Public Health England

National Chlamydia Screening Programme

Lessons learnt report

The incident/background:

Background:
Test request forms were sent to the laboratory through the internal NHS mail or by post.

The forms contained service users' name, date of birth, postcode and at least two ways of contacting them. All forms had the code and venue name from which they were taken.

When the specimens were tested at the laboratory, the completed forms were used to enter data onto the electronic patient management system. The test result was not put onto the forms. The forms were then sent to the chlamydia screening office to check information had been entered correctly onto the system and were then filed.

Previously the forms were sent to the chlamydia screening office using internal mail from the laboratory. These were in a brown envelope marked 'private and confidential', however, when the laboratory moved site, they continued to receive specimens through the internal mail, but the completed test forms were sent back to the chlamydia screening office via Royal Mail.

What happened:
A service user contacted the GUM service to say that he had received his chlamydia test form back in the post, and a member of the GUM staff then informed the chlamydia screening office. The private and confidential envelope sent by the laboratory arrived at the chlamydia screening office open and empty.

Who was informed:

- the chlamydia screening office
- the lead nurse for CASH/chlamydia screening office
- laboratory lead
- patient advice liaison service (PALS)
- Royal Mail
- the service users effected

What was done:

- the laboratory was able to supply names and contact details from scanned copies of the forms
- all service users effected were sent the following text message:
  'We regret to inform you that there has been a possible breach of confidentiality regarding your personal information (ie name, date of birth, contact details) following your recent test. Please contact CSO 'tel no' or 'email' NEXT WEEK for further details'
- those without a mobile number were sent a letter or email

- service users effected were contacted and some contacted the chlamydia screening office for more information, none wished to make a formal complaint, all were offered the PALS number
- Royal Mail was contacted but they were unable to track down the original forms, some of which were returned to the service user as they had included their postal address
- one form was returned to the chlamydia screening office and the service user whose form it was, was informed of this
- service users' main concern was whether or not their result was on the card- they were reassured that it was not
- an in house incident form/datix form was completed

Immediate and root causes:

How was it identified:

- due to the service user contacting GUM to say his form had arrived in the post the service provider were aware of an error and breech in confidentiality
- when the empty envelope arrived the laboratory was contacted and asked to confirm that the envelope left them sealed and also how many forms were in the envelope
- cause for losing the content of the envelop is unclear

What was done well:

- review of the process

Lessons to be learnt:

- paper transfer of test request forms is not secure
- forms sent in the post by the laboratory were stopped immediately
- it was arranged that forms would be scanned by the laboratory and emailed to a secure generic chlamydia screening office account daily so checking can continue to take place
- the laboratory now securely discards the paper copies of the completed test request forms after one week
- electronic copies are filed by the chlamydia screening office

Final Outcome:

- no injuries or 'near misses' to service users
- improved secure transport of test request forms

DATE: March 2015

PHE publications gateway number: 2015211