



National Chlamydia Screening Programme: Lessons learnt report

The incident

What happened

A chlamydia screening service received an upgrade to the computer system used for recording patient details and result notification. For a subsequent period of 8 days, no results were received through the upgraded system, even though the laboratory was able to send the results as usual.

What was done

Provider staff, laboratory staff, Trust management, computer software company staff were informed and a Trust incident form was submitted. The software company worked to resolve the problem, in the meantime laboratory and provider staff worked together through lists and manually cross referencing names and results with patient identification forms. Once validated, the contact details were manually entered into the Outlook/SMS system and patients notified of their results. This continued until the software problem was resolved 8 days later when a significant number of results were received in bulk. These were processed in the normal way. Approximately 120 patients received a duplicate test result due to this incident.

What was done well

Remedial action was taken through manual data checking/referencing and data entry. This ensured delays to result notification and providing treatment when required, was kept to a minimum.

Lessons to be learnt

When system upgrades are due, these are to be communicated to the laboratory and a demo account set-up to ensure results can be received before the upgrade goes 'live'.

When changes to computer systems are planned (eg upgrades, or new systems), providers, commissioners, laboratories and software developers need to work together to ensure that systems that support the care pathway can continue to work through testing the system prior to going live.

Final Outcome

Some patients received their test result with a delay of a number of days, and if found to be positive, may have received their treatment with some further delay as well. Future system upgrades are to be managed in a way that should reduce the chances of this happening again.