SUMMARY IN ENGLISH

In the spring of 2020, a man sought care due to fatigue and a feeling of swelling around the throat. In the course of several months, examinations, tests and various diagnostic imaging examinations were carried out. In October 2020, an unclear change was seen in the pancreas which prompted further tests and an additional diagnostic imaging examination. The patient was referred from the health care centre Achima Care Fristaden on 12 November 2020 to the surgical clinic at Mälarsjukhuset in Eskilstuna. At Mälarsjukhuset, it could not be ruled out that the change was malignant, which is why a referral was therefore sent to the surgical clinic at Akademiska sjukhuset in Uppsala. At Akademiska, there were initially difficulties in accessing the images that had been created during the diagnostic imaging examination carried out by Linköping Health Care earlier in November 2020. This delayed the care process. Based on the images, Akademiska assessed that the unclear change was likely to be a gastroentero-pancreatic neuroendocrine tumour (GEP-NET).

According to a special procedure the suspicion of GEP-NET prompted further tests and a specific diagnostic imaging examination. The special procedure is referred to as standardised care process (SVF). The tests and the imaging examination were ordered by a doctor at Mälarsjukhuset. The imaging examination was carried out at the Imaging Clinic at Akademiska.

The report on the diagnostic imaging examination was faxed to Mälarsjukhuset, which was the hospital that had ordered the examination, on 15 February 2020. A medical secretary at Mälarsjukhuset intended to fax the report to the surgical clinic at Akademiska. For some reason, which has not been possible to determine within the scope of this investigation, either the fax was not sent from Mälarsjukhuset or was not received by Akademiska. This caused a delay for the patient. The delay was discovered when the patient himself contacted Mälarsjukhuset. The report was thereafter faxed on 2 March 2021, from Mälarsjukhuset and at that time received by Akademiska.

When personnel at both hospitals realised that a delay had occurred, the patient was prioritised for surgery. On 23 March 2021, the patient underwent a successful operation at Akademiska.

The incident, i.e. the delay in care for the patient, was caused by deficiencies in the interaction between different health care providers.

Contributing to the incident was that developed routines for communication between care providers were not used in an effective manner. Additionally, the interpretation of rules regarding traceability and information security contributed to the linking of images not being carried out. When unexpected problems arose, as in this case that MR[1] images were not made available as planned, there was no pre-planned remedial action prepared for such an event. The problems were not documented in the patient's medical record and the patient's doctor was not made aware of them.

An underlying contributing circumstance was that standardised care processes are partly difficult to apply both in primary care and inpatient care. Among other things, this may involve unclearly formulated instructions and definitions of important functions. Within the

[1] Imaging examination with magnetic resonance camera.

standardised care process for GEP-NET, for example, it is not clearly stated which imaging examination is recommended in order to be able to make a diagnosis.

Safety Recommendations

Swedish Association of Local Authorities and Regions is recommended to:

- Consider whether there is a need for, and if so take action to, clarify how standardised care processes are to be used at an early stage, e.g. in primary care when an unclear change is discovered as a secondary finding. It is also appropriate in the context of such consideration to address the ambiguities identified for the standardised care process for GEP-NET within the framework of this investigation (see section 2.3.2). *(SHK 2023:02 R1)*

- Carry out an investigation of standardized care processes and the milestones and time limitations with the aim of better including the entire diagnosis and care process, where e.g. if there are regional differences pertaining the severity of the disease when the patient is included in a standardized care process, and survival and recurrence could constitute important parameters for evaluation. Possible displacement effects and other negative effects of SVF are also of interest to map and quantify. This can be done within existing organisational structures (see section 2.3.2). *(SHK 2023:02 R2)*

National Board of Health and Welfare is recommended to:

- Within the framework of the authority's task to provide knowledge to the health care sector, study whether the working method that has now been introduced at Akademiska sjukhuset in Uppsala - that the health care provider who requests an examination is also the one who must order it - could be advantageously implemented further within the health care system and if deemed appropriate work in cooperation with suitable organisations and authorities for such an implementation (see section 2.1.2). *(SHK 2023:02 R3)*

- In an appropriate way clarify what the regulations say about sharing other health care provider's images from diagnostic imaging examinations and how this can then be done in safely from an information and patient safety perspective (see section 2.4). *(SHK 2023:02 R4)*

- Study whether it is possible to simplify and clarify the application of the regulatory system for the use of NPÖ[2] to facilitate good care (see section 2.5). *(SHK 2023:02 R5)*

[2] NPÖ is a web-based tool that enables authorised health care personnel to access patient information from other health care providers.