The Royal College of Pathologists
Pathology: the science behind the cure

Patient Safety Bulletin

Case mix up

What happened and what were the issues/implications?

We use a scanning system with request forms and samples both being barcoded. Everyone in the department has access to a scanner, which is attached to their computer. When reporting a histology report, the barcode from the request form is scanned into our system, generating a blank report form, and the histopathology report is typed directly into the system. On this particular day, a scanner on one of the department's computers was not working, so a consultant was inputting the barcode number by hand. This led to one of the patient's barcodes being mistyped, leading to the incorrect report being input for the patient/sample on the database. This could have had significant implications, potentially leading to an incorrect diagnosis for the patient and resulting in incorrect surgery or treatment.

Fortunately, the surgeon who reviewed the histopathology report noticed the error (it was a mix up between a biopsy and resection case). They informed us of the error, allowing us to resolve the problem.

What actions were taken?

The slides for the mixed up cases were identified and the correct reports issued. The clinical teams for the cases were informed. No harm came to the patients involved.

What did you learn?

It is best to double check the patient's name and date of birth each time a report is inputted against the form, rather than relying solely on inputting a number or the scanning system. The department is looking into a protocol for managing the issue with barcode scanners not working in the future.

How was the learning shared?

The learning was shared at departmental meetings in both the clinical setting and the histopathology setting.