

108. In her response to the provisional opinion, NP B told HDC that the practice updated its referral and referral tracking policy in 2022. Administration staff are now tasked with checking that referrals are acknowledged (as received by the specialist service), and the task is completed when patients have been seen by the specialist; referrals are followed up if the specialist service does not respond as expected. I am pleased that this change has been made to identify referrals that are not progressing in a timely manner.

Changes made

Health NZ MidCentral

Clinical response

109. A contributing cause for the delay was the senior medical officer not identifying that an emailed draft letter had been overlooked and not actioned. Senior Gastroenterology clinical staff met with the Chief Medical Officer in January 2021 to discuss what could be done to reduce clinician workload for Gastroenterology senior medical officers and allow for prioritisation of administration requirements.

110. Health NZ MidCentral has updated the referral and prioritisation process for the Gastroenterology Department. Regarding the process delays while Mrs A's referral was assessed and transferred between Gastroenterology and General Surgery, Health NZ MidCentral advised that a working group was established to look at the referral and prioritisation procedure, and some changes to the transfer of a referral between specialties were made, and the work continues.

Administrative response

111. Health NZ MidCentral advised that as an interim measure, a new reporting function was implemented to identify referrals that have been waiting for triage for more than three weeks, although the reporting function relies on referral data being entered into the Patient Administration System in a timely manner. There is also a new internal process for transferring referrals between departments, which electronically indicates the transfer of service and updates the referral to reflect the new specialty and referrer.

112. Since this event, a business case for e-referral and triage has been approved to replace the paper-based referral process, and Health NZ MidCentral is continuing to progress the implementation of the electronic referral and triage process.

NP B

113. NP B told HDC that following Mrs A's experience, she reflected on her practice and discussed Mrs A's assessment and referral with her clinical supervisor. She said that she now sets aside time for administrative work, and clinical notes are reviewed to ensure that they record digital rectal examinations and all discussions.

Medical centre

114. Practice nurses and receptionists have been reminded that task reminders are an inappropriate means of communicating urgent issues. Urgent matters are to be entered into the practice's daily clinical template and discussed with the clinician in a face-to-face conversation.

115. The medical centre now has a policy of a recall task being generated for referring clinicians that prompts administrative staff to check that the referral has been acknowledged as having been received, and the task is not completed until the patient has been seen by the specialist service.

Recommendations

Health NZ MidCentral

116. In light of the changes already made by Health NZ MidCentral, as discussed above, I recommend that Health NZ MidCentral:

a) Provide an apology to Mrs A for the deficiencies in the care provided to her, as outlined in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Report back to HDC on the implementation of the e-referral and triage that was approved to replace the paper-based referral process.

c) Consider developing a live auditing system while waiting for the electronic system to be implemented.

d) Consider opportunities to document all calls to the booking office regarding referral progress, and to identify and escalate concerns from providers and consumers about delays or increasing urgency of referrals.

e) Provide a progress update to HDC on the working group established to look at the referral and prioritisation procedure and the transfer of a referral between specialties.

f) Consider whether it would be appropriate for the Gastroenterology and General Surgery Departments to review the Community HealthPathways information available to primary care about their services and localise the information relating to referrals from primary to secondary care.

g) Report back to HDC on the progress of recommendations b) to f), within three months of the date of this report.

NP B

117. Taking into account the changes made by NP B, I recommend that NP B review the current information regarding the referral of patients with features suggestive of bowel cancer and lead a peer group discussion on this topic. NP B is to report back to HDC with a reflection on the discussion within three months of the date of this report.

Medical centre

118. I recommend that the medical centre consider the process for identifying urgent tasks for follow-up, and whether these could be undertaken by a resource staff member rather than waiting for a particular staff member to return to work from leave or days off. The medical centre is to report back to HDC on this recommendation within three months of the date of this report.

Follow-up actions

119. A copy of this report with details identifying the parties removed, except Health NZ MidCentral, Palmerston North Hospital, and the advisors on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of NP B's name.

120. A copy of this report with details identifying the parties removed, except Health NZ MidCentral, Palmerston North Hospital, and the advisors on this case, will be sent to Te Aho o Te Kahu|Cancer Control Agency and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from Dr David Maplesden:

'1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a practising general practitioner. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided to his wife, [Mrs A], in relation to timeliness of the diagnosis of her colorectal cancer in October 2020. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

Complaint from [Mr A]

Response from MidCentral DHB

Clinical notes Palmerston North Hospital (PNH)

GP notes [medical centre]

Response and relevant policy documents received from [the medical centre] 5 May 2022

3. [Mr A] complains about delays in the diagnosis of his wife's low rectal cancer (colorectal cancer — CRC). [Mrs A] (B: …) was referred to MCDHB surgical service by [NP B] on 18 June 2020 following her review by [NP B] on 15 June 2020 with a history of change in bowel pattern and rectal bleeding. The DHB surgery service forwarded the referral to gastroenterology for colonoscopy, and the triaging gastroenterologist referred [Mrs A] back to general surgery. The internal referral to general surgery was not actioned until the 30th September 2020 due to administrative error. In the meantime, [Mrs A] re-presented to general practice with continuing signs and symptoms, and a second referral was made on the 7 September 2020. This referral was triaged as a semi-urgent request for colonoscopy (within 42 days). On 28 October 2020 a digital rectal exam was performed by a clinician prior to the colonoscopy and a hard mass was felt approximately 5cm from the anus which was later confirmed to be adenocarcinoma. The colonoscopy occurred 50 days after the second referral was received, and 140 days after the first referral was received.

4. Advice requested

Were the Nurse Practitioner's assessment and investigations appropriate to the severity and significance of [Mrs A's] presenting problems?

Did the referrals to MCDHB contain sufficient information for the triaging clinicians to make appropriate prioritisation decisions? In particular, was the referral urgency and level of suspicion of cancer appropriate?

What timeframes for referral management would be applicable in this case?

Are there any other matters regarding [Mrs A's] primary care management and coordination of care with MCDHB that you consider warrant comment or amount to a departure from accepted standards?

For each question, please advise:

What is the standard of care/accepted practice?

If there has been a departure from the standard of care or accepted practice,

How significant a departure (mild, moderate, or severe) do you consider this to be? Please also advise if there are any particular individuals responsible for this departure.

How would it be viewed by your peers?

Recommendations for improvement that may help to prevent a similar occurrence in future.

I note there has been no response obtained from [the medical centre] or [NP B]. I do not quantify any identified departure from accepted practice without input from the practice/clinicians concerned as there may be some context relevant to their actions that is not apparent from the clinical documentation. Additional information required is summarised in s14 and on receipt of this information I can then finalise the advice taking into account any additional information provided.

5. As a basis for accepted practice in the investigation and management of colorectal symptoms, I have used the Whanganui & MidCentral Community HealthPathways section "Colorectal Symptoms"[1]. I note this section has yet to be localised for the MCDHB region which might affect administrative details such as which department is preferred for patient referral, but the clinical aspects of patient management are applicable and incorporate the national guidance on direct access to outpatient colonoscopy[2] and high suspicion of cancer definitions[3]. With respect to tracking of important referrals or investigation results, as part of the basic accreditation standard for general practices there is a requirement for a documented policy and procedure covering how to manage and track laboratory results, imaging reports, significant investigations, clinical correspondence and urgent referrals[4]. A copy of this policy should be obtained from [the medical centre]. Current guidance and discussion of issues associated with referral of patients with symptoms suspicious for CRC is contained in an

[1] https://ccp.communityhealthpathways.org/ Accessed 30 March 2022
[2] https://www.health.govt.nz/system/files/documents/publications/referral-criteria-direct-access-outpatient-colonoscopy-computed-tomography-colonography-feb19-v2.pdf Accessed 30 March 2022
[3] https://nsfl.health.govt.nz/system/files/documents/publications/high_suspicion_of_cancer_definitions_0.pdf Accessed 30 March 2022
[4] https://www.rnzcgp.org.nz/Quality/Foundation/Manaaki_Haumanu_Clinical_Care/5_Continuity_of_care/Quality/Indicators/Indicator_5_Continuity_of_care.aspx?hkey=7a5eea05-d097-4d40-8041-d906fff0de56 Accessed 30 March 2022

excellent 2020 BPAC publication[5]. With respect to expected waiting times for urgent or semi-urgent colonoscopy, this varies significantly between DHBs and from month to month and is often not consistent with the Ministry of Health targets[6]. In the cited document Mid-Central DHB performed well with respect to urgent (within 14 days) colonoscopies (100%) but less well with non-urgent (42 days) procedures (58.1% in March 2020 improving to 88.9% in May 2020). This makes it somewhat difficult for referring clinicians to predict the likely wait for a procedure and when concern might be raised that the procedure has not been completed.

6. [Mrs A's] past medical history recorded in the GP notes includes epilepsy, cervical dysplasia, previous pelvic organ prolapse surgery and depression. Regular medication as at the start of 2020 was sertraline 100mg daily. On 15 June 2020 [Mrs A] saw [NP B] with history and assessment findings recorded as:

Comes in to discuss bowel changes since March; has known haemorrhoid but has noted change in bowel; in the past would pass bowel motion once–twice a day soft formed stool; feels like has an urge to pass a bowel motion all the time but not necessarily able to pass anything; can sit and get small amounts of loose stool passing with bright, red blood dripping into pan; has had occasional lower abdo pain, no obvious external haemorrhoids noted; notes rectal pain, worse last week but has now settled more to an ongoing discomfort; no hx of constipation.

wt 70.60, abdo slightly tender L & R lower quadrant. looks pale, for bloods and stool samples, review.

Forms were provided for blood tests including blood count and iron studies, and faecal occult blood (FOB) testing. Results showed unremarkable blood count (Hb 131 g/L, reference range 115–155), ferritin within the normal range but reduced iron levels (8 µmol/L — reference range 10–30). Iron studies were otherwise normal. CRP was mildly raised at 8.4 mg/L (reference range <5). Two FOB samples were positive. On 18 June 2020 [NP B] contacted [Mrs A] to inform her of her results and gain consent for referral. Electronic referral was sent to the MCDHB surgical service the same day (no priority specified) with the introduction: *Please see [Mrs A] who presents with a history of altered bowel habit, blood noted when passing stool and low ferritin to rule out malignancy.* The remainder of the referral was a copy of the relevant consultation notes, medical history and investigation results. A follow-up appointment was apparently scheduled for 29 June 2020 with [NP B's] notes on that date stating: *text sent asking if still wants followup appt for today, have sent referral already*. I have assumed [Mrs A] declined the follow-up appointment.

[5] BPAC. Referral of patients with features suggestive of bowel cancer: Ministry of Health guidance. 2020. https://bpac.org.nz/2020/bowel-cancer.aspx Accessed 30 March 2022

[6] https://www.health.govt.nz/system/files/documents/pages/colonoscopy-wait-time-indicators-may20.pdf Accessed 30 March 2022

7. Comments

(i) [Mrs A] presented with a three month history of change in bowel pattern (looser erratic motions) and outlet type rectal bleeding (bright blood dripping into the bowel after a bowel motion) with occasional lower abdominal pain. There was no abdominal mass palpable. The documented history is of an equal standard to that I have seen recorded in similar cases but departs from best practice in the following areas: family history of CRC not investigated; potential red flag of unintended weight loss not investigated.

(ii) Abdominal palpation was undertaken which is appropriate. Digital rectal examination (DRE) would also be expected in this clinical scenario with some guidelines also recommending proctoscopy (to identify or exclude local anorectal pathology such as haemorrhoids or anal fissure). I am critical a DRE was not performed. While it could be argued DRE was not going to alter the decision to make a referral, had DRE detected a rectal mass (and it is quite possible, with the benefit of hindsight, a mass might have been detected in this case given the location of the tumour close to the anal verge) the priority for colonoscopy would alter from the six-week category to the two week category as per the cited direct access to colonoscopy criteria.

The [medical centre's] response notes [NP B] undertook an anal inspection for haemorrhoids and *did not document a digital rectal exam was performed but reports this is part of her standard assessment when presented with [Mrs A's] symptoms. She cannot recall if this was performed at this time.* I would be mildly to moderately critical if a DRE was not undertaken as part of the assessment in question. I am mildly to moderately critical of the standard of clinical documentation if a DRE was performed and the result not documented, even if the result was negative. I recommend [NP B] reflect on the importance of DRE in the clinical scenario described even if a referral is being made for colonoscopy irrespective of the result, noting the increase in priority/urgency a positive result should confer.

(iii) Appropriate blood tests were arranged and did not show any evidence of iron deficiency anaemia, although iron stores were depleted. While some guidelines (such as that cited) refer to ordering FOBs, there is debate about the utility of this test when a patient presents with overt rectal bleeding as was the case here. A negative test (which can occur if bleeding is intermittent) should not alter the decision to refer someone with concerning colorectal symptoms and a positive test is merely confirming what is already known from the patient history.

(iv) If the cited referral guidance is strictly applied to the clinical scenario presented by [Mrs A] (noting she was [in her forties] at the time of her presentation to [NP B]), and taking into account the absent (or normal) DRE findings, there would be an expectation the colonoscopy referral would be accepted under the "six week wait" criterion: *Altered bowel habit where the motions are looser and/or more frequent > six weeks duration **plus** unexplained rectal bleeding* **and** age 40–50 years.* The asterisk refers to a footnote: *Benign anal causes treated or excluded* which, in this case, had not occurred

given there had been no anal inspection or DRE performed. However, it does not appear this omission altered the decision by the DHB that [Mrs A] required a colonoscopy and the cause for the subsequent delay in assigning a date was primarily administrative in nature.

(v) I believe the referral completed by [NP B] was adequate acknowledging the deficiencies in history and assessment already commented on above. I have assumed the pathway to access colonoscopy for patients with symptoms suspicious for CRC within the MCDHB area is via the surgical service rather than gastroenterology. There was sufficient information for DHB clinicians to assign a "six week wait" priority on the basis of the presented history alone although it could be argued they were within their rights to reject the referral until the findings of a DRE were presented (in case the findings indicated the "two week wait" category was more appropriate).

(vi) Given there was an apparent underlying suspicion [Mrs A] might have a CRC to account for her symptoms, I believe the referral required tracking to ensure colonoscopy was performed in a timely manner. The DHB response indicates receipt of the referral was acknowledged electronically so [NP B] was at least aware the "loop was closed" in that respect. [NP B] was not made aware the referral had been redirected within the DHB (from surgery to gastroenterology). It is somewhat difficult to determine what would be a reasonable and accurate "expected wait time" to convey to the patient given the issues discussed in section 5 but there would certainly be an expectation the patient would be seen within three months at the outside in the clinical scenario described. Further comment should be sought from [NP B] regarding tracking of the referral and expected waiting time advice provided to [Mrs A].

[The medical centre's] response states [NP B] informed [Mrs A] in the phone call of 18 June 2020 that there would be an expected wait of 6–8 weeks for her first specialist appointment (FSA) or colonoscopy. With respect to tracking of the referral, the response includes: *When referrals are sent, a task is automatically generated to follow up 2 weekly.* Noting the anticipated wait time, I would not expect concern regarding the referral until mid-August 2020 (eight weeks following referral) with the tracking to remain active until the procedure was performed or planned date of procedure confirmed. Some DHBs send notification when an e-referral has been received but noting errors can occur with subsequent DHB administration of the referral (as in this case), safest practice would be to keep tracking of the referral active until the colonoscopy has been undertaken.

8. The next contact from [Mrs A] was 31 July 2020 when she contacted a staff member of [the medical centre] with concerns regarding communication she had received from PNH. This is documented as: *Pt concerned by phone contact she had with PNH — was told that the referral sent by [NP B] was a "non-closure contact". Wants to know what happens now and if she is going to get a colonoscopy. Symptoms persist unchanged. I have advised her that I will send a task to [NP B] to follow this up with PNH and then get back to her. Pt was satisfied with the plan ... Advice given to patient: If condition gets worse, contact the practice.* On 10 August 2020 [NP B] has documented: *phone call to*

Bookings clerk at MidCentral. [Mrs A] is still in the system awaiting to be seen, advised [Mrs A] of this, await further couple of weeks and if no response for further letter.

9. [The medical centre's] response notes: *When [Mrs A] had concerns at the end of July 2020 regarding her contact with Mid Central DHB, [NP B] followed this up in early August 2020 and was advised that [Mrs A's] referral was in the system. [NP B] set herself a further task to follow up in two weeks. She telephoned [Mrs A] to advise of this and asked [Mrs A] to again contact the practice if she hadn't heard from Mid Central within this time frame. [Mrs A] and [NP B] had a conversation 7th September 2020 as no appointment had been made. [NP B] re-sent the referral to general surgery at this time and explained this was the second referral sent and outlined the relevant clinical information.* I believe it was reasonable for [NP B] to wait until the outside range of anticipated wait for colonoscopy was reached (eight weeks) before contacting the DHB herself. [NP B] was reassured the referral was "in the system" (the [medical centre] result notes [NP B] was assured by the bookings clerk *that [Mrs A] was in the system and could expect to be contacted within the next 2 weeks. [NP B] left this conversation feeling reassured that [Mrs A] would be followed up in a reasonable time frame)* and she apparently informed [Mrs A] of the situation and for [Mrs A] to make contact if she did not hear from the DHB in a couple of weeks. She tracked the referral for another two–three weeks and when notified by [Mrs A] on 7 September 2020 that no appointment had been received, she made a further referral to the surgical service. I believe this was reasonable management to this point but, in hindsight, a further telephone call to the relevant DHB service in addition to the written referral might have been more effective in expediting the colonoscopy.

10. The DHB response does not refer to this telephone contact with [Mrs A]. I recommend [NP B] is asked to provide, with her response, further details regarding what was discussed with DHB staff on 10 August 2020 including any reassurance regarding the prioritisation or scheduling of [Mrs A's] colonoscopy, and what tracking measures were in place to ensure the colonoscopy was completed within a reasonable timeframe. At this time, the expected "six week wait" (assuming categorisation was consistent with the cited guidance) was only just exceeded which would not be an extraordinary situation.

See section 9.

11. [Mrs A] had a routine cervical smear performed on 10 August 2020 (practice nurse). On 7 September 2020 (now almost 12 weeks since the surgical referral had been sent) [NP B] has recorded contact from [Mrs A] as: *[Mrs A] in to tell me has had no further followup from Surgical, remains on waiting list. Repeat bloods and monitor for appt*. Blood tests were taken and [NP B] sent a further referral to the DHB surgical service which included a copy of relevant consultation notes to date (including references to contact with the DHB regarding [Mrs A's] booking). The introductory statement was: *Please see [Mrs A] for review of her change in bowel habit and bleeding from the bowel. This is the second referral for [Mrs A], she continues with bleeding from the bowel and*

change in bowel habit. She reports feeling the urge to pass a bowel motion but when she does it is only blood in the pan. She had positive faecal occult blood and I have repeated her bloods today to review her ferritin and haemoglobin levels. She has started taking flurodix liquid due to worsening lethargy and tiredness. Blood tests showed haemoglobin 123 g/L (normal red cell parameters), ferritin within the normal range, stable though reduced serum iron level and drop in iron saturation. CRP was normal.

12. Comment: It was appropriate to re-refer [Mrs A] and it was clear from the referral that [Mrs A's] bowel symptoms were persistent and remained suspicious for CRC. Given the fact it had already been three months since the original referral, I would have expected [Mrs A's] colonoscopy to have been expedited rather than her going onto the "six week wait" list from the date of re-referral. The blood test results did not raise a need to increase the priority of the referral. Given [Mrs A's] symptoms remained unchanged there was no apparent need to re-examine her although, with the benefit of hindsight (and taking into account my previous comments), had a DRE been performed at this point it is likely a rectal mass was palpable and this finding should have increased [Mrs A's] priority for review. There is no further contact recorded from [Mrs A] in relation to her colonoscopy until following her diagnosis of CRC (see below). I would expect progress of the re-referral to have been tracked by [NP B] given the delays already experienced and further comment from her in this regard is required (what tracking was in place?; were any further enquiries made as to the scheduling of the colonoscopy?).

The [medical centre's] response does not refer to any additional tracking of the second referral or further contact with [Mrs A] prior to the eventual scheduling of her colonoscopy. While I think it was reasonable of [NP B] to assume the DHB would reassess [Mrs A's] priority with respect to the delays to date, and to undertake the colonoscopy within two weeks as she had apparently been led to believe, I am mildly critical there was no further enquiry after two weeks (or apparently no instruction to [Mrs A] to report if she had not had the procedure within two weeks) to ensure the by now significantly delayed procedure (noting particularly persistence of the suspicious symptoms) was undertaken in a timely manner. However, I note [NP B] had already sent two referrals and made telephone contact with the booking clerk (and [Mrs A] had also been in contact with the booking clerk) and these are regarded as mitigating factors. I acknowledge the primary reason for the delay in [Mrs A] is a result of secondary care rather than primary care issues.

13. [Mrs A's] colonoscopy was eventually scheduled for 28 October 2020 (19 weeks since the original referral and 7 weeks since the second referral). The endoscopist performed a DRE prior to colonoscopy and noted a palpable rectal mass. This was confirmed on colonoscopy to be about 5cm from the anal verge. Biopsies confirmed adenocarcinoma of the rectum with staging CT and MRI suspicious for local nodal involvement. [Mrs A] was referred for neoadjuvant chemo-radiotherapy prior to surgery for her cancer.

14. As per my previous comments, prior to finalising this advice I require a response from [the medical centre] and [NP B]. This should include:

A copy of the practice policy for management of referrals and clinical correspondence and referrals

Clarification of the expected process in the MCDHB area for accessing colonoscopy in patients fulfilling the criteria for direct access (as in this case), including to which department the referral should be made

Expected waiting times for colonoscopy based on GP experience of management of referrals they have submitted to MCDHB

Response from [NP B] with respect to clarification of specific issues identified in this advice and general comment on the clinical rationale for her assessment and investigation of [Mrs A's] symptom.

Any additional comments you feel might be relevant to [Mrs A's] management in primary care

Comment: Relevant policies have been supplied by [the medical centre] and reviewed. These appear fit for purpose and consistent with similar policies I have viewed from other practices.

Further comment: 9 January 2023 1. I have reviewed the response from [the medical centre] received via e-mail on 10 November 2022 and response from [NP B] received 16 November 2022. The response does not lead me to alter comments contained in my original clinical advice with respect to quantification of any departure from accepted practice (either clinical issue if no DRE performed or documentation issue if result of DRE (presumably negative) was not recorded). I remain of the view that the primary cause of delays in [Mrs A] receiving her colonoscopy were related to administrative errors within the DHB. Nevertheless, I remain of the view that DRE findings and CRC family history (or comment on negative family history) should have been included in the referral completed by [NP B] as both of these factors are considered in the colonoscopy triage process.

2. On reading the DHB response, it appears the referral was declined by the gastroenterology service and was meant to have been referred to the DHB surgical service because a local cause for the bleeding was suspected (based on the recorded history of outlet type bleeding and in the absence of comment in the referral on local causes having been excluded on anal inspection/DRE) despite [NP B's] comment in the referral that she wished to exclude a malignant cause for [Mrs A's] symptoms. Whether or not this was a reasonable triaging decision might be best commented on by a gastroenterology expert, as would the decision to place [Mrs A] into the "six week" wait category following the re-referral dated 7 September 2020 when it was now almost three months since the initial referral and her symptoms were persisting.

The [medical centre's] response refers to my comment regarding tracking of referrals in which I suggested the most thorough tracking would be until the procedure for which the patient was referred has been completed. However, I agree it is accepted practice to track the referral until it has been confirmed as prioritized and accepted by the DHB. This action, coupled with providing the patient with an approximate time frame within which they should expect a FSA/procedure and advice on what to do if the time frame is not met, provides a reasonable (although not absolute) safety net. I am acutely aware of the administrative burden faced by primary care with respect to inbox management and tracking of clinical correspondence and I am in total agreement with the [medical centre's] comment: *Secondary care systems should be fit for purpose and an acknowledgement of a referral should be acceptance that care has been transferred to the secondary care provider.* In this case, there were obvious deficiencies in the secondary care processes.'

Appendix B: Independent clinical advice to Commissioner

The following independent advice was obtained from NP Rosemary Minto:

'25th August 2022

Complaint: Nurse Practitioner [NP B]/[Mrs A]

Reference: 20HDC01999

I, Rosemary Minto, have read and agreed to follow the Guidelines for Independent Advisors as described in the documentation I have received from the Office of the Health and Disability Commissioner.

I am a Registered Nurse and Nurse Practitioner (NP), having graduated from Tauranga Hospital School of Nursing in 1983. I received a Master's in Health Practice in 2006 and gained NP registration in 2008. I have worked in general practice since 1999. I am currently working as an adult NP in an urban general practice.

I have been instructed to review the complaint and documentation provided and advise whether I consider the care provided to [Mrs A] by [NP B] was reasonable in the circumstances, and why.

Particular advice requested:

I. Whether [NP B's] assessment and investigations at each of [Mrs A's] presentations were appropriate, and whether any further assessments and/or investigations were warranted;

Whether the information contained in the referrals was appropriate and met expected standards, including communication of the level of suspicion of cancer and urgency for both first and second referrals;

Whether the referral tracking and follow-up by [NP B] of both the first and second referrals were appropriate in the circumstances;

Whether the relevant referral management policies and procedures in place at [the medical centre] at the time were adequate;

Are there any other matters regarding [Mrs A's] primary care management and coordination of care with MidCentral DHB that you consider warrant comment or amount to a departure from accepted standards.

For each question, please advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?

c. How would it be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

I base my assumptions on the facts that:

[NP B] as a registered Nurse Practitioner, thus has been trained to diagnose and treat patients, including those with colorectal symptoms, and has been judged as competent by the regulatory body.

[NP B] works in a general practice team with access to General Practitioners from whom she can request advice and guidance as she feels is required.

MidCentral DHB (as it was known as at the time of this episode of care) has clinical pathways guidance available to clinical staff regarding management of patients with colorectal symptoms.

Documentation provided includes:

Letter of complaint dated 29 October 2020

[Medical centre's] response of 5 May 2020

Clinical records from [the medical centre] covering the period March 2020–November 2020, and information about policies and processes.

Factual Summary of Complaint:

[Mr A] has complained about delays in [Mrs A's] referral for investigation of change in bowel habits and rectal bleeding. [Mrs A] presented to her general practice on the 15th June 2020 where she was seen by Nurse Practitioner [NP B].

Further investigation with blood tests and faecal occult blood testing was arranged. Results were discussed with [Mrs A], and she was referred to general surgery at MidCentral DHB on 18 June 2020 by [NP B] with a request to "Please see [Mrs A] who presents with a history of altered bowel habit, blood noted when passing stool and low ferritin to rule out malignancy."

The internal referral to general surgery was not actioned until the 30th September 2020 due to administrative error at MidCentral DHB. In the meantime, [Mrs A] re-presented to general practice with continuing signs and symptoms, and a second referral was made by [NP B] on the 7th September 2020. This referral was triaged as a semi-urgent request for colonoscopy (within 42 days).

On 28 October 2020 a digital rectal exam was performed prior to the colonoscopy and a hard mass was felt approximately 5cm from the anus which was confirmed to be

cancerous. The colonoscopy occurred 50 days after the second referral was received, and 140 days after the first referral was received.

1. Whether [NP B's] assessment and investigations at each of [Mrs A's] presentations were appropriate, and whether any further assessments and/or investigations were warranted;

1a.i. The assessment at [NP B's] initial consultation according to the clinical notes provided was deficient in that there was no rectal exam documented, particularly as there is documentation that [Mrs A] was experiencing rectal pain.

The second consultation on the 7th September provided another opportunity for a rectal examination which would have been very appropriate given ongoing symptoms and delay in secondary care assessment.

***This is a departure from accepted practice and Ministry of Health clinical advice of a moderate to severe degree, as it is recommended practice prior to referring to secondary services for further assessment* (*Midlands Health Pathways 2022*).**

1a.ii. If the rectal examination was done but not documented then this would be a moderate departure from the required standard of documentation.

The ordered blood tests were appropriate and warranted given [Mrs A's] symptoms.

It is not considered appropriate to order faecal occult blood tests as these have limitations and do not add any benefit to a diagnostic pathway *(Midland Health Pathways 2022, MOH 2019)*. This test would not have impacted negatively however on the referral process.

2. Whether the information contained in the referrals was appropriate and met expected standards, including communication of the level of suspicion of cancer and urgency for both first and second referrals;

No documentation is provided from the first consultation regarding advice or education given to the patient about the level of risk of bowel cancer and urgency given her symptoms. It would be expected for this to have occurred as part of the shared decision-making process regarding further testing and symptom management.

If this advice did not occur this is a departure from the expected standard of care of a moderate degree.

There is documentation that the NP provided advice regarding the need for secondary service review, however documentation does not include any advice provided regarding the urgency of the review required and the documentation of the initial referral on the 18th June does not provide evidence that this was made with any degree of urgency.

The initial referral on the 18th June 2020 does provide adequate information to indicate the relevant symptoms that should raise "red flags" in any colorectal symptoms referral

system, and the NP did note that there was suspicion of a malignancy in her request on the referral to "rule out a malignancy".

There is no evidence from the documentation that any urgency was requested regarding secondary care review at the time of contact with the booking clerk by the NP on the 10th August, or in any further documentation when the patient was seen again on the 7th September despite having ongoing symptoms including abnormal blood test results.

This would be considered a moderate to severe departure from standard care.

2e.i. If there was urgency indicated by the NP that was not documented then this would be a departure from a required standard of documentation of a moderate degree.

At no time in the clinical notes is there indicated any urgency regarding the secondary care assessment delay — the second referral does describe ongoing symptoms, and is reported as being sent as a semi urgent referral.

In my opinion there should have been more urgency indicated in the advice provided to the MidCentral DHB regarding the prolonged wait after the first referral, particularly given the ongoing symptoms and the delay in the secondary care review which departs from expected care (6–8 weeks). Whilst this may have occurred, there is no documentation indicating this. ***In my opinion this would be considered a moderate departure from standard care.***

3. Whether the referral tracking and follow-up by [NP B] of both the first and second referrals were appropriate in the circumstances;

3a. 3 days after the patient was seen by the NP, there was documentation indicating appropriate communication regarding the need for secondary service review being required.

On 29th June — 14 days after the initial consultation — there is documented further attempted contact by the NP to the patient regarding an invitation for follow up. This indicates that the practice policy was followed appropriately.

On 31st July the notes indicate that a "task" was sent from staff at the clinic to the NP, from a patient-initiated contact, to follow up the referral regarding the delay in secondary care review. A delay of 10 days between the task being generated and the NP documenting follow up with the DHB system on the 10th August is evident in the documentation. This delay is unexplained in the provided documentation.

There is further delay of longer than the documented notes indicated there should be — ie — on the 10th August it was documented that a wait of 2 further weeks would be followed by a further letter. The next contact is initiated by the patient ***4 weeks later*** as per the documentation — "patient in to tell me … sic".

In my opinion, given there was documented evidence that a review of the referral was to take place 2 weeks after the 10th August, this indicates an inappropriate length of time, a departure from the expected standard of a moderate degree.

Whether the relevant referral management policies and procedures in place at [the medical centre] at the time were adequate:

4a. The evidence provided by [the medical centre] indicates that the policies and processes are adequate and meet recommended standards, e.g., Royal New Zealand College of General Practitioners Cornerstone Quality Improvement standards.

Are there any other matters regarding [Mrs A's] primary care management and coordination of care with MidCentral DHB that you consider warrant comment or amount to a departure from accepted standards.

From the documentation provided there is clearly a lack of response from the DHB regarding a referral that made clear there was a suspicion of malignancy. This is a clear departure from accepted standards.

Whilst there were delays from the general practice in responding to the tardiness of the DHB, there is clearly an effort by staff to facilitate the review by DHB services.

Summary:

In my opinion, from the documentation provided, there has been departure from a standard of care by a moderate to severe degree by [NP B] in not completing a rectal examination at any time during the patient's journey of healthcare provision for her colorectal symptoms.

If there was an examination completed then the documentation was poor in that regard — a departure from the required standard of documentation of a moderate degree.

In my opinion there was a departure from standard of care of a moderate degree in not signalling more strongly the urgency of the referrals to the Mid Central DHB, particularly the second referral.

Recommendation:

It may be more effective to have a standardised referral form for colorectal symptoms that has required specific information to be inserted that can immediately raise the urgency of the referral — e.g. such as BOP DHB Gastroenterology service utilise via BPAC electronic forms. This would also guide providers as to best practice in terms of examination, testing and follow up requirements.

References:

BPAC (2020). Referral of patients with features suggestive of bowel cancer: Ministry of Health guidance. *https://bpac.org.nz/2020/bowel-cancer.aspx*

Midland Community Health Pathways: *https://midland.communityhealthpathways.org/*

Ministry of Health (2009). Suspected Cancer In Primary Care
https://www.health.govt.nz/system/files/documents/publications/suspected-cancer-guideline-sep09.pdf

Ministry of Health (2019). Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography.
https://www.health.govt.nz/publication/referral-criteria-direct-access-outpatient-colonoscopy-or-computed-tomography-colonography

RNZCGP Foundation Standards Programme: Continuity of Care Module (2022)
https://www.rnzcgp.org.nz/Quality/Foundation/Foundation_2022/Manaaki_Haumanu Clinical_Care/Quality/ Foundation_2022/Indicator_5_Continuity_of_care.aspx?hkey=0f596765-0ec8-4463-9300-a1980be532bc&iSession=0b366349ab194414b360df7a3a45a8b5|ping%20-c%201%20127.0.0.1||x%27

Further comment received 24 November 2022

Good afternoon,

In response to your request for further comment:

1) Whether the provider's comments change any aspects of your initial advice;-

The comments have described more fully as to [NP B's] work commitments and times spent at the practice concerned with the complaint. It also highlights well known pressures on primary healthcare that have only worsened since COVID pandemic. Whilst that is not an excuse per se it does impact on the effectiveness of system responses to more urgent health needs.

2) Whether there are any other matters in this case that you consider warrant comment;

No further comments.

3) Any recommendations that you could think of for future improvements to the provider's practice.

I see that [NP B] has already reflected on and changed her practice accordingly. It is good to see that she has ongoing clinical supervision to support her in the future.

I have no other recommendations.

I fully concur with Dr Mapleson that the failure is largely in the secondary care sector rather than primary care, and note it has highlighted the lack of a clear referral pathway for urgent high suspicion of cancer cases that should be prioritised to the highest degree.

Regards, Rosemary

Further comment received 14 December 2022

As far as I am aware it is best practice to complete a rectal exam — this is also included in the MOH guidelines as I have previously included in the references on my advice so I won't change my advice on this.

Regards, Rosemary'

Appendix C: New Zealand Health and Disability Services (Core) Standards

Standard 3.3 of the Service Provisions Requirements (Ngā Whakaritenga Whakaratonga) of the NZS 8134.1.3:2008 states:[7]

'**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.

Guidance notes 3.3.3: This may include, but is not limited to:

(a) Service provision time frames are documented in order to meet consumer needs in line with time frames specified in:

(i) Clinical pathways/desired clinical outcomes

(ii) The organisation's policies/procedures

(b) A monitoring process to ensure time frames are met;

(c) A process to identify and respond to variances/trends.

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

[7] New Zealand Health and Disability Services (CORE) Standards (NZS 8134:2008). These standards were in place in 2020. The Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 came into effect on 28 February 2022 and superseded NZS 8134:2008.