Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Safety in Practice: A View from the HDC

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Health and Disability Commissioner

Safety in Practice:
Primary Health Care, Ko Awatea
27 June 2016

HDC Vision

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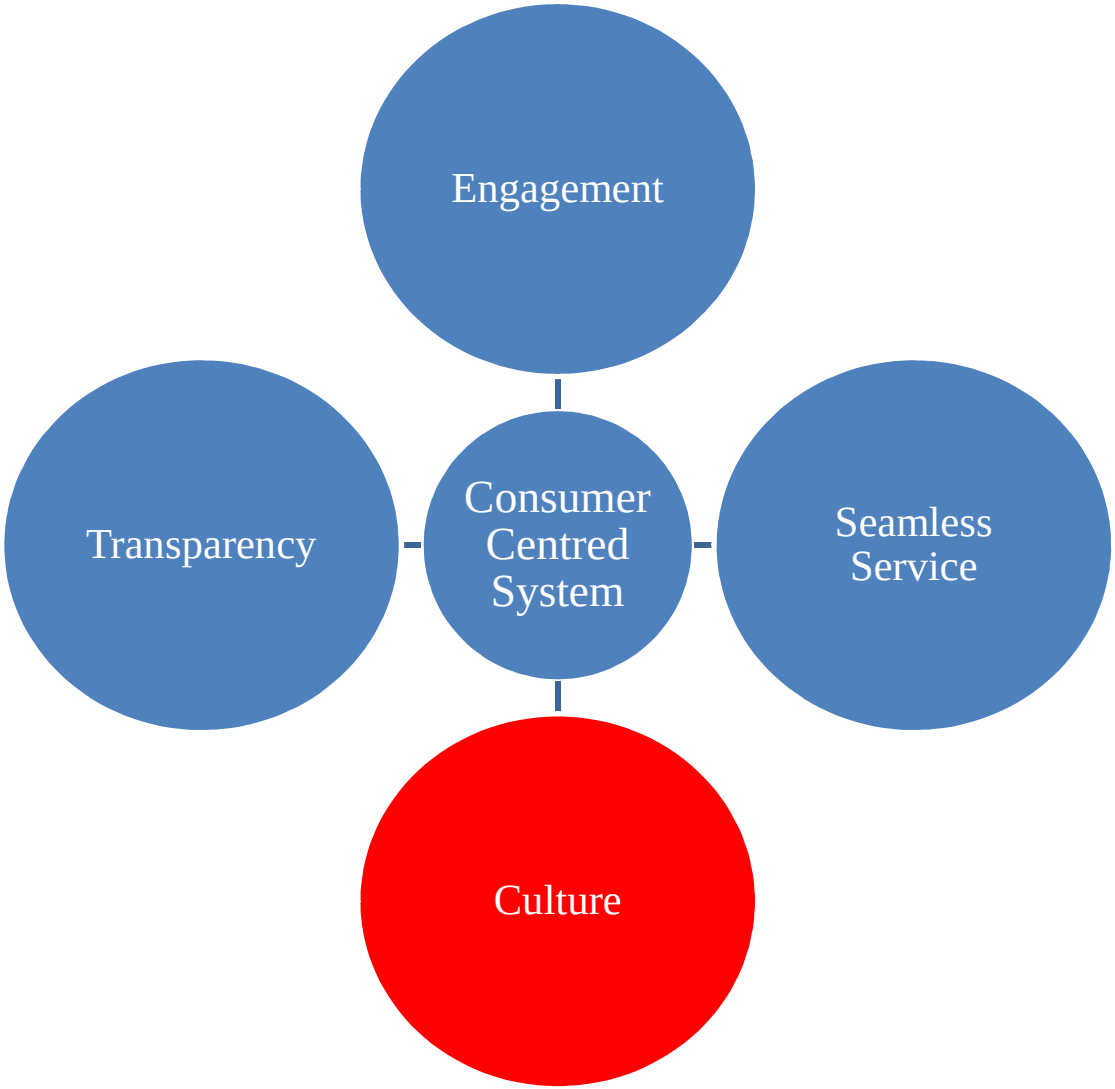

HDC Approach

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HDC contributes to the achievement of a safe consumer-centred system in a unique way:

- **Complaints resolution**
  Promote and protect consumer rights

- **Safety and quality improvement**
  Strengthen the system so that it continually improves

- **Public protection**
  Watchdog role

What is a consumer-centred system?

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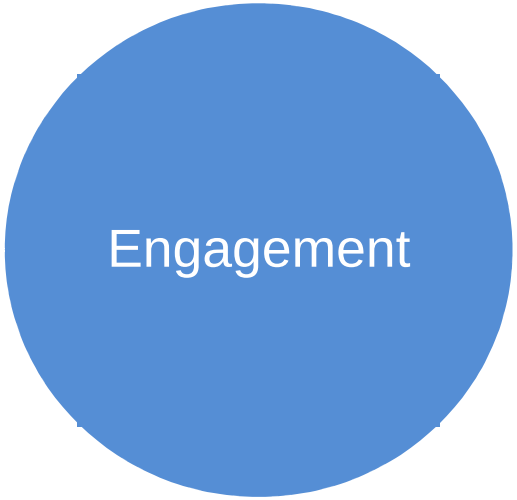
It is about Engagement

An engaged consumer is an empowered consumer

- **"If health is on the table, then the patient and family must be at the table, every table, now."**

  Leape and Berwick et al (2009)



- **There is increasing evidence that involving patients in decision making has positive effects in terms of patient satisfaction, adherence to treatment regimes and even their health outcomes**

  Van Steenkiste et al (2007); O'Connor et al (2003)

What is a consumer-centred system?

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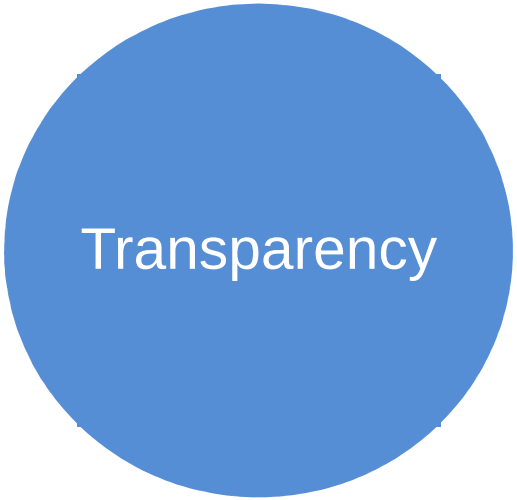
It is about Transparency



"Disclosure is a professional obligation…and is a marker of patient-centred care. It also reflects the transparency of an organisation, which is believed to be a key component of safe organisations."

Etchegaray et al (2012)

What is a consumer-centred system?

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It is about Seamless Service

The complexities of modern medicine demand that clinicians no longer work as "cowboys" – working alone in their specialist field

- **Modern medicine is most effective when it functions like a system – "diverse people working together to direct their specialised capabilities toward common goals for patients. They are coordinated by design. They are pit crews."**

Gawande (2011)

- **It is essential that different units within the same system communicate well**

Hill (2011)

What is a consumer-centred system?

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It is about Culture

"In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime."

Robert Francis QC (2013)

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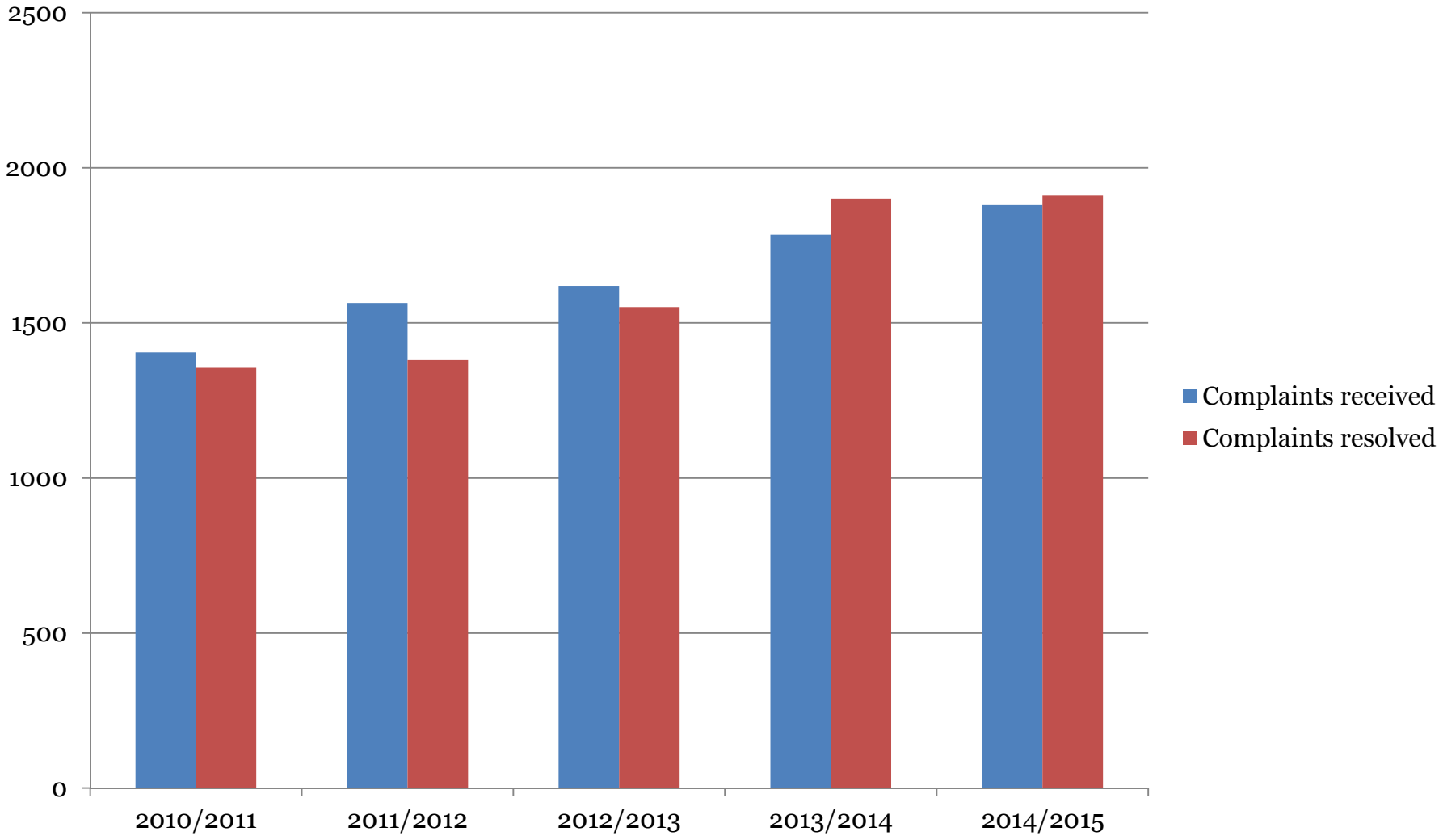
Complaint Statistics

Number of complaints received by HDC



Group providers complained about in 2014/15

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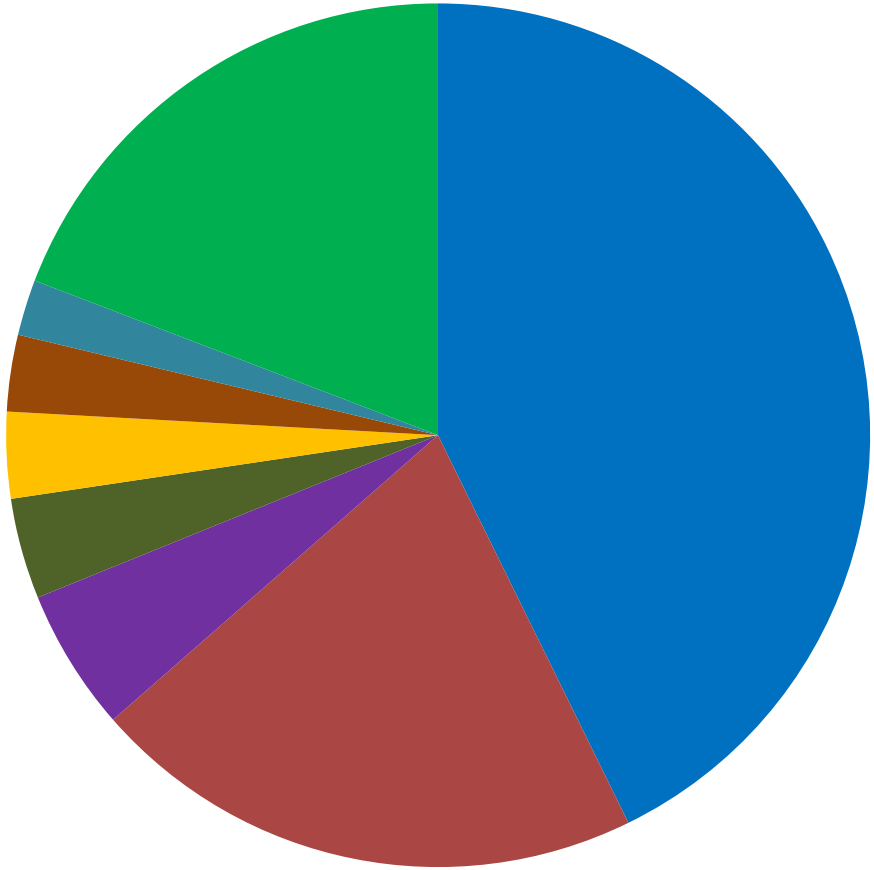

- DHB (43%)
- General practice (21%)
- Rest Home (5%)
- Dental clinic (4%)
- Disability provider (3%)
- Prison (3%)
- Pharmacy (2%)
- Other (19%)

Individual providers complained about 2014/15

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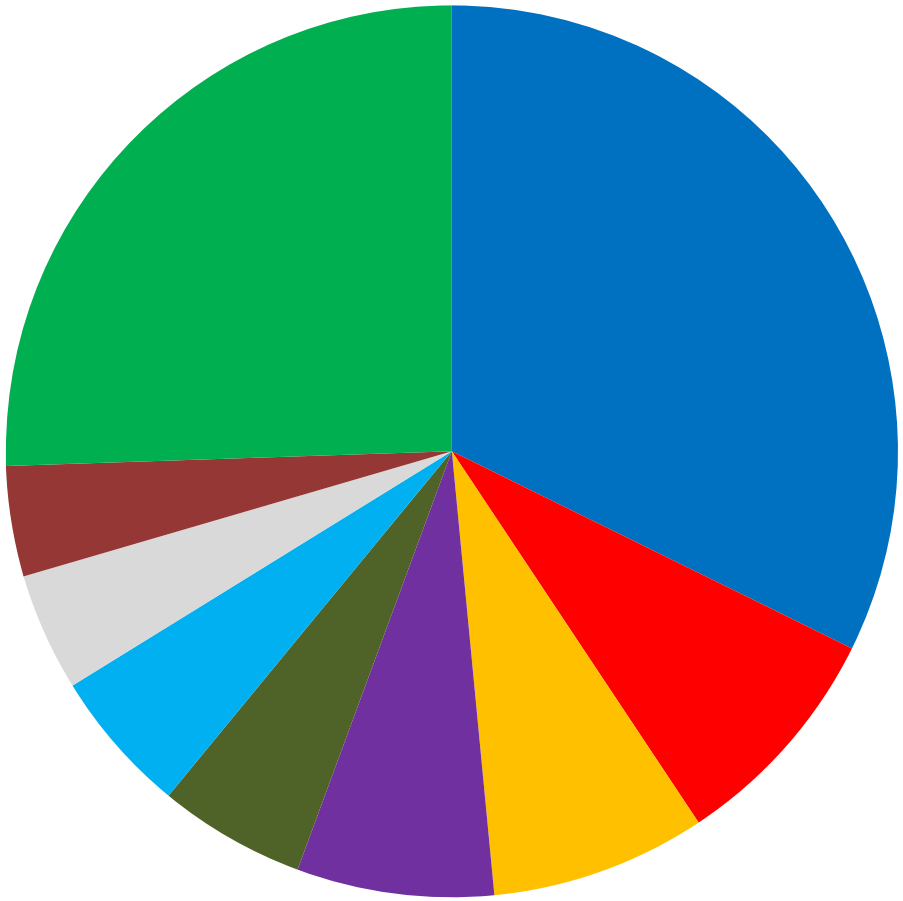

- General Practitioner (32%)
- Nurse (9%)
- Midwife (8%)
- Physician (7%)
- Psychiatrist (5%)
- Dentist (5%)
- Orthopaedic surgeon (4%)
- Obstetrician/Gynaecologist ($%)
- Other (26%)

Number of complaints received about general practices and general practitioners each year

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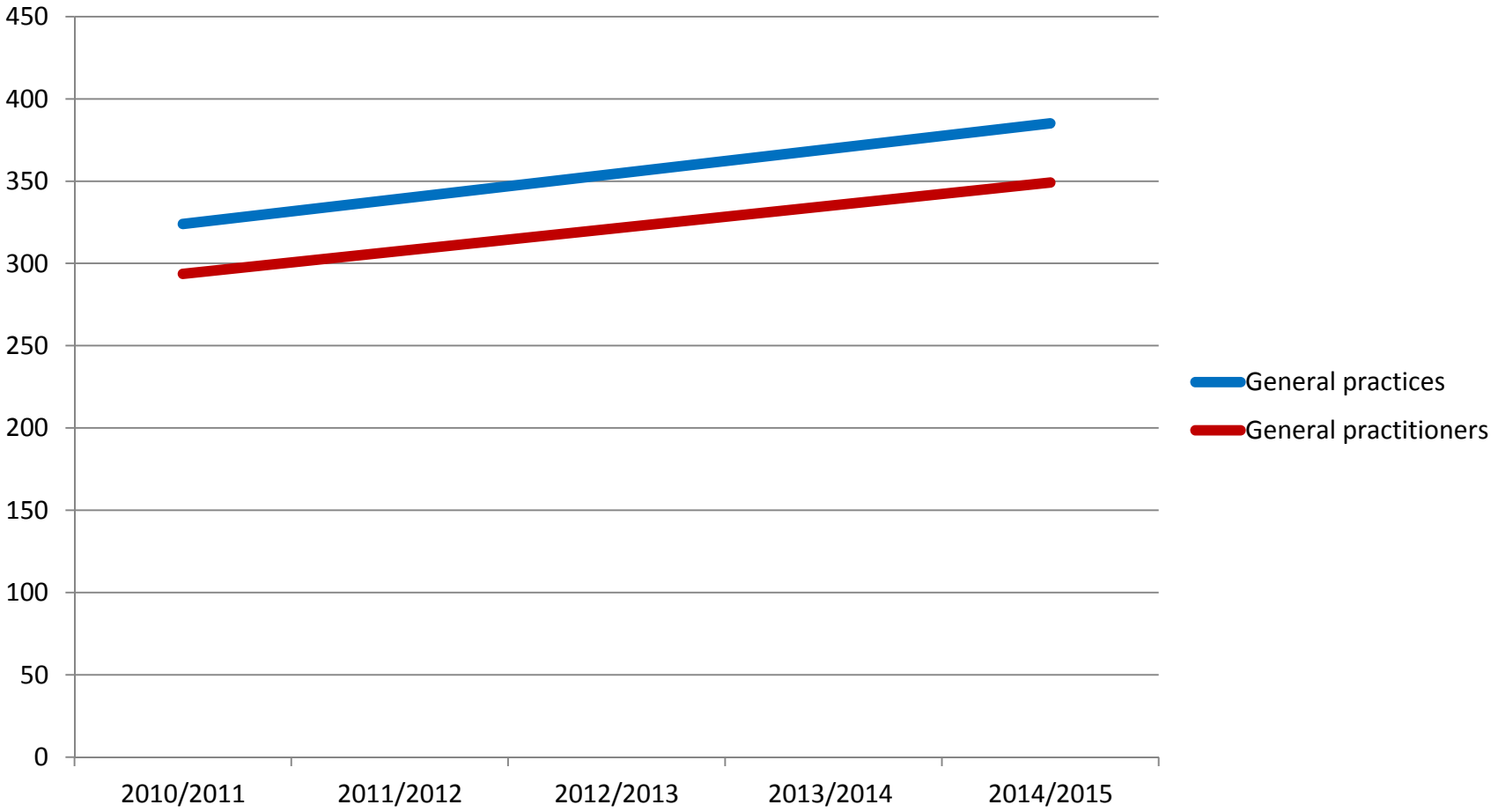

Complaints in context

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- 15 million GP consultations
- 564,000 acute hospital discharges
- 3,500 complaints to advocacy
- 1,800 complaints to HDC

Top issues complained about in complaints about GPs

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1. Missed/delayed/incorrect diagnosis
2. Disrespectful manner/attitude
3. Inadequate/inappropriate clinical treatment
4. Inadequate/inappropriate examination/assessment
5. Delayed/inadequate/inappropriate referral

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Case Studies

Wider learnings:
Delayed diagnosis of Cancer

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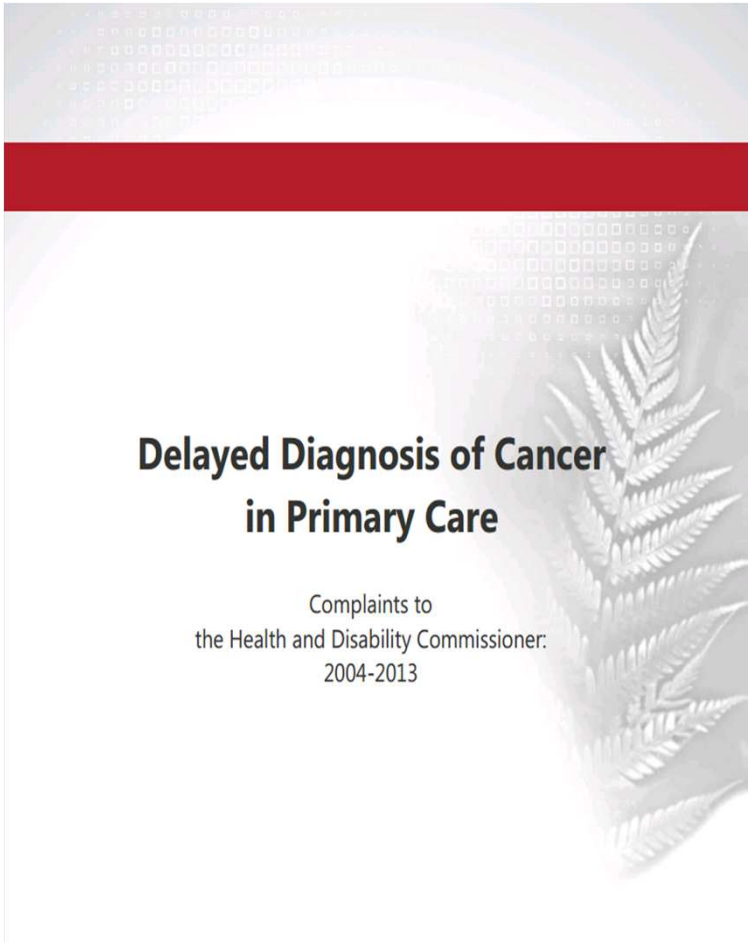
- Analysis of complaints in which the primary care management had contributed to delayed diagnosis
- Brought together the clinical recommendations made in the cases, including:
  - undertaking clinically indicated examinations and tests;
  - examining patients in the context of their past history;
  - being aware of the limitations of diagnostic testing;
  - providing 'safety-netting' advice
  - having robust follow-up systems
  - advocating for patients in the secondary care system



Prescribing error

14HDC01058

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- Mrs A was taking the statin cholvastin and the antidepressant fluoxetine
- Mrs A presented to her GP, Dr B, to discuss her hypertension
- Mrs A told Dr B that she was considering becoming pregnant
- Dr B prescribed cilazapril for Mrs A, which is contraindicated in pregnancy

Prescribing error

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- Mrs A obtained repeat prescriptions for fluoxetine, cilazapril and cholvastin from the medical centre on three occasions
- At no time was Mrs A's blood pressure checked
- Mrs A then advised Dr B she was pregnant. Dr B did not discuss with Mrs A the medication she was taking

Prescribing error

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- An obstetrician advised Mrs A's midwife that Mrs A should not be taking cilazapril and cholvastin
- Mrs A spoke to a nurse at the medical centre, who put an enquiry through to Dr B regarding Mrs A's medications
- Dr B told Mrs A that she should continue taking cholvastin and cilazapril, but should consider coming off fluoxetine
- Mrs A was then taken off cholvastin and cilazapril by her obstetrician

Prescribing error

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Findings – Dr B

Breach of Right 4(1)

- Failed to identify that cilazapril and cholvastin were contraindicated in pregnancy
- Failed to ensure that Mrs A's blood pressure was monitored appropriately

Breach of Right 6(1)

- Failed to provide information to Mrs A about the risks and benefits of continuing cilazapril, cholvastin and fluoxetine in pregnancy

Prescribing error

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Findings – The practice nurse

Adverse comment

- Poor management of her conversation with Mrs A

Findings – The Medical Centre

Adverse comment

- Failure by staff to follow its "Repeat Prescriptions Policy, Protocol and Procedure'
- Poor communication between the GP and practice nurse

"The provision of primary care is a team effort"

Follow-up of test results

14HDC00368

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- Mr A presented to his GP (Dr C) with flu-like symptoms
- Dr C undertook a physical examination and referred Mr A for blood tests
- The next day, Dr C reviewed the blood test results and noted that they were abnormal
- Dr C forgot to ask the practice nurse to advise Mr A of his results and to ascertain his current condition

Follow-up of test results

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- Mr A remained unwell and presented to an accident and emergency clinic
- The clinic doctor accessed Mr A's blood test results and referred him to the local public hospital
- Mr A was eventually diagnosed with a post-infectious inflammatory disease

Follow-up of test results

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Findings – Dr C

Breach of Right 4(1)

- Failed to ensure that the abnormal results were followed up in a clinically appropriate manner

Breach of Right 6(1)(f)

- Failed to fully inform Mr A of his abnormal blood test results

"Doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, results. This opinion highlights the importance of the effective and prompt communication of test results by providers to consumers. The primary responsibility for following up abnormal results rests with the clinician who ordered the tests, in this case, Dr C."

Follow-up of test results

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Findings – The medical centre

Adverse comment

- Failed to have in place a formal process for the tracking of urgent results

"Medical centres have a responsibility to have in place good systems to ensure that patients receive good quality care. In particular, they are responsible for having effective policies for the handling of incoming results and patient follow-up"

Getting the basics right

C13HDC01237

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- Mr A, an elderly man with complex morbidities changed GPs
- An electronic and a paper copy of the man's medical records were sent to the new medical centre

Getting the basics right

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The practice nurse

- received the paper copy
- reviewed the transfer summary
- noted incorrectly that there had been no changes to the man's medication since 2003

Getting the basics right

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The trainee intern

- Assessed the man as a new patient and did not establish/record:
  - cardiac surgery
  - a metallic "click" (associated with a mechanical mitral valve)
  - sternotomy scar
  - warfarin

Getting the basics right

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The GP

- Man said he was taking warfarin
- Assumed warfarin was for a rhythm disturbance
- Advised the man to stop taking warfarin

The man later died in hospital after suffering several strokes

Getting the basics right

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Findings - GP

Breached Right 4(1)

- Failed to review the medical records adequately and to investigate the reason for the warfarin before stopping it

Breached Right 6(1)

- Failed to provide the man with information about the risks and benefits of discontinuing warfarin therapy

Breached Right 7(1)

- The man was not in a position to make an informed choice and give informed consent to the discontinuation of the warfarin treatment

Getting the basics right

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"This opinion highlights the importance of getting the basics right to ensure that a good standard of clinical care is provided. This includes adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes, and examining the patient as appropriate"

Getting the basics right

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Findings – Medical Centre 1 & 2

Adverse comment

- Medical Centre 2 provided suboptimal electronic notes
- Medical Centre 1 did not ensure that its staff were clear about whose responsibility it was to review a new patient's medical record

"Ensuring that a patient's medical record is handled and reviewed carefully is fundamental to providing good clinical care. It also ensures that patients can have an efficient and safe transition between two practices and receive continuity of care"

Monitoring and follow-up

13HDC00619

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- In 1998 Ms A began consulting two GPs at two different medical centres.
- Until mid-2011, Ms A's original GP, Dr C, was not aware that she was consulting a second GP
- From 1998, the second GP (Dr B) requested thyroid function tests for Ms A and prescribed Etroxin

Monitoring and follow-up

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- In 2008, Dr B recommended a change from Eltroxin to whole thyroid, an unapproved medicine.
- Ms A reported that Dr B did not provide her with information about whole thyroid
- In 2009 Ms A's thyroid tests indicated a possible over-replacement of thyroxine
- Dr B had intended to follow up Ms A in one year's time, but this did not occur
- There was no review of Ms A's thyroid symptoms until 2011, but repeat prescriptions of whole thyroid continued to be dispensed

Monitoring and follow-up

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- In 2011, Dr B increased Ms A's dose of whole thyroid without first testing her thyroid levels
- Ms A later became clinically and biochemically hyperthyroid while overseas
- Ms A was found to have developed atrial fibrillation as a result of thyrotoxicosis caused by her treatment

Monitoring and follow-up

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Findings – Dr B

Breached Right 4(1)

- Failed to sufficiently inform Ms A about whole thyroid
- Failed to monitor Ms A's thyroid function appropriately
- Inadequate documentation
- Failed to establish Dr C's role in Ms A's care and treatment
- Failed to keep Dr C informed of her treatment of Ms A

Monitoring and follow-up

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Findings – Medical Centre

Breached Right 4(1)

- Lacked robust systems to ensure that an adequate quality of care was provided to Ms A

"It is imperative that providers are supported by robust systems to ensure that patient follow-up occurs in a timely and appropriate way"

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