Radiologist / Crown Health Enterprise

Report on Opinion - Case 99HDC02232

Complaint

The Commissioner received a complaint from the consumer that another consumer's ultrasound results were sent to her general practitioner by the radiology department of the public hospital. The complaint was that:

- *In early February 1999 the consumer contacted her general practitioner as she was still awaiting an appointment for an ultrasound at the public hospital's radiology department.*
- *The consumer's general practitioner told her that her ultrasound results were normal. The consumer explained that she had not had an ultrasound because she had not been able to keep the appointment arranged for early January 1999.*
- *The consumer's general practitioner was adamant that she had the consumer's ultrasound results and asked her to telephone the radiology department to follow it up.*
- *The consumer spoke to, the bookings clerk at the radiology department, and asked her to check whether there was any record of an ultrasound having been performed.*
- *The clerk confirmed there was no record of an ultrasound having been performed.*
- *The clerk said the radiology department contacted the consumer's general practitioner with details of the appointment in early January 1999 and informed her when the appointment was cancelled. The consumer's general practitioner said she was not contacted on either occasion.*
- *The consumer was asked by her general practitioner to collect the report and take it to the radiology department. The consumer went to collect the report the next day.*
- *The consumer's general practitioner told her she had spoken to a radiologist the previous afternoon and had been told that the department pre-codes patients and another patient's report had been sent by mistake.*
- *The consumer queried whether another consumer's report had been sent to this consumer's doctor and was told the doctor would have received the same report.*
- *The consumer's general practitioner said she would destroy the report.*

Continued on next page

Radiologist / Crown Health Enterprise

Report on Opinion – Case 99HDC02232, continued

Investigation

The complaint was received on 24 February 1999 and an investigation was undertaken. Information was obtained from:

The Consumer
The Radiologist
The General Practitioner
The Quality Co-ordinator, Radiology Department, the Public Hospital

The Commissioner obtained a copy of the public hospital's radiology report sent to the GP.

Information Gathered During Investigation

The consumer was referred to the radiology department at the public hospital by her GP. An appointment was arranged for early January 1999. The consumer did not attend and contacted the radiology department to arrange another appointment after this date. The booking clerk advised the consumer that another appointment notice would be sent to her. The quality co-ordinator, radiology department at the public hospital advised the Commissioner that the referral form indicated a second appointment was made for mid-February but the consumer did not attend this appointment.

The consumer said she did not receive an appointment notice and contacted her GP to advise she was still waiting for notification from the public hospital. The GP informed the consumer that her ultrasound results were normal. After discussing the matter the GP advised the consumer to follow up with the radiology department. The consumer spoke with the booking clerk who informed her there was no record of an ultrasound scan having been performed.

Continued on next page

Radiologist / Crown Health Enterprise

Report on Opinion – Case 99HDC02232, continued

Information Gathered During Investigation *continued*

The quality co-ordinator advised the Commissioner that when a consumer cancels an appointment the sonographer informs the receptionist who immediately cancels the appointment and records DNA (did not attend) on the computer system. When the consumer failed to attend in early January 1999 the appointment was not cancelled and remained as a pending procedure. However, as an episode number had already been assigned to the consumer, her name could be picked up by a typist from the digital dictation system. The typist is required to read the episode number relating to a specific report from a small screen and verify the number against the consumer's name, which is dictated by the radiologist. In this instance the typist input the wrong episode number (the last digit was entered incorrectly) and the report sent to the GP should have been sent to another consumer. The quality co-ordinator stated that the radiologist who authorised the report did not notice it was attached to the consumer's episode number. Once authorised it was posted to the GP.

The quality co-ordinator advised the Commissioner that, following the consumer's telephone call, the radiologist and the typist concerned realised that a mistake had been made, and that the consumer's appointment was still registered on the computer as a pending procedure. The typist de-authorised the report, which deleted it from the system, at 1.30pm. on the day after the original appointment was scheduled. The consumer's episode number was recorded as DNA. The typist then retyped the report for the other consumer using the correct episode number.

The consumer complained that the booking clerk told her that her GP had been contacted regarding the appointment scheduled for early January 1999 and had been contacted again when she had been unable to keep it. The GP disputed this.

The quality co-ordinator advised the Commissioner that the recommended best practice is to return the request form to the consumer's referring doctor or general practitioner when a consumer cancels an appointment. However, if the consumer requests another appointment the request form is retained and another booking is made. The general practitioner is not contacted directly in either situation.

Continued on next page

Radiologist / Crown Health Enterprise

Opinion – Case 99HDC02232, continued

Information Gathered During Investigation ***continued***

The GP advised the Commissioner that following her conversation with the consumer, she (the GP) contacted the radiology department and was told consumers are pre-coded and that another consumer's report had been sent to her by mistake.

The quality co-ordinator advised the Commissioner that pre-coding is not standard practice in the radiology department, but did occur in this case. She advised that a number of staff were on leave over the New Year period and that pre-coding may have been carried out by night staff attempting to ensure efficiencies in the next day's schedule.

Radiologist / Crown Health Enterprise

Report on Opinion – Case 99HDC02232, continued

The public hospital's Response to Provisional Opinion

"It is submitted that [the radiologist] *took reasonable steps in the circumstances to give effect to the rights, and comply with the duties, in the Code. He did all the things which a reasonable radiologist using the systems provided by* [the Crown Health Enterprise] *could be expected to do. He used the digital dictation system and the approval system in the recommended manner".*

The public hospital explained it is difficult for a radiologist to check a consumer's name is correctly matched against their episode number because:

- *"at the time of checking the report the radiologist does not have the x-rays and/or the original x-ray request form with the episode number bar code;*
- *the digital dictation system and the computer system for reports are not interfaced but are completely separate;*
- *unless the radiologist remembers a patient for some reason, he or she will not know whether the report is linked to the correct patient, particularly where the radiological investigation is of a non-procedural "plain film x-ray" type (where the patient has not been seen by the radiologist who is simply reporting on the x-ray films) and no abnormality is shown.*

…
The only way in which the radiologist could check that the correct patient is matched with the correct episode number would be for the radiologist to check the envelope in which the x-ray is filed. This is not routine practice at [the public hospital] *or at any other hospital nor is it practical or efficient. Radiologists would not be able to provide timely and effective services to patients if it were necessary for them to check x-ray packets when approving reports. Radiology departments in New Zealand and internationally use systems similar or identical to* [the public hospital]*".*

Continued on next page

Radiologist / Crown Health Enterprise

Report on Opinion – Case 99HDC02232, continued

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

…

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

Opinion: No Breach The radiologist

In my opinion the radiologist did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

Verification of Report with Episode Number

The typist who picked the report from the digital dictation system made an error in the last digit of the episode number which resulted in the incorrect report being prepared under the consumer's name. The public hospital's protocol required the typist to verify the episode number against the consumer's name, and also required the radiologist, who dictated the report, to check that clinical details were correct. As the digital dictation system and computer system for reports are not interfaced, the radiologist was unable to verify that the consumer's name was correctly matched with the episode number. The error that arose cannot be attributed to an individual, but rather the system that exists at the public hospital. In my opinion the radiologist provided services of an appropriate standard and did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Continued on next page

Radiologist / Crown Health Enterprise

Report on Opinion – Case 99HDC02232, continued

Opinion: Breach The public hospital Limited

In my opinion the public hospital breached Right 4(2) of the Code of Health and Disability Services Consumers Rights as follows:

Right 4(2)

Cancellation

The public hospital's recommended best practice is that if a consumer cancels or does not attend an appointment the request form is sent back to the referring doctor or GP. While the consumer's request form was retained because another appointment was requested, I note that the consumer did not attend the appointment scheduled for mid-February 1999 and her request form was not returned to the GP. In my opinion the public hospital's failure to adhere to is own recommended best practice standard breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Pre-Coding

The public hospital's protocol is that when a referral is received from a GP an appointment is made, and an appointment letter is computer generated. An episode number is created only when the consumer attends the appointment. A number of labels are generated, one of which is attached to the referral form. When the ultrasound scan has been completed the findings are dictated by the provider and are recorded against the pre-coded number. The provider then checks and authorises the report. In this case the protocol was not followed. The consumer's episode number was generated in advance of her appointment and, as the result of an error during typing, a report was incorrectly generated under the consumer's name. In my opinion the public hospital failed to follow its own protocol with respect to pre-coding and breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Continued on next page

Radiologist / Crown Health Enterprise

Report on Opinion – Case 99HDC02232, continued

Actions Required

I recommend that the public hospital take the following action:

- Provide a written apology to the consumer for its breach of the Code of Health and Disability Services Consumers' Rights. This apology is to be sent to the Commissioner and will be forwarded to the consumer.

Actions Taken

The public hospital has taken steps to ensure established protocols are followed including ensuring that referral forms are returned to GPs when consumers cancel an appointment or do not attend; that pre-coding does not occur, and that typists always check the episode number against the name on the report.

I do not intend taking any further action on this complaint and will close my file once the consumer's letter of apology has been received.