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

Summary:

A patient presented to an Emergency Department (ED) with acute abdominal pain. A CT scan was ordered to rule out acute appendicitis and the test was scheduled at another facility for the following morning. The patient improved clinically while being held for observation in the ED. It was decided to discharge the patient home. Instructions regarding the need to have the CT scan completed were communicated to the patient and their next of kin.

The following day, the patient went for the CT scan. The patient left for home immediately after the completion of the test. Two days later, the patient returned to the same ED with unresolved abdominal pain. At this time the patient was transferred to a second acute care facility for emergency surgery.

The patient had a laparoscopic appendectomy for a perforated appendix. The patient recovered well following the surgery and was discharged home.

Keywords:

Delay in Diagnostics

Device Name *(if applicable)*:

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

Type of Analysis: single event

Topic: Other

Findings of the Review:

The varying expectations of how CT scan results would be communicated amongst the care team increased the likelihood of a delay in diagnosis/treatment.

The lack of discharge communication/documentation and roles/responsibilities of the care team increased the likelihood of a delay in diagnosis/ treatment.

Recommendations for Improvement:

Develop and implement a provincial policy & procedure for radiology reporting of critical test results to the ordering clinicians. (E.g. revise and standardize requisitions as appropriate with access to e-chart reports.)

Implement a discharge instruction/communication sheet for the ED/Observation area that is to be provided to patients requiring subsequent treatment/follow-up. This shall include and not be limited to the following: instructions on what to do post follow-up procedures, tests, and any future appointments.

Develop a consistent /standardized process for clinical handovers from clinician to clinician regarding discharged patients from the ED/Observation area that require subsequent follow through (e.g. pending test results).

Date Posted: