Are we properly tracking tests and referrals?

RISK: DELAYED DIAGNOSIS

Three years after being tested for celiac disease, a delayed diagnosis is uncovered

Closed Malpractice Case

An 8-year-old with a history of forearm fractures and osteopenia was referred to an endocrinologist, who made an interim diagnosis of idiopathic juvenile osteoporosis (IJO). The girl was referred to a gastroenterologist to rule out celiac disease. An upper endoscopy, performed by a different physician, indicated all structures appeared normal. Five days later, the pathology report was positive for celiac disease.

Over the next three years, the child was treated by her gastroenterologist, endocrinologist, and orthopedic surgeon for IJO. When she developed abdominal pain and constipation, her PCP (different from three years prior) conducted a celiac test, which was positive. When asked by the endocrinologist if a patient could become celiac positive three years after a negative test, the gastroenterologist saw the previous (positive) results in the patient's chart. (Neither the endocrinologist nor the referring gastroenterologist had ever reviewed them.)

When notified, the girl's parents said they had been told the initial test results were negative, but couldn't recall by whom. A gluten-free diet gradually improved the girl's condition.

Diagnostic Process of Care in Ambulatory Diagnosis Cases*

Inadequate management of test results is a contributing factor in 4% of CRICO (5% of CBS) ambulatory cases alleging a missed or delayed diagnosis.

	PERCENT OF CASES**	
STEP	CRICO (N=175)	CBS† (N=2,919)
1. Patient notes problem and seeks care	1%	1%
2. History and physical	10%	8%
3. Patient assessment/evaluation of symptoms	35%	31%
4. Diagnostic processing	43%	35%
5. Order of diagnostic/lab test	40%	31%
6. Performance of tests	5%	3%
7. Interpretation of tests	37%	23%
8. Receipt/transmittal of test results to provider	4%	5%
9. Physician follow up with patient	21%	18%
10. Referral management	13%	21%
11. Provider-to-provider communication	12%	12%
12. Patient compliance with follow-up plan	14%	17%

* Cases with claim made date 1/1/11–8/31/16

** A case will often have multiple factors identified

† CBS is CRICO's Comparative Benchmarking System

Patient Safety Vulnerabilities

1. The pathologist routed the celiac test results to the gastroenterologist who performed the endoscopy, but not to any of the patient's other caregivers.

   SAFER CARE: Patients undergoing a test/procedure expect coordination among all of the providers involved. A system that allows abnormal results to be go unnoticed by subsequent providers needs to be assessed and fixed.

2. Several caregivers proceeded with a misguided treatment plan for three years after the celiac test results were reported.

   SAFER CARE: The decision to order a test must include a commitment to close the loop all the way through reviewing and sharing the results with subsequent providers and the patient.

Are we properly tracking tests and referrals? (continued)

Quick Assessment

1. Has this type of event happened at our practice?
2. What is our process for closing the loop on test results/consult reports?
3. Do we document an expected turnaround time for test results/consults?
4. What is our turnaround time goal for reporting results to a patient?

Improvement Opportunities

RECOMMENDED PRACTICE	CURRENT STATE	HOW TO IMPROVE (IF NECESSARY)
1. Obtain a baseline assessment by performing a random audit of normal and abnormal result notifications		
2. Ensure that all providers involved in a single patient's care know who is responsible/ accountable for reporting test results to the provider and the patient, and the expected timing		
3. Develop written procedures for managing the critical results of tests and diagnostic procedures		
4. Rely on a system, rather than memory, to close the loop on the receipt of results for all ordered tests		
5. Encourage patients to inquire about test results if they haven't been notified		

AYS 010

CRICO *Are You Safe?* materials are designed to help all members of a multidisciplinary team reduce the risk of patient harm in the course of diagnosis and treatment. Office-based events that trigger malpractice cases present valuable opportunities to identify vulnerabilities in communication, clinical judgment, and patient care systems. Successful practices shared by local and national peers inform the *Are You Safe?* recommendations. CRICO works closely with your organization's Patient Safety and Risk Management staff to build expert resources for individual and team-based education and training.

Email comments, resources, or questions to areyousafe@rmf.harvard.edu.

Additional Resources

www.rmf.harvard.edu/safercare

Please visit the CRICO website for related:

- CME Bundles
- Podcasts
- Clinical Decision Support
- PowerPoint presentations to share with your team
- Patient Safety Alerts
- Additional topics in the *Are You Safe?* series

How to Earn Category 2 Risk Management Credits

This *Are You Safe?* case study is suitable for 0.25 Category 2 risk management credit for Massachusetts physicians. Risk Management Study is self-claimed; complete, date, and retain this page for your record keeping.

About CRICO

CRICO's mission is to provide a superior medical malpractice insurance program to our members, and to assist them in delivering the safest health care in the world. CRICO, a recognized leader in evidence-based risk management, is a group of companies owned by and serving the Harvard medical community.

 The CRICO *Are You Safe?* case studies offer suggestions for assessing and addressing patient safety and should not be construed as a standard of care.