



PATIENT SAFETY

Bulletin No. 4

Making Assumptions and Challenging Confirmation Bias

Never assume...

This edition brings together a series of incidents from organisations that have occurred in different areas, but which have one thing in common...they all illustrate the problem with making assumptions. In particular, this is about challenging confirmation bias and getting to the real bottom of the problem.

Pregnancy test...

An organisation had a clinical incident related to an inaccurate pregnancy test using a standard pregnancy test kit, during chemotherapy. The result was given as negative, when actually it was positive. This was initially assumed to be human error, but using a test set of positive and negative urine samples for quality assurance that were sent out to the wards, it became clear that there was a significant problem with poor technique and inaccurate reading. The organisation implemented standardisation of test type, restricted testing to specific areas and made sure that training and regular quality assurance testing was rolled out. In another hospital that had a very similar problem, the introduction of point-of-care pregnancy testing meters that read the strip improved their situation. Do remind staff that the lab can do a serum hCG for confirmation.

What training?

Training compliance records and attendance at competence assessment days suggested that staff at one hospital with a haematological oncology service had received good training in the testing of nasogastric tubes prior to their use for feeding. Two 'never' events then happened, both resulting in harm to patients from feeding into the lungs via a misplaced nasogastric tube. Staff were then asked in an audit whether they had received training, and about their knowledge. It was soon apparent that there was a real disconnect between what staff thought they had been trained on and what they knew, and what it was assumed that they knew. Lots of training was then rolled out, and sequential knowledge re-audits provided better reassurance about the effectiveness of staff training.



Penicillin allergy

Following a series of 'near miss' events, where penicillin was prescribed for, and given to, penicillin allergic patients, those involved were interviewed and indicated that they had been busy and had failed to ask the patient about allergies or look at the allergy band. There was still a worry that this was not the whole story. Whilst no-one admitted to making a mistake about knowing what class of drug was prescribed, the investigator began to wonder about the underlying knowledge of which antibiotics were penicillins, and so undertook an audit. This revealed a deficit in knowledge, in medic and nursing staff, about some antibiotics that would help to explain these incidents. Further enquiry established that the medical school prescribing examination at the time required a pass mark of only 50%. A programme of education about antibiotics was rolled out that helped reduce events.

Look at me...

We tend to assume that when we send out a result, those requesting the test will actually look at the result. There is a professional duty of care to ensure that you follow up on test results you request. Lots of studies have shown that this is not actually the way things are. This has been shown repeatedly across a range of different organisations and different pathology disciplines.

One organisation, investigating a missed diagnosis following a serious incident, noted that up to 20% of microbiology results were never looked at. They worked hard to improve this. This issue is not only a clinical risk, but also a waste of resource. Do check to see that your results are being looked at, and if some aren't, find out why!