

## SAFETY MATTERS: ERROR LEADS TO DELAYED CANCER DIAGNOSIS



*"It was utterly preventable, which was the frustrating thing."*

*This was one of the sentiments expressed by a patient's daughter upon learning that her mother's cancer diagnosis was delayed due to an error. Although she noted that the delay probably would not have changed the outcome for her 85-year-old mother, who ultimately lost her battle with cancer, she feared that this error could easily happen to someone else.*

*"At some point, there will be a 35- to 40-year-old mother with a breast cancer diagnosis, and it will make a difference for her," she said.*

*Approximately 12 million adults in the U.S. experience a diagnostic error every year, according to a 2014 study in BMJ Quality and Safety. Missed or delayed diagnoses remain a challenge in many areas of health care, particularly outpatient settings.*

*This issue of Safety Matters explores what led to this patient's cancer diagnosis being delayed for five months.*

### WHAT HAPPENED

The patient was being followed for a nodule in her lung that appeared to be benign. After two years, her primary care physician (PCP) ordered a chest X-ray to determine if the nodule continued to be stable or was growing. The x-ray identified an area of concern. The radiologist called to discuss this critical finding with her PCP, and he immediately ordered a follow-up CT scan to clarify the diagnosis.

The results of the test were sent to the PCP. However, the radiologist did not send a critical abnormal notification on the CT, assuming that the PCP was aware, having already been notified for the abnormal chest x-ray. However, the PCP overlooked the CT report and failed to follow-up on the findings, which were suggestive of lung cancer.

About five months later, the patient visited her PCP and reported doing well. As the physician was writing a note and updating her record, he noticed the report with the test results for the first time and immediately ordered a new CT scan. The scan showed further progression of lung cancer.

Immediately after receiving a new CT scan, the PCP disclosed the error to the patient and apologized. The two had a good relationship – so good that the patient actually felt bad for her physician, according to her daughters.

The patient's oncologist and thoracic surgeon felt that the delayed diagnosis did not significantly impact the patient's prognosis. The cancer was treated, but the patient passed away about a year later.

### WHAT WENT WRONG



Typically, radiology test results are sent to an ordering clinician electronically. If the result is critical, then the test result is marked with high importance by the radiologist.

In this case, the initial test results that indicated cancer were not marked "high importance" because the radiologist reading the scan had expected a cancer diagnosis based on the clinical history. Had the diagnosis been unexpected, the results would have been marked differently.

What was most surprising to the patient was the system that led to the delay – a radiologist sends a report and assumes that the PCP received it, with no other back-up to ensure that this is actually the case.

"It doesn't matter whether a finding is 'expected' by the radiologist or not; it's important, and the patient certainly isn't expecting that result," said the patient's daughter, referring to the fact that the results were not marked "high importance."

### WHAT WE'RE DOING



#### **Morbidity and Mortality Rounds Discussion**

The PCP invited the patient and one of her daughters to attend Morbidity and Mortality Rounds (M&M). M&Ms are hosted by some departments to provide a forum to learn from errors or unexpected situations that arise during patient care. "My mother loved going to the M&M," said her daughter. "It was an opportunity to talk to staff and express her concerns. They were really receptive to what she had to say."

Her other daughter said that attending the M&M was “one of the proudest moments of my mother’s life.” She shared her appreciation for the honest apology of her physician and also discussed other ways her care could have been improved, including shortening treatment delays after diagnosis.

### Thoracic Care Treatment Packages

During the M&M Rounds, the patient shared a timeline of her diagnosis and care delivery that highlighted the duration and other delays in care, even after the diagnosis. Clinicians who care for patients with lung cancer and other thoracic conditions are working to bundle and schedule services together to reduce the number of times a patient needs to visit BWH and to reduce time between diagnosis and treatment.

### High Reliability Results Management

Given the challenges of managing test results, Partners has formed a committee, Communicating Clinically Significant Test Results Task Force (CCSTR), that focuses on improving the management of test results. Some principles CCSTR identified for high reliability results

management include\*

1. Standardized approach for all test areas to define and flag clinically significant abnormal results
2. Track tests from ordering to completion to receipt/acknowledgment and action on results.
3. Eliminate ambiguities regarding how to return a result or who to contact
4. Patients should be informed about all test results, even normals.
5. System tracing and oversight/monitoring
6. Advanced systems to support clinicians in result management activities.

For this patient and her daughters, it was important to talk about the error and their experience to help prevent it from happening again. “My mother would be happy to know if this makes a difference for somebody else,” said one of her daughters.

\* Partners CCSTR Task Force and Schiff JAMA 2011

## JUST CULTURE CORNER: TRANSPARENCY

*BWH is committed to adopting the principles of a Just Culture and creating an environment where we feel safe speaking up and supported after mistakes. Safety Matters will highlight a new concept or learning around this important culture change in each issue. This month's update is an overview of how we think of human behavior within the Just Culture framework.*

We're all human and errors will happen. We work within imperfect systems and often make decisions in the face of competing priorities. Through the Just Culture approach, our goal is to evaluate systems and behaviors, to learn and prevent error.

**Human error** refers to an unintentional mistake that anyone can make. Factors such as stress, time pressure, fatigue or defects within systems can predispose us to making errors. One example of a human error is rushing to place a medication order and inadvertently ordering it for the wrong patient. When a human error occurs, our goal is to support and work with the employee to develop better systems to catch such mistakes.

**At-risk choices** involve decisions or actions we think we are justified and/or safe, but actually are not. At-risk choices are often a result of competing priorities, like safety and productivity. Performing a rushed and partial medication reconciliation in order to complete other patient care tasks is an example of an at-risk choice. We're trying to do the right thing, but we drift away from the protocol and do not recognize the increased risk. When we see at-risk choices, our goal is to coach the employee. (In this case, that means not only clarifying the need for full medication reconciliation, but also helping to develop a strategy for managing competing priorities).

In a **Just Culture**, we strive to find and mitigate risk, not assign fault or blame. We are all accountable for our choices, but we do not punish for the human errors that we are all prone to, or for a decision that we all could make in the face of competing priorities. Instead, we improve the systems that support our employees and the safety of care provided to patients.

For more information visit: [www.bwhpikenotes.org/justculture](http://www.bwhpikenotes.org/justculture)



## Share Your Story in Safety Matters

Do you have a patient safety story to tell about an error? *Safety Matters* seeks to feature stories from staff to help others prevent the same errors from occurring. Email [BWHSafetyMatters@partners.org](mailto:BWHSafetyMatters@partners.org).

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