Case Review – SEA
Bladder Cancer

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SEA Workshop

• Overview
• Detailed Case Review
• Group Discussion
• Feedback & Actions
SEA

• Familiar Format in Primary Care
• Contributes to GP appraisal
• Quality Improvement a RCGP priority
• NCDA

“To err is human, to cover up is unforgivable and to fail to learn is inexcusable.”
Sir Liam Donaldson 2004
Definition

A process in which episodes where there has been a significant occurrence, either beneficial or deleterious, are analysed in a systemic and detailed way to ascertain what can be learnt about the overall quality of care and to indicate any changes that might lead to future improvements.

Prof. M Pringle 1995
SEA 7 Steps

• Identify significant event.
• Describe what happened.
• Discuss with team involved, what went well, what could be improved?
• Analyse events and clarify root cause of incident.
• Identify learning points for individual, practice, wider community
• What changes or actions can be agreed, implemented and monitored?
• Write report and share findings
Case Review

- 65yr old women with spina bifida who regularly self-catheterises.
- Presents with 2/52 history of pelvic pain and recurrent LUTS
- Initial +ve MSU developed into sterile pyuria, then frank haematuria & incontinence
- TWW referral 31 days after presentation & 3 attendances to GP
- Day 13 Seen in hospital : USS inconclusive
- Day 24 CT: Bladder tumour identified
- Day 42 Cystoscopy under GA: Histology confirms diagnosis
- Day 88  Resection of bladder.

On the face of it, one may ask, what went wrong? What is the significant event?
What is the whole story?

What are the details behind the data?

The detailed log of events tells a different tale.

Please read and review the log which was created from information and reflections provided by the patient herself.
Group Work

• Is there anything which could have improved this patient’s pathway?

• Identify 3 Learning Points?
  – Primary Care
  – Administration
  – Secondary Care

• Detail one area where change can be implemented.

• Describe how can this be monitored?
Reflection

Patient
• increasingly anxious by deteriorating symptoms and loss of function.
• She felt that she had to push appointments through herself.
• And that information was being withheld from her.

Administration
• At referral not clear where she would be seen
• Txn appointments do not allow a response

Hospital
• Not clear who would relay results
• Communication at pre-op clinic
• Information relayed in immediate post-op period not retained.
Patient feedback

I feel very sad and let down at the lonely and painful journey I have travelled and can only hope that things improve.

I felt very low in spirit, that I don’t belong to anyone, the targets and breeches are more important than I am.

I was passed from team to team with only conflicting information being shared with me.

However, the treatment I received after my operation has been the opposite of my pre-operation experiences.
Actions

Are there any actions you can take away from today's discussion and implement in your place of work?
Thank You

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