Shared Learning in Suffolk

Type of Event:
Surgical / Invasive Procedure

Event:
Patient in remission and receiving treatment. At a planned follow-up appointment blood tests were taken prior to further treatment being given. The biochemistry results were reported as indicative of acute organ failure requiring urgent life-saving intervention. The patient was admitted to the critical care unit (CCU) for intensive treatment. Later the same day it was found that the blood samples had been booked into the laboratory under a different patient’s number. When this was discovered, the treatment was discontinued. The second patient, who was a known patient, suffered no harm as the error was reported to the relevant department soon after it was noted.

Notable Practice:
• Due diligence on the part of the Consultant Haematologist
• The conscientiousness of the Oncology Pharmacist and also the speed with which CCU responded to the request to admit patient
• The Pathology Partnership’s quick response to address the issues that had been raised

Improvement:
• Trust staff who request tests to be reminded to complete request forms in full to ensure that contact details are recorded accurately
• Guidance to be issued to staff in the Trust and in the Pathology Partnership as to the process for reporting results when the requester is not recorded or not available

Learning:
As a result of this incident the following improvements have been made:
• Request forms will be completed with the correct Consultant and location of the patient
• Contact numbers for clinicians are to be stated on the request forms
• Update SOP’s to reflect the safeguards required to confirm that the sample and request form match from the outset, prior to preparation and analysis occurring
• Shared learning of good practice and areas of change and development in processes Trust wide

If you have any constructive comments please send them to WSCCG_SUI@nhs.net  Q3 2016-17