Manitoba
Health, Healthy Living and Seniors

Manitoba Health, Healthy Living & Seniors (MHHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Communication of Biopsy Results & Treatment Delays

Summary:

Biopsies from a lesion were sent to the Laboratory for diagnosis. The paper laboratory requisitions did not properly identify the specific physicians who were to receive a copy of the paper biopsy reports.

This contributed to an unacceptable and lengthy delay in treating the patient for the correct type of cancer. The patient was initially treated for a type of cancer that is common and slowly progressing instead of a rare and aggressive type of cancer confirmed within the pathology report.

Keywords: Delay in treatment, cancer treatment, communication of test results

Device Name *(if applicable)*:

Drug/Name/Fluid Name: (*if applicable*):

Type of Analysis: single event

Topic: Care Management

Findings of the Review:

Two requisitions were processed for multiple biopsy specimens. The names of the physicians who were to receive the test results were not located in the correct area of the requisition. The pathology report was sent to the hospital and not the surgeon or family physician. Documentation was that the final pathology report was to be available at a later date; this was required for a definitive assessment and diagnosis.

The surgeon notified the patient's family physician. Follow-up was requested with a medical oncologist for treatment of the common and slowly progressing cancer identified in the Immunology (Supplemental) Report.

The referral package sent to the oncologist did not include final pathology report. It did include the preliminary pathology report identifying the pathology report number containing the rare and aggressive cancer diagnosis. An oncology team member requested the final report. After the patient's oncology assessment, a referral was sent to a surgical oncologist with the intention of treating the rare and aggressive cancer.

The surgical oncologist requested a copy of the patient's paper chart for review. At the time of the consultation, the information about the rare and aggressive cancer was located in the electronic chart but not in the paper chart. The surgical oncologist read the paper chart, which indicated the common and slowly progressing cancer. The electronic health record information with reference to the rare and aggressive cancer was not printed and placed into the paper chart prior to the surgical oncologist's review.

The inconsistencies between the paper and electronic chart contributed to the patient not receiving treatment for the rare and aggressive cancer at the time of the consult. The patient was referred back to the family physician.

System Learning:

- Revise the process for distribution of pathology reports to improve the consistency of the distribution of pathology reports to the referring physician and other intended recipients.
- Modify the Health Records Pathology Tracking Form to include an additional column to indicate that a carbon copy of the report was sent to the surgeon.
- Have the cancer agency establish a process to receive notification of patients diagnosed with rare and aggressive cancers. This will help to ensure the receipt of a patient referral and supporting documents from the patient's treating physician in a timely manner.
- Have the cancer agency maintain a single patient chart using the Electronic Health Record.
- Improved communication between the health system and the patient had the potential to reduce the treatment delay

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