SIGNIFICANT EVENT AUDIT OF CANCER DIAGNOSIS

Cancer SEA Report Template

Diagnosis:	Cancer of head of pancreas
Date of diagnosis:	15/11/12
Age of patient at diagnosis:	67
Sex of patient:	F
Is the patient currently alive (Y/N):	Y
If deceased, please give date of death:	
Date of meeting when SEA discussed:	29/11/12

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.

1/11/12: patient presents with dark urine and jaundice, abdominal pain
2/11/12 urgent referral
Previous consultations
28/9/12 BP check and medication review
14/9/12 consulted with tiredness. No cause apparent.

2. WHY DID IT HAPPEN?

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).

Prompt referral at first consultation. No delay in assessment.
USS, CT scan and ERCP done as inpatient.
Inoperable cancer of head of pancreas, palliative treatment only.

3. WHAT HAS BEEN LEARNED?

Comment [QA1]:
Not all relevant information appears to have been given to put the background of the SEA into context.

No information about who saw the patient on each occasion or where.

No description of negative findings, duration of symptoms/signs or exclusion of 'red flag's in earlier consultation (may not be in records).

Where/Who was the urgent referral made to?

Comment [QA2]:
No comment on deficiencies of earlier consultations.

Specifically, the 14/09 consultation was for a symptom that could have prompted more assessment than is reported, and have been managed with safety-netting arrangements. The 28/09 consultation was an opportunity for this.

Prompt referral claimed but not defended – given there was potentially a 6 week delay in diagnosis.

Comment [QA3]:
No evidence of reflection and discussion in a team meeting.

No comment on
•team working (assuming 28/09 consultation was with a nurse),
•educational needs,
•or role of guidelines versus more urgent management of patient with apparent obstructive jaundice.

No description of the assessment of symptoms of tiredness on 14/09 and any appropriate investigation or follow up.

Were other partners in agreement with management?

Did the patient perceive any delay?

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:

Prompt and appropriate management.

Learning point 2:

Appropriate use of urgent referral pathway.

4. WHAT HAS BEEN CHANGED?

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.

No changes required.

WHAT WAS EFFECTIVE ABOUT THIS SEA?

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.

Confirmed current quality of care and that guidelines for urgent referral are being adhered to.

Comment [QA4]:
Could have considered:
•assessment of tiredness in the elderly,
•extent to which nurse in BP clinic should review recent consultations.

Comment [QA5]:
A cursory SEA with no evidence of reflection.

In part due to choice of case but also failure to adequately consider events surrounding the patient's presentation.

No learning demonstrated and no actions arising.

Poor choice to benefit from 'opportunity-cost' of analysis.

SOME INFORMATION ABOUT YOUR PRACTICE *

How many registered patients are there?					7500	
How many F.T.E. GPs are there (inc. principals, salaried GPs, trainees etc.)?					3.5	
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