Unacceptable delay in providing patient with results of spinal X-ray (03HDC02380, 24 February 2004)

Public hospital ~ Systems error ~ Reporting of results ~ Co-ordination of care ~ Rights 4(4), 6(1)(f)

A 49-year-old woman was admitted to hospital acutely with severe abdominal and back pain. All admissions to the Emergency Department at the hospital at that time were seen by one of three medical teams on duty. The hospital clerks would identify the team that had accepted the patient and print the patient identification labels. The labels would be used for ordering tests and X-rays. However, due to an imbalance of workload, the patient was transferred to another team, and initially her labels were not updated.

On admission a chest X-ray was normal but blood tests revealed abnormal liver function. The patient was discharged with follow-up at the outpatient clinic. When she was discharged, some of the incorrect labels remained on her file. This meant that when she was seen at outpatients, the registrar did not realise that results of her spinal X-ray would be sent to a different doctor's team, not to her consultant. She was subsequently seen by another registrar of the same consultant, who was unaware that an X-ray had been performed. This occurred because the clinical record filing system was arranged in such a way that the medical team registrar's notes were filed under two different sections under the individual doctor's name rather than a generic internal medicine section. As a result, the abnormality present on the patient's X-ray was not reported to her, and follow-up did not occur. When her general practitioner ordered another spinal X-ray several months later, it revealed the problem in a more advanced stage. The patient was diagnosed with myeloma.

The hospital recognised that its systems had failed this patient and amended its procedures for allocation of new admissions and the generation of patient labels. It also updated its computer systems so that most results are signed off electronically. The clinical records processes and booking and scheduling processes were also reviewed, taking into account the errors that had occurred. The hospital was held to have breached Right 4(4) in failing to provide services in a manner that minimised potential harm. It had a responsibility to ensure that the patient's results were provided to her and the team responsible for her care. The delay amounted to a breach of Right 6(1)(f).