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 look closely 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

Delayed Diagnosis of Abdominal Pain

A client presented to the Emergency Department with complaints of abdominal pain and vomiting. The client had to wait for diagnostic studies and subsequent referral to a surgeon. The client was found to have an ischemic bowel. The client died as a result of the delay in diagnosis.

Keywords: delay in diagnostics, abdominal pain

This review is based on a single event.

Findings of the Review:

The physician on call ordered laboratory work within 30 minutes of the client's assessment. These orders were not communicated to the triage nurse. The orders were not discovered until some time later. When the delay in obtaining laboratory tests was recognized, a decision was made to complete the laboratory tests the next morning. Laboratory results showed the patient suffered from a critical anemia.

The handover report between care providers did not contain all necessary client status information.

The contact information for the client's next of kin was missing on the inter-facility transfer form sent with the client to the receiving facility.

Antibiotic and anticoagulant medications administered were not documented on the inter-facility transfer record. This resulted in the receiving facility assuming that these medications, vital to the patient's outcome, were not administered.

Incomplete communication between members of the health care team and at transitions of care may have contributed to patient harm.

System Learning:

Develop a structured communication method for physicians to alert nursing staff when new orders are written on the Emergency/Outpatient Record.

Document direction and authority for designated healthcare providers to be able to call in diagnostic imaging and laboratory staff after hours if deemed necessary by the physician ordering these investigations.

Provide Situational Leadership Training for nurses who work as the nurse in charge.

Standardize information to be shared during transitions of patient care including admission, handover between health care providers, transfer and discharge.

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