Open Book
Learning from close calls and adverse events

Ensuring referrals happen

This report alerts providers to key findings from three similar recent incident reviews at different hospitals. Each incident involved failures in referral and follow up processes. We advise providers to consider this report, and whether the changes being made are relevant to their own systems.

This report is relevant to:

- managers responsible for medical records and patient booking and scheduling
- all clinicians sending and receiving referrals.

Incident 1

A patient had delayed care because a biopsy result was not responded to appropriately.

Chronology

- A patient who was admitted with pregnancy complications complained of a neck lump. The admitting service referred her for biopsy.
- A biopsy of the lump was performed and reported as 'inadequate for diagnosis', but no further action was taken.
- The patient presented five years later with a neck lump at the same site as before. The result of the previous biopsy was noted, a further biopsy taken and treatment started for a malignant diagnosis.

Review

The incident review found:

- there was no consistent process for communicating non-obstetric issues to other specialties
- the biopsy results were not communicated to the patient's lead maternity carer (LMC)
- the lab report involved was one of a large number of unacknowledged reports reviewed in a short space of time. The significance of 'inadequate for diagnosis' was not recognised
- pathology did not follow up the result at the time of the biopsy, for reasons unknown.

Actions subsequently taken

- After the incident, the hospital introduced an electronic clinical record system. The record works in conjunction with inpatient notes and provides a summary plan for discharge documentation.
- If a patient receives maternity care, information is now sent to the relevant LMC and general practitioner.

Incident 2

A patient referral to another service failed, with cause unknown.

Chronology

- An internal referral was made from general surgery to oncology, but the referral was never received so further care was not provided.
- Nine months later, following a query from the patient, it was realised that the referral had not occurred. An additional referral was made, resulting in the treatment being provided.

Review

The incident review was not able to identify the exact cause of the referral system failing. It noted, however, the referral process between hospital services relied on a paper system. There was wide variation in how referrals were sent and received (letter, fax, referral form, etc).

Actions subsequently taken

- A new system for managing referrals (both sending and receiving) between surgical and oncology services was introduced:
  - The service that **receives** a referral must acknowledge receipt to the service making the referral.
  - The service that **sends** a referral must ensure an acknowledgement has been received.
- The provider communicated to all clinicians that the service making the referral remains responsible for the patient until an acknowledgement of receipt of referral has been received.

Incident 3

It was intended that a patient who had surgery for cancer was to be followed up by the oncology service after discharge, but this did not occur.

Chronology

- A patient had surgery for breast cancer. The patient was to be referred to the oncology service for further treatment after discharge from surgery, but this referral did not occur.
- A mammogram was performed on the patient in another hospital 23 months later. This resulted in a referral to oncology and further treatment for recurrence of breast cancer.

Review

The incident review found:

- dictation from the earlier surgical clinic was performed after the doctor had left the clinic
- the dictation was subsequently lost, therefore there was no record of the requirement to follow up the patient
- the record of the multidisciplinary team meeting (which referred to the need for further oncology care) was not included in discharge documentation
- various systems were used to make oncology referrals.

Actions subsequently taken

- All dictation of clinic notes is to be done with patient notes available and before doctors leave the clinic.
- The multidisciplinary team notes are included in the electronic record, and in discharge and referral documentation.
- Referral systems are to be standardised.

Health Quality & Safety Commission comment

- Incidents similar to these – where a patient suffered a delay in treatment due to system failings – have been increasingly reported. The relevance of these cases is not limited to oncology services, but to all referral communication.
- Typically, New Zealand health providers have ‘systems’ for requesting diagnostic tests or patient referral that have evolved piecemeal, without the rigor of safe process design. The second incident illustrates the introduction of a reconciliation component. This, in addition to robust tracking and audit processes, can dramatically reduce unacceptable risk from human factors.

- These cases emphasise the importance of involving patients in the expected next steps of their care, so they can provide a further 'safety net' to ensure actions planned take place. Ideally, written information would be given to the patient stating the expected follow up timeframe, and who to contact if follow up does not occur.
- The Health and Disability Commissioner has found that both hospitals and primary care providers have a clear responsibility for having systems to ensure diagnostic test results are available and acted on (13HDC00926, 13HDC00599, 12HDC00203, 10HDC01250 and 12HDC00112) and referrals are managed appropriately.
- ACC has published a treatment injury case study detailing failure to follow up report results.