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

Patient Safety Bulletin

The devil is in the details

What happened and what were the issues/implications?

I was on call on a busy weekend. As usual I went to the microbiology laboratory in the morning to collect positive culture results. I started with the blood culture bench and started handwriting the details of a positive culture into the handwritten cards. I realised halfway through that there was a patient with a similar name (first and last name) who already had a positive culture being planned for follow up. I noted the culture details on that follow-up card without checking the date of birth or hospital number/NHS number. I phoned the ward, reported the positive culture, and gave advice about changing the patient's treatment. The next day I realised that my advice was directed to the wrong patient. There were two patients who shared the same first and last names and because of my rush, I did not notice they were in fact different patients. Luckily, the gentleman whose team were unaware of the positive blood culture did not come to any harm and was on appropriate antibiotic therapy.

What actions were taken?

The team looking after the patient whose result had been attributed to a different patient were informed of the positive result and made aware of the incident. Their patient was subsequently followed up and did not come to any harm. The reporting system has been redesigned to ensure reports are not missed/misinterpreted. Personally, I have moved into double checking patient identifiers to ensure this error never recurs.

What did you learn?

The work stream design was flawed as manually picking up results can result in transcription errors. Current fail-safe measures were inadequate and resulted in a 24-hour delay before the error was picked up. Therefore, the process was reviewed and changed into an electronic notification system, which collates important results in an electronic list within the authorisation queues.

To err is human! No matter how well trained and motivated we are, sometimes we are 'set up' by the system to fail. The challenge is to develop error-intolerant systems and to prevent errors from occurring.

Busy workloads can put individuals under pressure and increase the possibility of making errors. Rather than working under such pressure, the answer could be as simple as asking for help. We often avoid asking for help as it may imply incompetence, which is untrue.

How was the learning shared?

Locally, the incident was discussed in the daily clinical meeting involving myself and other colleagues. I was involved in the redesign of the new adapted process.

I have submitted an incident report against myself and we have shared the outcome and recommendations with the responsible clinical team to reassure them this was an isolated incident.

This was included as a case for learning and shared with other colleagues within the organisation in the monthly patient safety bulletin.