

# PATIENT SAFETY

*Bulletin No. 8*

## Missing in action

### Definitely not rubbish

A specimen was delivered to the laboratory, but no report was issued, and on investigation the specimen appeared to have gone missing. Despite extensive searching, the specimen was not found. During the search, it became apparent that specimens and forms were being removed from the plastic bags in which they arrived, and that open waste bins were present in the area, at the edge of the bench. The waste bins were emptied daily. It was concluded that the specimen had fallen into the bin. Open bins under a specimen reception bench area, especially a crowded or busy one, are a risk.

### Under and out

A specimen was received in five separate pots and logged in as such. When reporting the result, the pathologist noted that there were only four samples for reporting. The booking-in clearly stated that five pots were received. The benches were searched, to no avail. The department was searched again by a 'fresh pair of eyes', and the small fifth sample pot was eventually located. It had fallen to the floor and rolled under a bench. During the clearing of the narrow space under the bench and review of the spaces under other benches, another 'lost' sample that had been missing since an incident two weeks earlier was also located.

### There are several learning points here:

- be aware of potential hiding places for dropped samples
- include low areas and areas under benches in your searches
- ensure that everyone is aware that checking and cross-checking numbers of specimens is routine and very important
- raise awareness and train everyone that a lost or mismatched sample is an urgent priority to sort out
- persistence is also important – these are patient samples, so it is vital to not give up.

### Lost in space

A new pneumatic tube was installed in a hospital and appeared to be working well. Samples from one department that used the system occasionally would apparently go missing. However, no specific problems were raised, and the missing samples were blood tests that were repeated. A month later, a facilities team were repairing a roof space and found a spur section of collapsed air tube with sample pods.

### Out of sight

An external department stated that a result for two samples had not been received. There was no electronic link, and results were usually sent by post to that external lab. The receiving lab had processed and reported on the sample, but the result had not been received by the referrers. On investigation, it transpired that for several weeks all 'send-away' results had not been received by a range of referring departments. The root cause was a busy member of the administration staff who had been stockpiling send-away results in a drawer to avoid anyone noticing that they were behind with their work, since they didn't want to get into trouble with their boss. They had not alerted anyone to this.

### Again, several lessons:

- a single incident may be indicative of a larger problem
- a lack of complaints is not indicative of a lack of a problem
- end-to-end monitoring audits are helpful to monitor receipts where electronic audit systems are not available
- overloaded staff or those who don't know how to perform a task do need to feel able to ask for help without fear of recrimination
- all staff need to remember that there is a patient at the end of result.

