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

Misreading Pathology Report Results in Omission of Treatment

Summary:

A patient diagnosed with left breast cancer was treated with chemotherapy to shrink the tumor before surgical removal. The patient met with the radiation oncology team to learn about treatment options. At Breast Cancer Case Conference, the patient's case was discussed. Consensus was that the patient should have a lumpectomy. The lumpectomy was performed as well as a sentinel node biopsy.

The surgical pathology report was subsequently reviewed by the clinic. As a result of miscommunication, the physician understood that the patient had had a mastectomy and that adjuvant radiation treatment would not be required. However, proper course of treatment for a lumpectomy would be adjuvant radiation therapy. Due to the misunderstanding, no treatment was offered.

In early 2016, a small mass was found on the left breast. A lumpectomy performed in July 2016 showed a 7 mm invasive ductal carcinoma.

This event was reported as a critical incident because the patient did not receive adjuvant radiation therapy after the first lumpectomy as is standard practice. It is possible that if radiotherapy had been provided the cancer recurrence might have been prevented.

Keywords: lumpectomy, breast cancer, mastectomy, radiation

Device Name *(if applicable)*:

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

Findings of the Review

- This series of event occurred because the pathology report was misread by the clinic staff. When the report first came to the cancer treatment agency, the pathology was read correctly; a note from the oncologist stated that a lumpectomy was performed. However, a few weeks later, a letter from the oncologist to the surgeon indicated that the oncologist was now under the impression that the procedure performed was a mastectomy. As a result, the oncologist “errored out” the pending order for the treatment directive on the same day. The next day a note from the clinic nurse indicated that the oncologist decided not to give adjuvant radiation.

- The patient had their original biopsy and first consultation completed out of province before coming to the cancer treatment agency. . Communication between and across jurisdictions can present risk due to different processes, faxing correspondence issues etc. In addition, there was some confusion in thinking that the patient was receiving treatment at the other clinic.

- Reviewing the patient’s chart at the hospital where the surgery was performed, the surgery was often referred to as "lumpectomy (partial mastectomy)" or "quadrectomy". Both terms could result in confusion when considering the treatment. In discussions with the CI review committee, it was agreed that this procedure should only be referred to "lumpectomy". The regional health authority has an ongoing project that is addressing this issue.

- The Electronic Health Record has a field for procedures or surgeries. This field is typically not completed as clinics have this information in the patient’s paper chart. Electronic documentation in this field will provide another check for the clinic to know what surgery was performed.

- As in this case, patients who receive neoadjuvant therapy and do not require adjuvant therapy are not always scheduled for a follow up appointment. This investigation determined that a post-surgery follow up appointment for neoadjuvant patients should be the accepted standard of care.

- Upon investigation, it was noted that the treatment directive for this patient was never approved. Rather, the directive was left in a “pending state” as the oncologist was waiting the pathology report before approving the directive. Following this event, it is now standard practice for an oncologist to approve the Treatment Directive immediately after it is entered to avoid multiple pending Treatment Directives in the system. According to staff responsible for the Radiation Therapy Department practices, there were no policies or evidence of written documentation to enforce this practice. After physician consultation, it was suggested that there should be a double check for any treatment directives which are canceled.

- The patient was followed by Medical Oncology by use of a “Chart Check”. A “Chart Check” is a flag put in the patient’s schedule to remind the clinic of an event or task. Due to miscommunication, a chart check was not put in after the patient had surgery to remind Medical Oncology to review the pathology results.

System Learning:

- ❖ Breast cancer patients who are on chemotherapy to shrink a tumor prior to surgery must be followed up by their treating oncologist after surgery whether further treatment is offered or not.

- ❖ Radiation Therapy Treatment Directives must be approved by the radiation oncologist immediately after being entered in the electronic health record.

- ❖ A standardized process to record telephone conversations with patients that involve a change in patient management should be developed to include a standard note template in the electronic chart.

- ❖ The feasibility of using other features, such as reminders in the electronic chart, to enhance communication of tasks to clinic about patients should be explored. Before this process change, a standardized procedure will be developed to use “Chart Checks” in the system.

- ❖ The agency needs to review the process and documentation requirements related to scenarios where patients receive components of their care outside of the province.

- ❖ The Procedure/Surgical tab in the patient history in their electronic chart must be completed when a procedure or surgery is performed.

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