Missed abnormal histology result

2015 (November) – Day 2, Q3

Medical Leader	✓
Medical Expert	•
Communicator	•
Advocate	•
Scholar	
Professional	•
Collaborator	
Manager	•

You are the Deputy Director of Medical Services for a tertiary-level hospital. Your complaint investigator notifies you of a complaint from a woman who has presented with a missed diagnosis of malignancy and is terminally ill. In the process of investigating the recent presentation, the clinician found an unacknowledged histology result which was reported 18 months earlier as "strongly suggestive of malignancy". The patient and GP were unaware of this result, and on further investigation it has come to light that the patient had had a brief admission at the earlier time for elective surgery. At that time, the surgeon had observed some unusual tissue well away from the presenting problem and had biopsied it at a time. This was recorded in the operation note but the note had not been copied to the GP, and it was not mentioned in the very cursory discharge summary.

Your EDMS is supporting the clinical team and managing an investigation of the credentialing, handover and communication issues. You are tasked with investigating and rectifying urgently, the wider situation with unacknowledged laboratory tests.

You find to your dismay that there are 140, 000 unacknowledged laboratory results in your laboratory IT system. You realise this situation may also be affecting radiology results and indeed, there are 120,000 of them in the system also.

Questions:

1. **How will you prioritise your actions in managing the situation?**
2. **What are the medicolegal implications of this scenario?**
3. **What are the risks and how would you address them?**

Guidance for Censors

First priority is:

1. best possible patient care, safety and well-being in these unsatisfactory circumstances - identify and provide care for patients whose results are not unequivocally normal
2. immediate initiation to prevent further results going unacknowledged

Use emergency management plan:

- Notify CEO, Ministry or Dept of Health, insurer
- Alert communications/media manager in your organisation
- Prepare interim report for CEO and Board
- Brief clinical and managerial service leadership – request they provide appropriate staff and time resource to assist both processes, and to provide urgent further care for those patients who need it
- Prepare an initial media statement to be used if information reaches media before problem fully defined and resolution underway.

Establish a team to attend to each of the priority tasks

1. Patient care –
   Urgent triage of all missed results by staff who are competent to identify those of concern
- All results that are not clearly normal to be followed up by or under oversight of Clinical Service Leader, open disclosure with apology and care initiated, including urgent liaison with patients' GPs
- Establish psychological support process for those patients needing support in coping with unexpected information about a test done some time ago.
- Make whatever arrangements are needed to provide prioritised care to these patients

Investigate why results are not being acknowledged by clinicians

2. Checking of results
   - Urgent memo to all clinical staff informing them that some issues have arisen from results not being checked and acted upon, reinforce absolute requirement to follow existing protocols and escalation procedure
   - Identify which teams have high compliance and which have low compliance with checking. Find out how the good compliers achieved this; use this model to guide the poorly complying teams.
   - Individual discussions with HODs where compliance poor, remind them of their responsibility for all care, that consultants remain responsible for the work of junior staff regardless of any delegation of tasks
   - Ensure all relevant staff are competent in using the lab/rad IT systems, and understand their responsibilities for reviewing results escalated due to failure of acknowledgment at the initial level. Older staff and IMGs in particular may

need additional training. Some staff may be reluctant to admit incompetence, some may be stubborn and see this as not their job – ultimately a disciplinary matter if persists.
- Ensure part time consultants are fulfilling their hospital responsibilities
- Reinforce message that person ordering test is responsible for reviewing and acting on the result, and for formal hand over of outstanding results at shift change, going on leave and resignation.
- Ensure clinical HODs understand and act on their ultimate responsibility for seeing that all these things are in place and being audited regularly to ensure there are no lapses

Medico legal risks

In NZ:

Complaints to Health and Disability Commissioner, some may be referred by HDC to Health Practitioners' Disciplinary Tribunal where individual practitioners may have failed in their professional responsibilities, outcome protracted, could end in loss of registration or restrictions being placed on practice. HR implications – may need to consider suspension or restrictions on practice at hospital level.

Assessment Rubric:

		Knowledge	Skills	Attitude/Behaviour
Poor	**1**	Prioritises identifying abnormal results and follow up ahead of ensuring acknowledgment or the reverse	Does not describe a practicable approach, or considers only limited aspects of the situation presented	Does not describe risks or urgency of interventions Does not mention wider implications at reputational, political and media level Speaks of blame rather than quality improvement
Limited	**2**	Identifies the key aspects needing urgent action but does not provide a workable strategy for investigating and rectifying situation	Describes self as leading both processes, does not delegate or reinforce responsibilities of clinical HODs	Recognises that quality culture may be lacking May not convey sufficient urgency in managing situation and preventing further possible harm to patients
Marginal	**2.5**	Provides a limited strategy, requires prompting to describe practical ways of achieving tasks Mentions need for open disclosure for all patients with abnormal results	Identifies some of risks in this situation Does not describe need for diversion of resources to resolve this issue promptly	Able to convey appreciation of wider significance of this situation May not link this to own role in leadership to move organisation forward with learning from this major lapse
Meets standard	**3**	Identifies equal priorities in identifying abnormal results and ensuring those patients' safety and good care, and in ensuring no further results go unacknowledged Organises additional training for the less computer literate	Recognises need to carry out both tasks simultaneously Delegates appropriately Uses emergency plan, redirects resources Ensures compliance with acknowledgment procedure is understood to be non-negotiable Recognises and manages wider legal and other risks Foresees and plans for media management	Provides leadership and overall responsibility for both processes, keeps EDMS updated Recognises failing in overall commitment to providing good patient care
Good	**4**	Give priority to working with clinical leadership of	Uses strategies employed by teams with high	Identifies need for harmed patient to know what

	teams where compliance is poor Ensures reasonable support given before performance management initiated for reluctant or stubborn staff	compliance to support those less compliant Ensures adequate ongoing audit to prevent any further incidents Works to ensure strong senior leadership in clinical excellence throughout organisation Identifies partnership of patients in provision of care as an important safeguard against such lapses	actions being taken to spare others her fate Ensures focus on quality improvement rather than blame More directive in clarifying governance responsibilities with HODs and acknowledges own contribution to failings
Outstanding **5**	Able to articulate management of all aspects of complex situation Able to discuss need for community level disclosure of lapses to rebuild community confidence	In partnership with EDMS, uses incident to lead a cultural change in organisation, based on partnership with patients and a commitment to the best possible care	Clarifies best patient care as reason for clinical governance responsibilities at all levels in organisation