Manitoba Health 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

Delay in Diagnostic Test to Rule out Cancer

Summary: A patient had a colonoscopy booked for a change in his/her bowel habits and weight loss. The procedure could not be completed due to stool in the bowel, and the clinician requested a repeat colonoscopy be performed due to incomplete bowel prep and visualization at that time.

The request for the repeat colonoscopy was never booked. The next of kin (NOK) contacted the primary care physician approximately five months later to inquire when the repeat test would be performed. The rebooking form was discovered in the patient's health record, and the patient had never been rebooked. An urgent colonoscopy was completed and it was discovered that the patient had a large cancerous mass.

Keywords: Delay referral, cancer.

This review is based on a single event.

Findings of the Review:

Two units at the facility recently underwent re-structuring (operating room [OR] and post-anaesthetic care unit [PACU]), leading to the need to cross-train staff to be ready to work in both areas. This amalgamation led to a staff turnover leading to a number of new staff members to the PACU area in a short period of time. Not all staff members received the full two-week orientation. During the interview process some staff stated they were not familiar with the normal Urgent Re-Booking Process for patient's requiring another procedure for incomplete bowel preparation. It was later discovered that staff had not removed and processed the re-booking form (which should have gone to slating) from the chart.

The normal process for re-booking patient's whose endoscopy could not be completed due to incomplete bowel prep was not followed.

Five months after the procedure, the patient/NOK inquired when the patient would be rebooked for the endoscopy.

System Learning:

Revise onboarding for orientation to the OR/PACU to include the process for urgent referrals to Cancer Care Manitoba (CCMB) and rebookings for endoscopies that could not be completed (for any reason).

Include in the standardization for rebooking patients when an endoscopy procedure cannot be completed for any reason (i.e. poor prep) to be rebooked within 2 weeks.

Develope a regional "Discharge Instructions for endoscopies" to include "instruct patients to contact their primary care provider/surgical program if they have not heard/received any follow-up from procedures performed in the OR after 2 weeks".