SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS

Cancer SEA Report Template

Diagnosis:	Bronchial CA
Date of diagnosis:	21/08/12
Age of patient at diagnosis:	61
Sex of patient:	M
Is the patient currently alive (Y/N):	Y
If deceased, please give date of death:	
Date of meeting when SEA discussed:	13/09/12

N.B.: Please DO NOT include the patient's name in any narrative. Please anonymise the individual involved at each stage by referring to them as GP1, GP2, Nurse1, Nurse2, GP Reg1 etc.

1. WHAT HAPPENED?

Describe the process to diagnosis for this patient in detail, including dates of consultations, referral and diagnosis and the clinicians involved in that process. Consider for instance:

■ The initial presentation and presenting symptoms (including where if outwith primary care). ■ The key consultation at which the diagnosis was made. ■ Consultations in the year prior to diagnosis and referral (how often the patient had been seen by the practice; for what reasons; the type of consultation held: telephone, in clinic etc; and who - GP1, GP2, Nurse 1 - saw them). ■ Whether s/he had been seen by the Out of Hours service, at A&E, or in secondary care clinics. ■ If there appears to be delay on the part of the patient in presenting with their symptoms. ■ What the impact or potential impact of the event was.

11/6/12: Patient first presented to Dr A with a 3 wk history of non-productive cough and general malaise. History of recent URTI in close family members. No weight loss or haemoptysis.

Moderate alcohol intake, stopped smoking 30 years ago.

Known to have hypertension for past 2 years, now controlled on lisinopril and bendroflumethiazide. Had CXR at time of diagnosis – reported as normal.

Physical examination - nil of note

Advised likely URTI and to return in 2 wks if no better.

25/6/12: returns to usual GP, Dr B. Cough no better, though feels a bit better generally. Thought due to lisinopril and option of stopping discussed. Switch to ARB and 2 week review.

23/7/12: Saw Dr A (Dr B on holiday) Cough still troublesome, and now some pain in upper chest, left worse than right, thinks due to coughing. Review in further 2 weeks when Dr B back.

6/8/12: Dr B. Cough no better, thinks has lost some weight in past few weeks. CXR arranged .

10/8/12: phone call from Xray department taken by Ms C, receptionist. Opacity Left upper zone, referral advised. Message left for Dr B, who is on 2 day trainers' course.

12/8/12 2WW referral made by Dr B.

2. WHY DID IT HAPPEN?

Comment [QA1]:
Clear description of sequence of events with active participants identified.

In this section the submitter could also have discussed:
- impact/potential impact of the event – eg delayed diagnosis and potential effect on doctor patient relationship
- communication of 'urgent' results when doctor away or on holiday.

Comment [QA2]:
Some insights provided into thought processes at time of consultations.

Additional considerations for potential underlying reasons could include:
- Why was Dr A reassured by an X ray from 2 years previous?
- Did the practice follow current guidelines for investigation of cough?
- How quickly should ACEI cough resolve on stopping medication?
- Was the receptionist's action in breach of practice arrangements?
- Is there a training issue for the practice staff?

Reflect on the process of diagnosis for the patient. Consider for instance:

■ If this was as good as it could have been (and if so, the factors that contributed to speedy and/or appropriate diagnosis in primary care). ■ How often / over what time period the patient was seen before a referral was made (and the urgency of referral). ■ Whether safety-netting / follow-up was used (and if so, whether this was appropriate). ■ Whether there was any delay in diagnosis (and if so, the underlying factors that contributed to this). ■ Whether appropriate diagnostic services were used (and whether there was adequate access to or availability of these, and whether the reason for any delay was acceptable or appropriate).

Dr A considered viral infection most likely, and was reassured by normal CXR 2 years earlier. Nevertheless, instituted safety-netting arrangement.

Dr B places ACE-induced cough as next most likely cause, still reassured by previous CXR . Makes appropriate change to meds and makes follow up arrangement, but for a time when he is not available.

Dr A concurs with Dr B's diagnosis and makes a holding arrangement until his return, on the basis that more time needed for ACE effect to disappear. Chest pain +cough should trigger alarm by now, but lack of continuity of care also at fault.

Ms C takes report but no mechanism in practice for phoned-in results to be reviewed each day. 2WW referral delayed as a result.

3. WHAT HAS BEEN LEARNED?

Comment [QA3]: Honest analysis that ranges across all aspects of the care provided.

Demonstrate that reflection and learning have taken place, and that team members have been involved in considering the process of cancer diagnosis. Consider, for instance:

■ Education and training needs around cancer diagnosis and/or referral. ■ The need for protocols and/or specified procedures within the practice for cancer diagnosis and/or referral. ■ The robustness of follow-up systems within in the practice. ■ The importance and effectiveness of team working and communication (internally and with secondary care). ■ The role of the NICE referral guidelines for suspected cancer, and their usefulness to primary care teams. ■ Reference the literature, guidance and protocols that support your learning points ■ Is the learning the same for all staff members or who does it apply to

Learning point 1:

That a normal CXR can't be relied upon when there are persistent symptoms. Repeat if in any doubt.

Learning point 2:

The patient was an ex-smoker. At the point of attributing his cough to ACEI, this should have carried more weight.

Learning point 3:

Safety-netting ensured this man was reviewed in a timely way, but it was let down by poorly-planned continuity of care.

Learning point 4:

The practice systems for dealing with results by phone is not fit for purpose.

4. WHAT HAS BEEN CHANGED?

Comment [QA4]: Specific, measurable actions identified.

Outline here the action(s) agreed and/or implemented and who will/has undertaken them.
Detail, for instance:
■ If a protocol is to be/has been introduced, updated or amended: how this will be/was done; which staff members or groups will be/were responsible (GPs, Nurses; GP Reg 1, GP2 etc); and how the related changes will be/have been monitored. ■ If there are things that individuals or the practice as a whole will do differently (detail the level at which changes are being/have been made and how are they being monitored). ■ What improvements will result/have resulted from the changes: will/have the improvements benefit(ed) diagnosis of a specific cancer group, or will/has their impact been broader. ■ Consider both clinical, administrative and cross-team working issues.

Clinical staff reminded of the criteria for urgent CXR and 2WW referral. The prevalence and nature of ACEI-induced cough and its management is to be reviewed by Dr B and will be presented at a practice meeting.

Arrangements for planned review at time of holidays discussed. Dr going on holiday will email or discuss with others those patients he wants to be reviewed in his absence, and reasons why.

System for dealing with phoned results reviewed. All results to be reviewed and actioned by Dr on call. Audit of this planned for 3 months time, to be undertaken by practice manager.

WHAT WAS EFFECTIVE ABOUT THIS SEA?

Comment [QA5]: Full team present. Good practice celebrated. Both actions have identified responsible individuals and timescales.

Consider how carrying out this SEA has been valuable to individuals, to the practice team and/or to patients.
Detail for instance:
■ Who attended and whether the relevant people were involved ■ What format the meeting followed ■ How long the meeting lasted ■ What was effective about the SEA discussion and process ■ What could have made the SEA more effective in terms of encouraging reflection, learning and action.

Full PHCT present, including nurses and staff for this SEA meeting, which lasted 45 minutes.

Good practice identified – use of safety netting.

Area for organisational improvement identified with criteria for audit. Areas for clinical improvement identified with specific arrangements for shared learning .

SOME INFORMATION ABOUT YOUR PRACTICE *

How many registered patients are there?	5200					
How many F.T.E. GPs are there (inc. principals, salaried GPs, trainees etc.)?	2.5					
Is your practice a training practice?	Yes		No			
Does your practice teach medical students	Yes		No			
What were your QOF points last year?	Clinical		Organisation		Total	
OUT OF:		650		167.5		1000

* This information is useful when collating results across practices and/or localities