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Case Report

Is Patient's Identification Improving with Advances Information Technology?

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Aim

To illustrate the importance of registering a patient's ID particularly in specimens submitted to the Laboratory for investigations of blood transfusion. Mix-up of patients' identification remain the commonest factor in producing erroneous reports or giving wrong blood products with potential serious ramifications. We are documenting 3 cases in which this mistake happened despite robust measures in the clinical settings and upon receiving the specimen in the Laboratory with variable consequences.

Case 1

Patient A presented with abdominal pain and was diagnosed with cholelithiasis. A laparoscopic cholecystectomy was planned. Upon registration the receptionist typed the unit number of the patient but with one different digit which resulted in producing labels of a different patient's name and details. These were not checked and were filed with the notes. At operation the sticky label was peeled off from the notes and put on the specimen and was submitted to the Laboratory. At the Laboratory registration everything seemed fine and a histology report was produced confirming chronic cholecystitis associated with cholelithiasis. A few weeks later the pathologist received a letter from the clinician indicating that he did not perform this procedure on that patient, but he did the surgery on a different patient on the same day. The pathologist reported this as a clinical incident and asked for a formal letter from the surgeon outlining the details of the mistake, registering the incident and taking measures to identify and resolve the problem with further checking in the specimen to stop this incident from happening again.

Case 2

A young patient and her mother visited an outpatient clinic in a private hospital for a routine cervical smear for the daughter. A cervical smear was performed by the gynaecologist and the specimen was submitted for the cytology department for assessment. During screening and at the time of reporting the consultant cytopathologist noted that this patient had a history of a hysterectomy in the past which is documented in our records. The age of the patient was also noted which was 65 years old, but the smear showed no evidence of atrophy compatible with a young patient. Upon calling the gynecologist it was discovered that the sticky label on the request form was showing the mother's details and not those of the daughter. It transpired that both the mother and the daughter had exactly the same first and surnames producing the confusion and mix-up at the time of registration. The gynecologist confirmed that he performed the procedure on the daughter and not on the mother. It is only by the robust procedure in the cytology department where previous records of each patient should be checked before issuing a new report helped to identify the problem. Again the gynecologist sent a letter documenting the incident and confirming the correct patient details and a correct cytology report was issued.

Case 3

A middle-aged patient presented with labor at term. She required caesarean section and requested sterilization at the same time. The operation was performed which was uneventful and segments of both fallopian tubes were submitted to the laboratory for histological confirmation. At the time of histological examination, the consultant noticed complete cross sections of both fallopian tubes but one of which also contained tumourous tissue consistent with squamous cell carcinoma. The pots were immediately checked and the patient's details and macroscopic examination of both specimens were confirmed. A report was issued, and the obstetrician informed of the findings. His reaction was the pelvis appeared unremarkable at the time of surgery and the results were total surprise to him. Upon extensive investigations including imaging–no tumor could be found. Checking the operative list on the same day showed that another elderly patient presented with a vaginal polypoid tumour which was biopsied on the same day. It transpired that the specimen was put on a container and no label was attached to it and no request form was filled by the obstetrician or nursing staff. When the second patient came in for the surgical procedure, the nursing staff thought that the container was empty and put one of the fallopian tubes in it together with the label of the second patient's details.

The problem which faced the Histopathologist and Obstetrician that how to prove that the squamous cell carcinoma does not belong to the young lady. Tracing the elderly woman yield to dead end as she passed away in a Nursing Home so afterwards and no post mortem examination was requested. The Histopathologist contacted forensic laboratory which was very helpful. They promised to help in carrying out DNA analysis on tissue sections provided that blood samples from both patients are submitted as well to compare DNA findings. As one patient remained alive they agreed to carry out the testing to prove that the fallopian tubes belonged to her and hopefully the squamous cell carcinoma will show a different DNA profile. I think the bill for carrying out the procedure was in thousands of pounds hence the laboratory was hesitant to pay the bill but the Department of Obstretic and Gynaecology were keen to do so. Luckily, the test was successful and DNA profile confirmed that the fallopian tubes belonged to the young patients' blood sample DNA hence the squamous cell carcinoma which carried different DNA profile must belong to the elderly woman. This happy ending took weeks of stress to both patients, doctors, nurses and Trust.

Discussion

Despite massive improvement in Information Technology with potential further changes soon such as producing one unique NHS number, one identifying card per patient carrying all his/her past medical history, and new Telepath systems with fail safe mechanism to spot any anomalies. Using digital imaging, finger prints, facial recognition ...etc. for accessing the data will improve confidentiality. However, human errors remain as the most common factor in mix up of patients' identity and site of specimens. It is well documented that clinicians do not always provide adequate clinical information nor properly fill request forms used for pathology. This is a recipe for disaster as enough information is required by the pathologists to produce relevant reports and to spot any anomaly.

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