Public Health England

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National Chlamydia Screening Programme: Lessons learnt report

The incident

Background:

On 19 October 2016 virology was contacted by a chlamydia screening office (CSO) and a Genito-urinary Medicine service to ask if there was a delay in reporting results for chlamydia and gonorrhoea testing as they were still awaiting results for samples taken on 13 October 2016. Investigation showed that the samples had been received on 13 October 2016 at the laboratory and registered consecutively on the Laboratory Information and Management System (LIMS) and sent to the laboratory for processing.

From LIMS there were 74 samples from 69 patients that had been registered but no results were available. Samples came from the CSO, a number of GUM services and from GP practices.

What happened

A search of the laboratory and related areas failed to find the samples. Usual procedure is for the samples to be placed into the automated analysing unit, processed, confirmation that the results for the processing are available and then for the samples to be discarded. This is a relatively new analyser and workflow.

Discussions with the staff present that day were unable to confirm precisely what had occurred and why no results were available. The presumption reached was that due to operator error the samples either were never placed onto the analyser or that the samples had been removed from the analyser before testing had been completed and then the samples were discarded.

Who was informed

On 20 October 2016 virology contacted the CSO and GUM services to inform them that the samples could not be located and that patients would need to be advised and offered repeat testing. General Practices affected were also contacted, as were local commissioners. A Datix and SI review meeting was arranged to commence review and investigation.

What was done

GUM patients were contacted via a text message, apologising and advising of a sample processing error and the need to re-attend for repeat testing. Audit trail shows all messages delivered. To date (December 2016), a limited number of patients have re-attended for repeat screening.

Procedural change introduced in the laboratory so that racks of samples are not discarded until the results from the analyser for each rack are confirmed and matched to the rack of samples.

Training was given to the laboratory staff on reviewing overdue (>48 hours) results on a daily basis, in addition to the existing weekly overall review meeting.

Immediate and root causes

- incomplete samples (samples receipted but not reported) were not being checked frequently enough to prevent patients being retested if sample lost
- procedure for not discarding samples until results confirmed not adhered to

What was done well

Communication between departments was rapid and transparent.

Lessons to be learnt

- revised checking frequency of incomplete samples (receipted but not reported)
- checking of results on the system before samples are discarded

Final Outcome

The incident has been reported as a STEIS.

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