Mr Anthony Hill

Health and Disability Commissioner

Wellington

Friday, June 9, 2017

(Room 6)

14:00 - 14:55 WS #49: Effecting Change; Towards a Consumer-centred System

15:05 - 16:00 WS #61: Effecting Change; Towards a Consumer-centred System (Repeated)

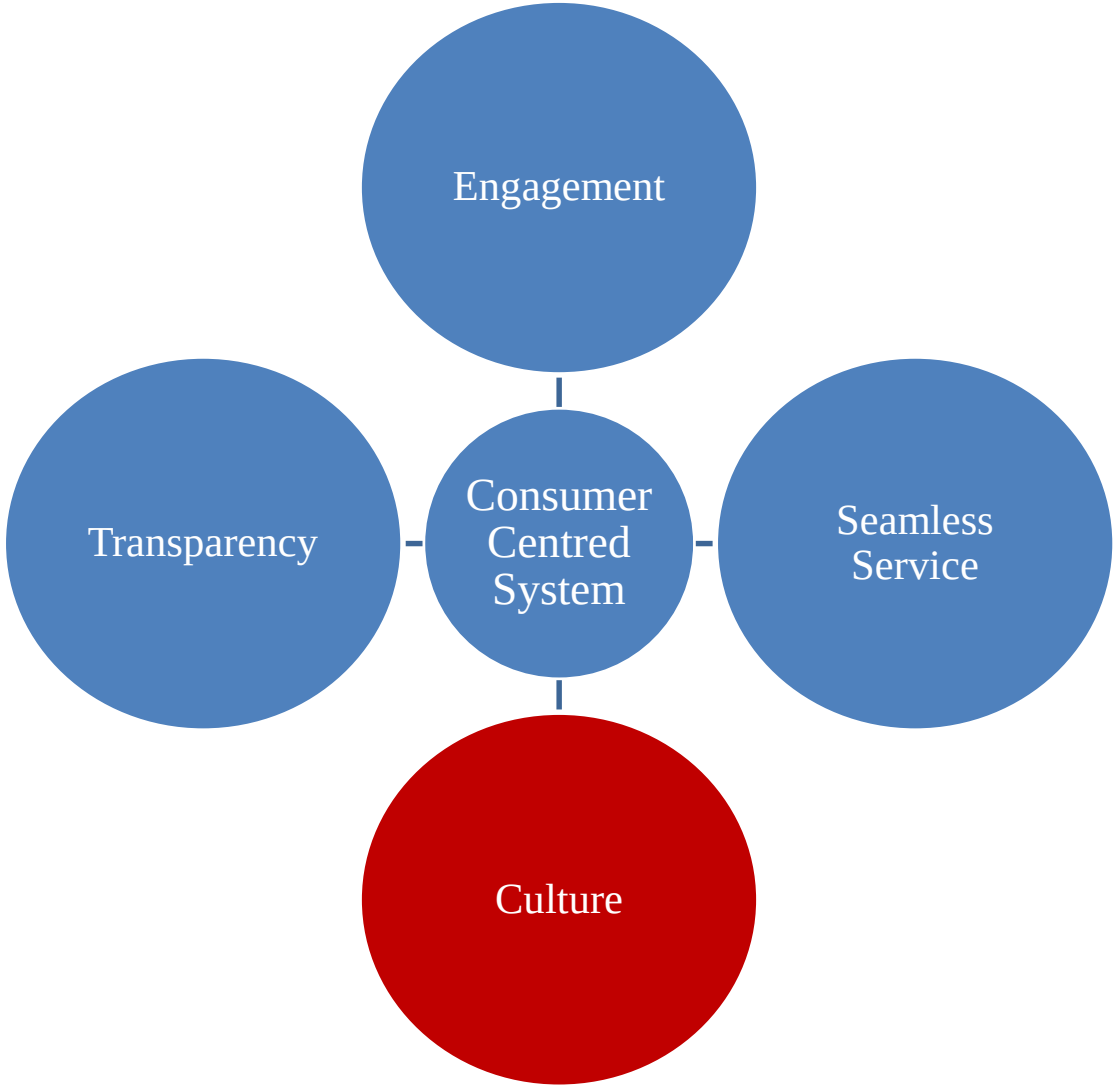
Effecting change: towards a consumer-centred system

Anthony Hill
Health and Disability Commissioner

GP17 conference
9 June 2017

HDC Vision

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga



Purpose of HDC

"To promote and protect the rights of … consumers and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints"

HDC Act 1994

HDC Approach

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

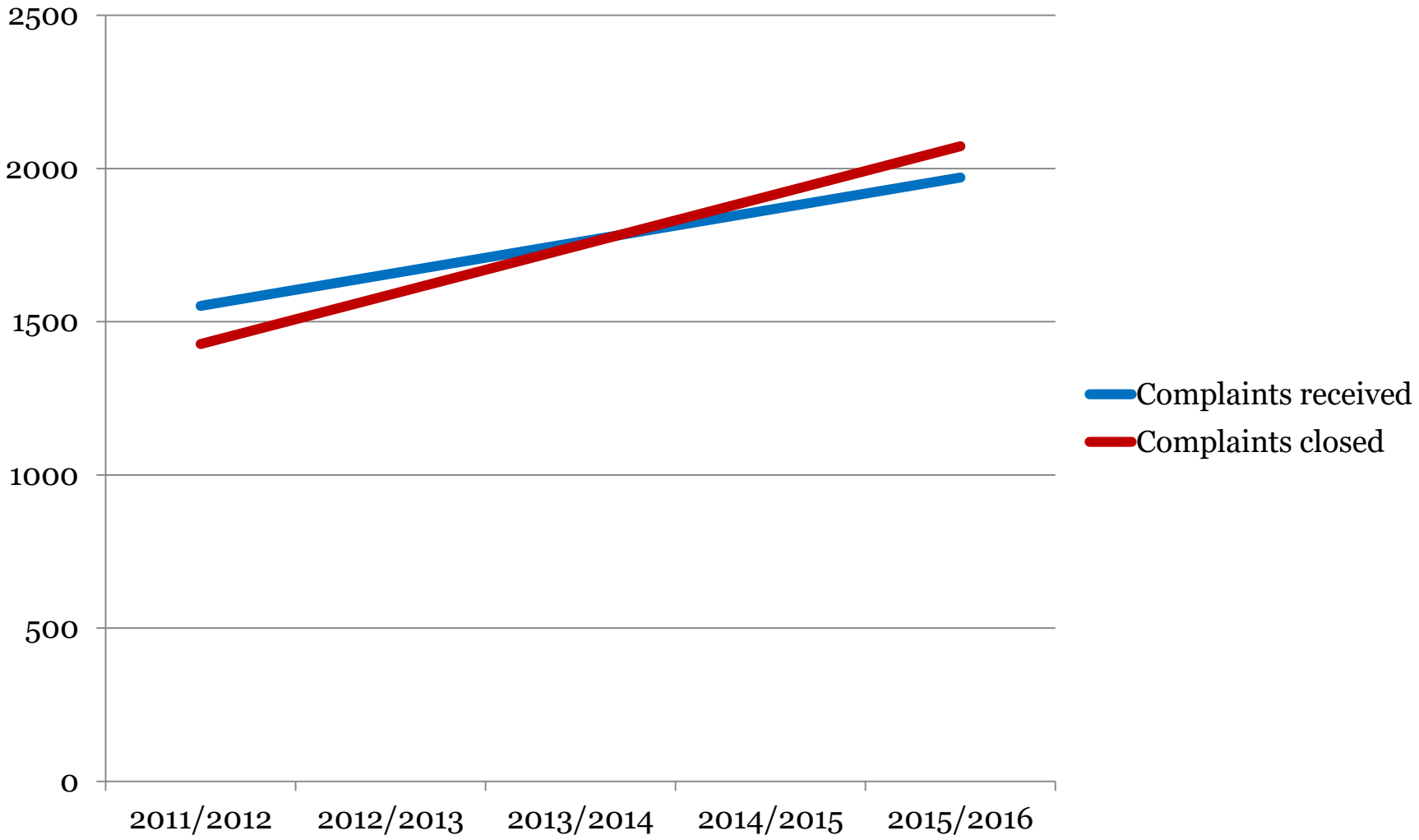
HDC contributes to the achievement of a safe consumer-centred system in a unique way:

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

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

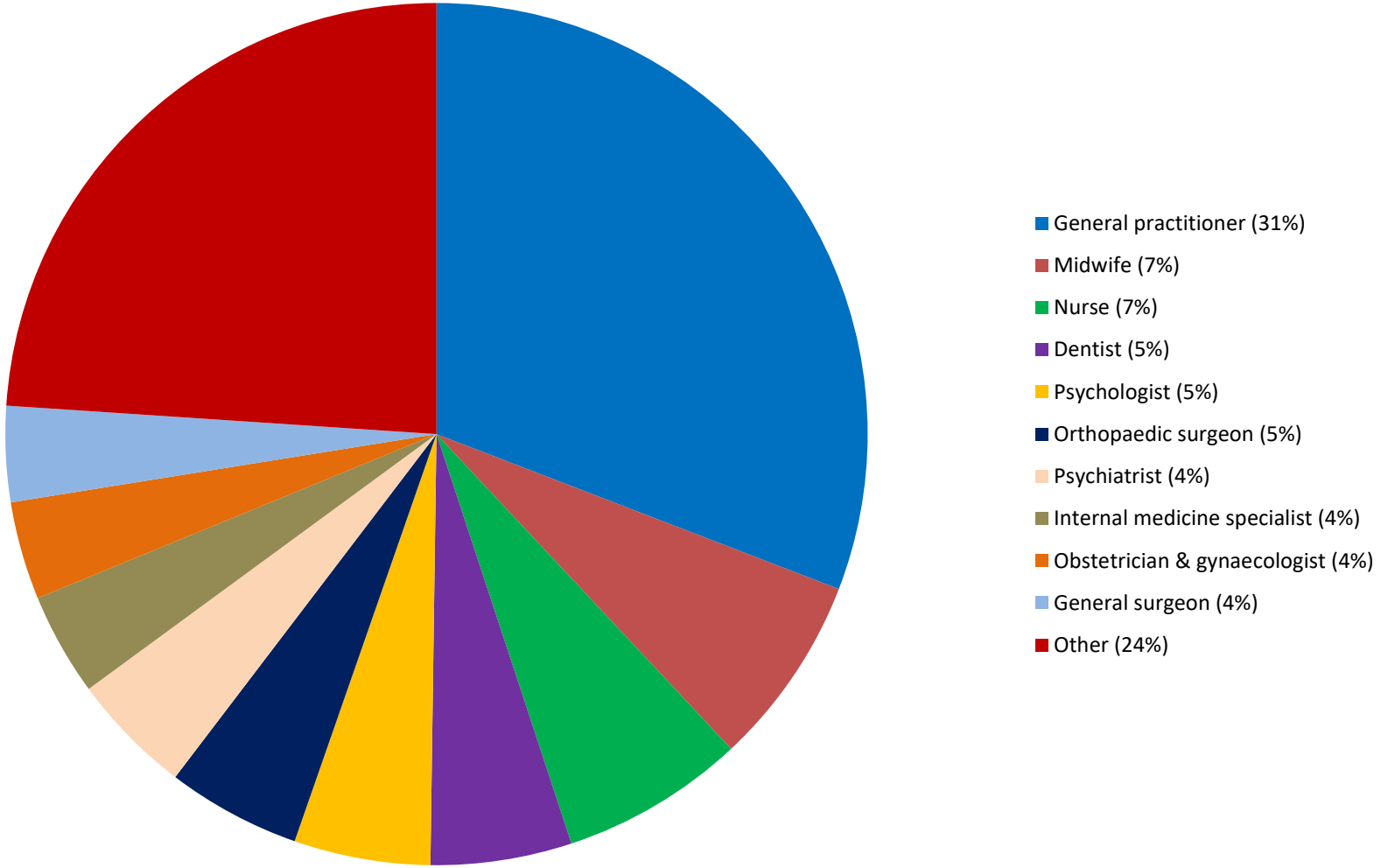
- **Public protection**
  Watchdog role

Number of complaints received by HDC



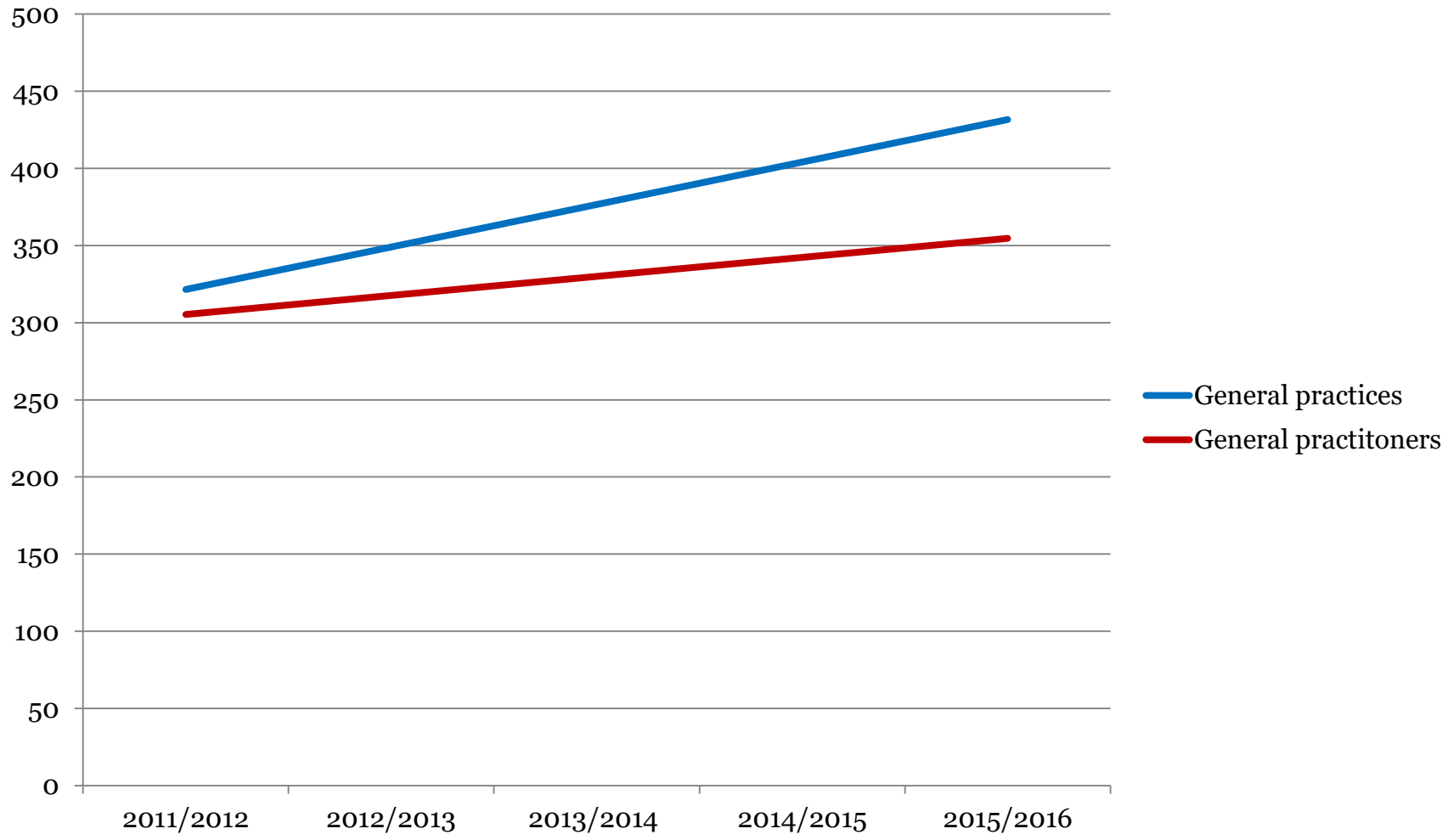
Individual providers complained about in 2015/16

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga



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

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga



Top issues complained about in complaints about GPs

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

1. Missed/delayed/incorrect diagnosis (37%)
2. Inadequate/inappropriate clinical treatment (34%)
3. Inadequate/inappropriate examination/assessment (32%)
4. Disrespectful manner/attitude (32%)
5. Delayed/inadequate/inappropriate referral (27%)
6. Failure to communicate effectively with consumer (16%)

Themes in primary care complaints

- Management of referrals
- Test result follow-ups
  - Clarity of roles between primary and secondary care
- Clinically indicated examinations and assessments
- Continuity of care – multiple GPs
- Locum GPs – training and orientation
- Getting the basics right

What is a consumer-centred system?

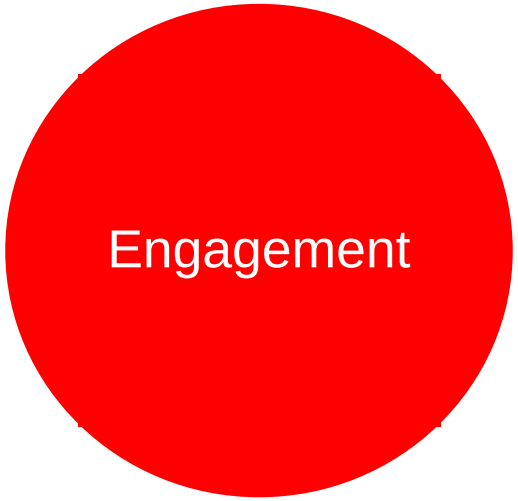
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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**

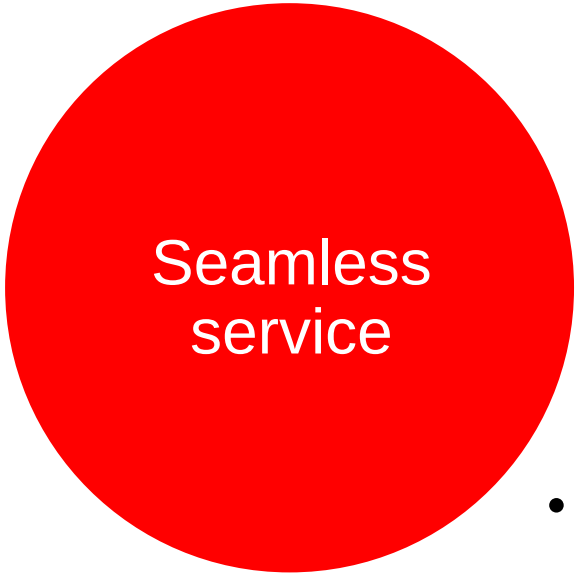
  Van Steenkiste et al (2007); O'Connor et al (2003)

What is a consumer-centred system?

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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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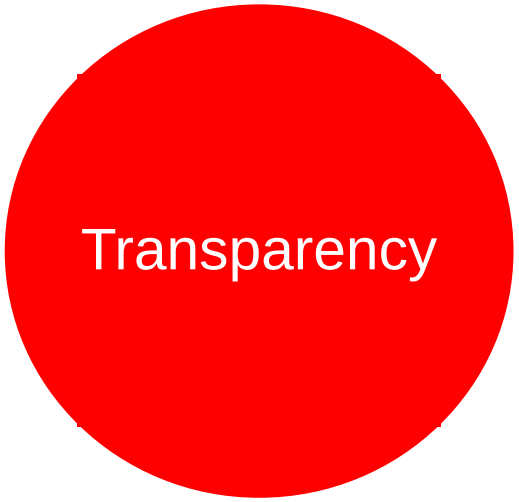
It is about Transparency



"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)

The recurring message

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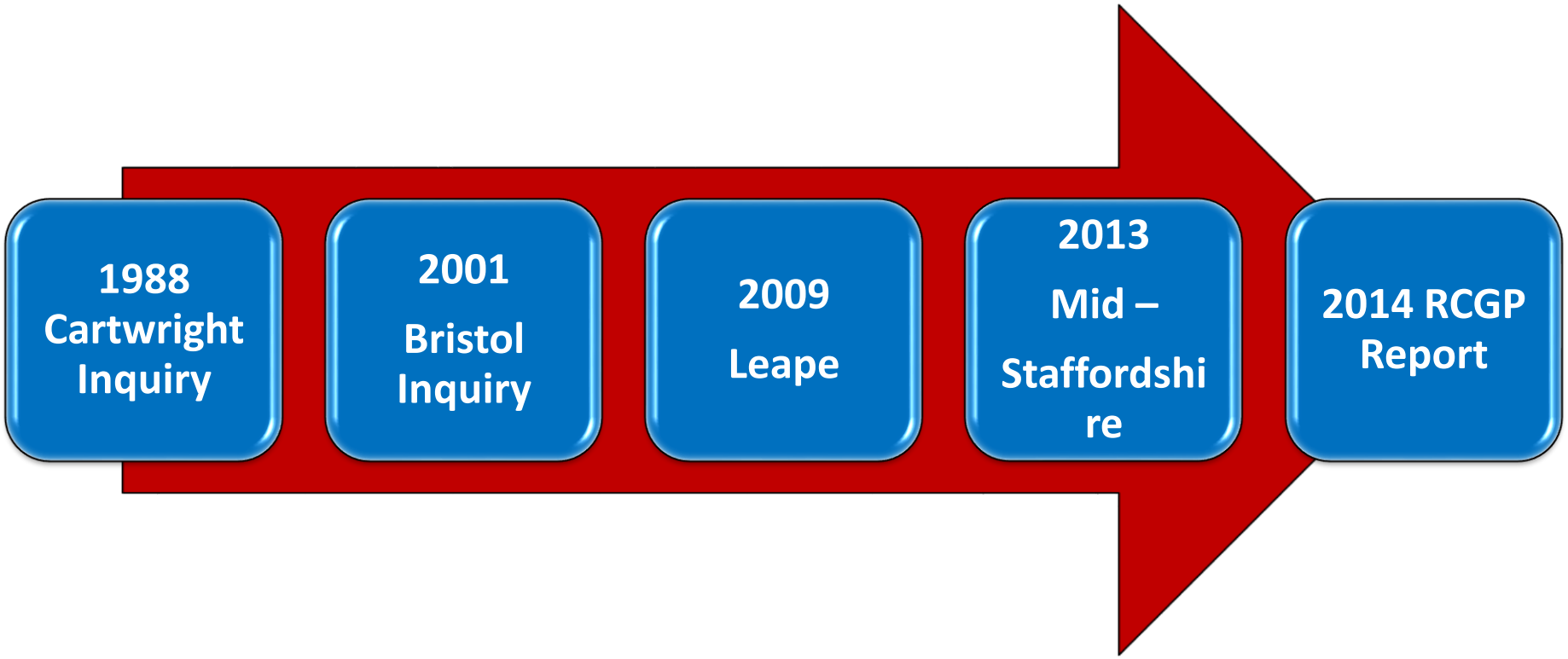

What is a consumer-centred system?

It is about Culture

Culture matters. It goes to the very core of the quality of care provided.

Wider learnings:
Delayed diagnosis of Cancer

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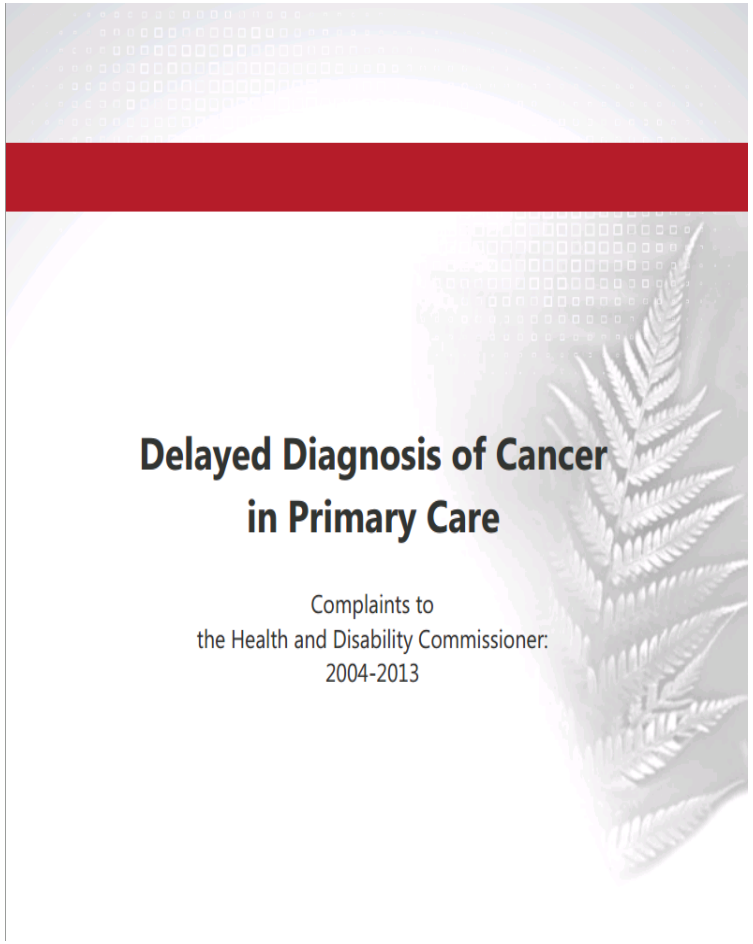
- Analysis of complaints in which the primary care management had contributed to delayed diagnosis
- Brought together the clinical recommendations made in the cases, including:
  - undertaking clinically indicated examinations and tests;
  - examining patients in the context of their past history;
  - 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



Top issues complained about in complaints about GPs

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Case Studies

Advocating for Patient: Referral Management

14HDC00919 - 31 October 2016

- Mr A, who was overweight, a smoker, and had been diagnosed with diabetes, began experiencing coughing fits
- His GP, Dr B, prescribed antibiotics
- Mr A re-presented with further coughing fits, bleeding from the nose, and shortness of breath
- Dr B sent semi-urgent referral to DHB's respiratory service
- Referral letter contained little information

Advocating for Patient: Referral Management 14HDC00919 - 31 October 2016

- Mr A returned to see Dr B after experiencing continual coughing
- GP ordered a full set of blood tests and documented that the man needed an urgent respiratory appointment
- GP said that he also sent a referral to the DHB for urgent specialist assistance.
- The DHB did not receive this referral

Advocating for Patient: Referral Management 14HDC00919 - 31 October 2016

- Four days later, Mr A returned to see Dr B
- Dr B sent a new referral to the DHB for gastroenterology review
- DHB advised that an appointment had been booked
- Dr B assumed that appointment was for the specialist respiratory appointment
- DHB informed Mr A that he was booked in for respiratory testing on different date, but did not inform Dr B

Advocating for Patient: Referral Management 14HDC00919 - 31 October 2016

- Approximately a week later, Mr A visited the Dr B again
- Dr B did not examine Mr A, but prescribed antibiotic
- Sadly, the next day, Mr A died

Advocating for Patient: Referral Management 14HDC00919 - 31 October 2016

Findings – Dr B

Breaches of Rights 4(1) and 4(2)

- Failure to advocate appropriately for Mr A
- Failure to carry out the appropriate physical assessment of Mr A
- A pattern of inadequate documentation

Adverse comment was made about the DHB regarding its communication with Dr B

Delayed Diagnosis: Follow-up of test results and open disclosure

15HDC00677

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- Mr B presented to Dr A with reduced energy and breathlessness
- Dr A ordered blood tests and included a prostate specific antigen (PSA) test
- Dr A received the PSA result, which was well above the normal range
- Dr A filed the elevated PSA result as "normal", and did not discuss it with Mr B

Delayed Diagnosis: Follow-up of test results and open disclosure

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Te Toihau Hauora, Hauātanga

- Over two years later, Mr B presented to Dr A with urinary complaints.
- Dr A ordered another PSA test, which came back significantly above the normal range
- During, or soon after the consultation, Dr A noticed the earlier elevated PSA result
- Dr A informed Mr B of the new PSA test result, but did not disclose the missed result from two years earlier at that time
- Dr A informed Mr B of the missed result approximately two months after discovering it

Delayed Diagnosis: Follow-up of test results and open disclosure

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Findings – Dr B

Breach of Right 4(1)

- failed to recognise and take appropriate action on the abnormal PSA result

Breach of Right 6(1)

- failed to inform Mr B promptly about the missed PSA test result

> *"… Dr A should have made contact with Mr B in a timely manner once realising his error, and certainly before Mr B left for his overseas trip".*

Appropriate assessment and referral

15HDC00792

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

- A man presented to a GP with difficulty swallowing and weight loss
- The GP considered that the weight loss was a result of lifestyle changes, therefore not unexplained
- The GP's working diagnosis was gastritis. She weighed the man, arranged blood tests and prescribed medication
- The GP did not weigh the man at a consultation a few weeks later when he again presented with difficulty swallowing. The man was told to continue with lifestyle changes and return if symptoms continued

Appropriate assessment and referral

15HDC00792

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Te Toihau Hauora, Hauātanga

- The man reported continued difficulty swallowing and further weight loss at the third consultation approx two months later
- The GP arranged blood tests and chest X-ray, formed a possible plan to refer the man for a gastroscopy
- The GP reviewed the man again the following week. The man complained he felt food was getting stuck in his oesophagus, reported some weight gain. The GP was reassured by reported gain, advised the man to take his medication regularly and return for further review if not better

Appropriate assessment and referral

15HDC00792

Health and Disability Commissioner
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- The man consulted his regular GP several months later and was referred for an urgent endoscopy. This revealed a signet-ring carcinoma in the lower oesophagus

Appropriate assessment and referral

15HDC00792

Health and Disability Commissioner
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Findings – GP

Breach of Right 4(1)

- failed to assess the man appropriately and arrange for urgent referral for an endoscopy

Getting the basics right

13HDC01237
February 2015

Health and Disability Commissioner
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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, Ms F

- 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:
  - previous 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

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Findings – Medical Centre 1 & 2

- Adverse comment was made about Medical Centre 2 for providing suboptimal electronic notes
- Adverse comment was made about Medical Centre 1 for not ensuring that its staff were clear about whose responsibility it was to review a new patient's medical record.

Findings – Ms F

- Criticised for recording incorrect information in a consultation note.

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

www.hdc.org.nz

Culture

13HDC00917

June 2014

Health and Disability Commissioner
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- Ms A attended medical centre for Depo-Provera injection
- Another patient was also waiting for same injection
- RN C placed two syringes in same kidney dish

Culture

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

- After first injection, RN C put used needle back in box, and in kidney dish
- RN C injected Ms A with used needle. Realised mistake but did not disclose this
- Advised practice manager of error the next day, and was told to advise GP and Ms A, but went on leave for four days
- Told GP when returned from leave
- Ms A contacted and blood tests arranged, all of which were negative

Culture

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Findings – RN C

Breach of Right 4(1)

- Reused needle

Breach of Right 4(2)

- Failed to assess blood pressure and weight, but documented that she had
- Failed to openly and promptly disclose error to GP

Breach of Right 6(1)

- Failed to promptly notify woman of adverse event

Culture

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Findings – Medical centre

Adverse Comment

Needed to be more cognisant of:

- individual staff stress
- ongoing responsibility to ensure nurses comply with policies

> *"… the medical centre had an organisational responsibility to ensure that the work environment and culture supported staff to adhere to its policies. It is meaningless to have policies in place if staff are under too much pressure to follow them."*

Findings – Practice manager

Adverse Comment

Lack of action after made aware of error – expectation that would follow up with RN C to confirm she had spoken to GP and made arrangements for Ms A to return for blood tests, or take the initiative to alert GP of the event