Date of Report	Reference	Nature of Inquiry	Key Issues	Key Learning / Recommendation
8/09/2020	19HDC00458	Medication error by general practitioner	The GP "gave the woman access to a quantity of medication that could be misused dangerously, which increased the risk of harm to the woman" and "failed to provide services to the woman in a manner that minimised the potential harm." There were significant gaps in clinical documentation.	Reflect on the failings and changes to the practice, including documentation and being stricter when prescribing large quantities of psychotropic medications; undertake further education on 'safe prescribing.'
24/08/2020	18HDC01892	Delayed diagnosis of bladder cancer	Not informed patient of test result; lack of effective cooperation between practitioners Not reviewing clinical history adequately	Have clear policy for reviewing test results; the importance of critical thinking; consider overall history Review processes around provision of care to patients who present repeatedly with the same problem
19/06/2020	18HDC01697	Informed consent for an intimate examination	The patient did not receive sufficient information to give informed consent to the examination of her breast	Should the GP return to practice, the MCNZ should consider whether a review of the GP's competency is warranted
18/06/2020	19HDC00915	Misidentified patient	GP did not establish the patient's identity before consultation and did not obtain an accurate history of her presentation. Antibiotic was administered incorrectly. The patient was 14 weeks pregnant.	The GP to undertake training on communication.
10/06/2020	18HDC01066	Reporting of skin cancer results and arrangement of follow up	GP removed a basal cell carcinoma (BCC) and failed to communicate the results to the man and no relevant follow-up was arranged. The man presented to the medical centre many times over the next five years Over five years later, the man was diagnosed with a recurrent BCC	Patient has right to receive information regarding the histology report, its implications and the GP's plan for follow up care. The medical centre's policy relating to the management of investigation results was not sufficiently robust. The medical centre to undertake an audit of 30 minor surgeries.

10/06/2020	18HDC01905	GP's response to a child's behaviour during consultation	During the consultation, the GP inflicted physical contact on a restless child's face using her hand.	Regardless of the precise nature of the physical contact, any contact to the child's face, unrelated to a clinical assessment, was disrespectful to both the child and his mother.
04/06/2020	19HDC01197	Failure to maintain professional boundaries with a patient	Female GP breached professional boundaries with a current patient; GP was the doctor for wife and children; breached the woman's confidentiality	One-year mentoring relationship with a senior college re maintaining appropriate professional boundaries with patients and their families.
26/05/2020	17HDC01683	Failure to recognise sepsis in a deteriorating patient	Despite several convincing factors, Dr B failed to identify the patient had sepsis along with other omissions. The health centre had not taken reasonable steps to prevent Dr B's omission, and that it was vicariously liable for Dr B's breach.	Both medical officers reflect on their failings The health centre to review the effectiveness of the changes it made following these events
18/05/2020	19HDC01086	Management of a woman with post-menopausal bleeding (PMB)	GP failed to document anything about a speculum examination, failed to visualise the woman's cervix, complete a bimanual examination of a cervical smear and to refer her for a transvaginal ultrasound.	Highlights the importance of thorough investigation of PMB symptoms, including timely referral for further investigation if indicated
08/05/2020	17HDC01829	Oversights in the diagnosis of skin cancer	Providers did not communicate effectively with one another, without a good system in place for sharing clinical information. GP failed to mention SCC history, refer in a timely manner, did not inform patient of oversight. Skin clinic GP also failed on various fronts on cooperation, communication, follow up plan and SCC history Drs failure to openly disclose her error	The skin clinic to a. implement a process of notifying GP of significant lesion, b. undertake an audit of 30 skin cancer removal procedures to determine whether the operation report, follow up information and histology results have been sent to the patient's GP within a week. The importance for providers to communicate effectively with one another and to have a good system in place for sharing clinical information.
29/04/2020	19HDC00695	A six-year-old girl presented to practice four times. Acute	The lack of critical thinking and continuity of care, particularly when a patient	Two GPs attend the "Mastering Your Risk" workshop, one GP

		Rheumatic Fever not diagnosed by 3 GPs	has presented multiple times in a short timeframe A pattern of poor care across the practice	take an online learning module on joint swelling.
21/04/2020	18HDC02354	Alternative diagnoses for coccyx pain Patient had pain in the perineal region and change of bowel habit. DRE not performed. Rectal cancer diagnosis followed.	GP's lack of critical thinking about alternative diagnosis Second and third GPs should have performed a DRE, should have given more attention to first GP's note, and the three-week wait for the man's next review was too long	Flaw in thinking for Mr A's case was not one of screening but of diagnosis based on symptoms, a very important distinction. Any results from the National Bowel Screening program should not factored in when a patient presents with symptoms possibly due to colo-rectal cancer. For a person presenting with the same symptoms, or symptom complex, three or more times, a practitioner needs to exclude cancer, and referral to a specialist must be considered.
17/04/2020	19HDC01795	The assessment of a patient with abdominal cramps	GP in breach for not conducting an abdominal examination when it was clinically indicated, and not documenting the provisional diagnosis in the clinical notes	GP to apologise to the diseased man's wife, arrange an independent audit of his clinical notes, and to undertake further training on "Achieving Safer and Reliable Practice"
16/03/2020	19HDC00803	Monitoring of a prostate condition	GP not conducting Digital Rectal Exam (DRE) when PSA levels are high. GP not recording his treatment plan and not using the recall system correctly	GP to apologise to the man, arrange an independent audit and undertake further training on communication and informed consent