Manitoba
Health, Seniors and Active Living

Manitoba Health, Seniors and Active Living (MHSAL) 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

Missed Amended Pathology Report

Summary:

A patient who was treated for Chronic Myeloid Leukemia (CML) had a CT scan that showed a large lung mass that was suspicious of a cancer as well as fluid on the lung. The patient was referred to the thoracic Disease Site Group (DSG) to determine if radiation therapy would be an option. However, the patient declined the appointment because of their deteriorating condition. The patient was enrolled in the palliative care program.

The patient was transferred to a home dedicated to end of life patients. After 14 months in the home the patient was improving. The physician at the home asked for a review of the CT scan. This showed that the mass was not a cancer but rather a pleural effusion (collapse of the lung due to accumulation of fluid in the lung).

If this diagnosis was known, the patient would not have been considered for palliative care and placed in that facility and instead would have been paneled for a Personal Care Home.

Keywords:

Misdiagnosis, referrals, palliative

Findings of the Review:

During the year prior to this incident, the patient had pleural effusions multiple times which were likely due to the medication they were taking for their CML.

In the CT scan report indicating a lung mass, it was suggested that further evaluation with bronchoscopy be done; but this evaluation was never done. The ordering physician referred the patient to Radiation Oncology and assumed that they would

follow up with care. However, since the patient ended up declining the appointment, neither the referring physician nor the Radiation Oncology team continued to follow the patient. There were no notes in the patient's chart nor was the referring physician made aware that the patient declined the appointment.

According to 5(2) in the Standards of Practice of Medicine from the College of Physicians and Surgeons of Manitoba "A member who orders a diagnostic test and directs a copy of the results to another member remains responsible for any follow up care required, unless the member to whom a copy of the results is directed has agreed to accept responsibility for the patient's follow up care".

Upon review, it was determined that there was no issue with the physician or clinic process with the referring the patient.

System Learning:

An aggressive treatment time line can result in gaps in care processes. In this case, the CT scan, referral, admission to hospital, declining referral and enrollment in palliative care all occurred within 24-48 hours. The patient was not followed by the cancer agency after being enrolled in palliative care.

Although it is standard practice for the referring physician to be made aware when a patient declines the referral, it was not done in this case. A standard process for all referring clerks to document referral cancellations is needed.

The importance of educating clerical and nursing staff on the importance of communicating referral cancellations to the referring physician requires reinforcement.

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