Te Kaunihera o Ngā Kāreti Rata o Aotearoa
COUNCIL OF MEDICAL COLLEGES
NEW ZEALAND

PO Box 10 375
The Terrace Lobby
Wellington 6140

P +64 4 471 2334
E enquiries@cmc.org.nz
www.cmc.org.nz

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To: all District Health Boards

Continuity of Care and Safe Follow up of Patient Investigations: Letter of Expectation

It has come to the attention of the Council of Medical Colleges (CMC) that there are systems issues with transfer of information between hospitals and community-based care that put patient safety and care at risk.

This letter outlines some of these issues and we would welcome a response from District Health Boards (DHBs) on how they will improve these system issues to enable safer transfer of care.

It is well known that transfer of care is a point at which harm often occurs. Transfer of care is a common occurrence between hospitals and community-based care and the CMC expects that the transfer of care between medical professionals is not hampered by systems issues.

In November 2020 the CMC was presented with a letter of concern from the Royal New Zealand College of General Practitioners (RNZCGP). This outlined several instances where the transfer of care to and from hospital doctors to the General Practitioner did not meet Medical Council's expected standards of 'Maintaining the trust of colleagues and treating them politely and considerately' or 'working with colleagues in ways that best serve patients' interests.'

The two areas of concern were:

- patient information in referrals not transferred into the hospital record
- investigations ordered in hospital were not followed up and were left for 'GP to chase'.

Recent cases highlighted by the RNZCGP include:

- medication information being recorded in a Specialist GP letter to the Hospital specialist service not being recorded in the hospital record, causing significant impact on the patient;
- Specialist A asking Specialist GP B to follow up an abnormal result 'A' had ordered, five months after the investigation and

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- 'GP to chase ' becoming a frequent addition to hospital discharge summaries.

The CMC represents sixteen Medical Colleges who provide support to over 9000 medical practitioners working in a range of 34 specialties in the New Zealand health system. The CMC expects that vocationally trained specialists will work together to provide appropriate continuity of health care for their patients that includes adequate referral to and from each other and respect for each other's role in the patient journey. It is also an expectation that each specialty will work under the guidance of the Medical Council of New Zealand.

Patient information in referrals

The CMC expects systems within hospitals to enable all relevant information from a referral to be recorded into the hospital record, to ensure safe, high-quality transfers of care. General Practitioners (GP) are expected to use electronic documents that are set up by the DHBs across the country. Filling all the relevant fields with the appropriate information for the safe transfer of the patient is essential. It is the expectation of the patient, the GP, and the Hospital Specialist they are referred to, that the information provided will easily be read and loaded into the hospital patient record and used to support safe quality care.

Investigations ordered in hospital

Medical Council guidance on management of test results recognises that inappropriate management is a cause of harm to patients[i]. Both the RNZCGP[ii] and MPS[iii] have statements on result management and GPs are aware of these. However, there is a general expectation that the person who requested the test is responsible for that test.

The CMC is aware that systems within hospitals may not be adequately set up for an individual who requests a test to follow up on that test. However, leaving investigations ordered in hospital for 'GP to chase' is an inappropriate solution to challenges within the hospital system. GPs are the medical practitioners who hold the broadest information about their patients and should be informed of all that is going on, but they should not be expected to search for test results that they have not requested or may not have the expertise to action if they are abnormal.

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In the interests of patient safety the CMC would like the DHBs to:

1. Review the systems within their organisations for recording relevant information from GP referral letters and make sure this information is passed into the hospital record.

2. Make arrangements to support their hospital based medical practitioners to easily follow up tests they have requested or provide adequate handover of the result to the GP.

3. Inform hospital staff that 'GP to chase' in a discharge summary does not constitute appropriate handover and work with hospital systems to enable more appropriate transfer of care.

The CMC considers clear information flow between hospital and community-based care and appropriate follow up of medical tests is essential for safe, high quality patient care. The CMC will promote this message within its own member colleges, so that vocationally registered medical practitioners across the sixteen specialty colleges CMC represents are aware of the above issues.

Nāku noa, nā

Dr John Bonning
Chair

[i] Lillis S. The management of clinical investigations. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

[ii] https://www.rnzcgp.org.nz/gpdocs/New-website/Advocacy/PB6-2016-Apr-Managing-patient-test-results.pdf
[iii] https://www.medicalprotection.org/newzealand/casebook-may-2015/handling-test-results