HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

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Summary

Wrong site surgery – wrong patient: invasive procedures in outpatient settings

Independent report by the
Healthcare Safety Investigation Branch I2019/018

June 2021

Providing feedback and comment on HSIB reports

At the Healthcare Safety Investigation Branch (HSIB) we welcome feedback on our investigation reports. The best way to share your views and comments is to email us at **enquiries@hsib.org.uk** or complete our online feedback form at **www.hsib.org.uk/tell-us-what-you-think**.

We aim to provide a response to all correspondence within five working days.

About HSIB

We conduct independent investigations of patient safety concerns in NHS-funded care across England. Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Our investigations identify the contributory factors that have led to harm or the potential for harm to patients. The safety recommendations we make aim to improve healthcare systems and processes, to reduce risk and improve safety.

We work closely with patients, families and healthcare staff affected by patient safety incidents, and we never attribute blame or liability.

Considerations in light of coronavirus (COVID-19)

We have adapted some of our national investigations, reports and processes to reflect the impact that COVID-19 has had on our organisation as well as the healthcare system across England. For this report, the way we engaged with staff and families was revised.

A note of acknowledgement

We would like to thank the Patient at the centre of the incident detailed in this report for taking the time to share her experience and giving the investigation valuable insights into her care. We would also like to express our gratitude to the healthcare staff who were involved in the investigation. They gave their time to provide open and honest accounts of events in order to support learning and improve patient safety.

Our investigations

Our investigators and analysts have diverse experience of healthcare and other safety-critical industries and are trained in human factors and safety science. We consult widely in England and internationally to ensure that our work is informed by appropriate clinical and other relevant expertise.

We undertake patient safety investigations through two programmes:

National investigations

Concerns about patient safety in any area of NHS-funded healthcare in England can be referred to us by any person, group or organisation. We review these concerns against our investigation criteria to decide whether to conduct a national investigation. National investigation reports are published on our website and include safety recommendations for specific organisations. These organisations are requested to respond to our safety recommendations within 90 days, and we publish their responses on our **website**.

Maternity investigations

We investigate all incidents in NHS maternity services that meet:

- the criteria of the Royal College of Obstetricians and Gynaecologists' Each Baby Counts programme, or
- our HSIB defined criteria for maternal deaths.

Incidents are referred to us by the NHS trust where the incident took place, and, where an incident meets the criteria, our investigation replaces the trust's own local investigation. Our investigation report is shared with the family and trust, and the trust is responsible for carrying out any safety recommendations made in the report. In addition, we identify and examine recurring themes that arise from trust-level investigations in order to make safety recommendations to local and national organisations for system-level improvements in maternity services.

For full information on our national and maternity investigations please **visit our website**.

Executive Summary

Background

This investigation focuses on patient safety issues that relate to the delivery of invasive procedures (surgical or interventional procedures) in an outpatient setting. As an example, we consider the experience of a woman who attended a gynaecology outpatient clinic for a consultation to assess her suitability for fertility treatment. Unfortunately, she was mistaken for another patient and received a colposcopy (an examination of the cervix, the lower part of the womb and top of the vagina) which was intended for a different woman. This incident is referred to as the 'reference event'.

'Outpatients' are people who attend hospital for consultations, diagnostic tests and procedures, but who do not need to stay overnight. Those who need to stay in hospital for one night or more are known as 'inpatients'. Many minor surgical procedures can now be carried out in an outpatient clinic, whereas in the past they would have been carried out in an inpatient operating theatre setting.

Visits to outpatient clinics have nearly doubled in the past decade with an increase in the number of clinical interventions and minor procedures being undertaken in these clinics. Health policy and best practice outlines the requirement for professionals to correctly identify patients and service users at the point of care, and as part of the consent process, prior to invasive procedures and interventions. The mismatch of patients and intended care is a recognised risk across all healthcare settings, with procedures, guidance and checks implemented to reduce the risk. Much of the work to consider the risk of patient misidentification has been focused on the inpatient setting and the risks associated with outpatient services may not be well understood.

The reference event

In July 2019 a woman aged 39 years (Patient A) visited the gynaecology outpatient department for her first fertility treatment appointment. Another woman (Patient B) also attended at a similar time for a colposcopy appointment. At the reception desk they were both checked in and directed to the same waiting area. A nurse entered the waiting area and called out patient B's first name and surname twice. As the nurse received no response she then called patient B's first name. Patient A's surname was similar to patient B's first name, and, as no other person had responded, Patient A believed the nurse must be calling for her. She was unfamiliar with the nurse's accent so she sought to clarify that she had understood correctly, by repeating her surname to the nurse. The nurse showed Patient A the outcome sheet (a document detailing a patient's identifiers and clinical activity) intended for Patient B and asked if this was her. The nurse and patient both believed they had confirmed Patient A's identity. There

were no further formal recorded identification checks completed during the consultation. Further misunderstandings occurred during the consultation and the opportunity to recognise the misidentification did not materialise. Patient A went on to receive a colposcopy procedure and left the outpatient clinic. Patient B then went in for her appointment. The error was quickly identified by staff who telephoned Patient A and asked her to return to the outpatient clinic on the same day, where staff explained what had happened and apologised for the incident. Patient A then had her intended fertility clinic appointment.

The national investigation

HSIB identified that the scale and impact of misidentification of patients in an outpatient setting is unknown, as historically national incident reporting systems have not explicitly recorded this type of incident.

The investigation considered the effectiveness of existing safety controls that are relied upon in an outpatient setting. It analysed how and which system-wide factors may influence the reliability of these safety controls and increase the risk of a patient receiving an unintended intervention.

During one appointment, patients may move between different areas of an outpatient department multiple times and be seen by different staff. The investigation recognised that these multiple transitions increased the frequency of the need to correctly establish the identification of a patient. The reliance on verbal communication, the format of checks, the physical environment, workload and the design of tools used to assist with patient identification were all identified as factors that contribute to the reliability of safety controls that are currently used to ensure the right patient receives the right procedure. The investigation identified a lack of integration of technology within outpatient clinics. This can lead to staff not using these systems and inhibiting the potential role technology could have as an effective safety control.

These considerations may help in the analysis of risks specific to an outpatient setting. As healthcare increasingly moves towards delivering interventions in settings other than inpatient departments, and even remotely from the hospital setting, there is a need to understand how the context in which interventions are delivered in influences existing and emerging risks.

Findings

- The task of calling a patient through for an outpatient appointment presents as a safety issue and contributes to the risk of an unintended patient being selected, influenced by the clarity of verbal communication. This creates a dependency upon the reliability of subsequent identification checks to prevent this error.

- The number of clinics running at the same time within a department, the number of patients required to wait in a similar area and the number of transitions patients make within an outpatient department affect the risk of the wrong patient being selected.
- The format of processes and tools used to identify patients varies across trusts, with limited use of the unique NHS identifying number.
- Technology can be used to support the patient identification process. There is a lack of integration of technology in outpatient departments.
- There is a localised approach to the assessment of risks within outpatient settings and variation between trusts in the knowledge required to develop appropriate and sufficient controls to support patient identification.
- There are no formal safety controls to manage the risks that can arise when patients have similar names.
- The increased workload and time pressure associated with delivering interventions in outpatient settings may have a negative impact on the quality of communication and safety checks relied upon for effective patient identification.

HSIB makes the following safety recommendation

Safety recommendation R/2021/131:
HSIB recommends that NHS England and NHS Improvement leads a review of risks relating to patient identification in outpatient settings, working with partners to engage clinical and human factors expertise. This should assess the feasibility to enhance or implement layers of systemic controls to manage these risks. It should also consider existing challenges relating to the usability and practice of including the NHS unique identifier in patient identification processes, and consider technological solutions to support its use.

HSIB makes the following safety observations

Safety observation O/2021/110:
It would be beneficial if scheduling, resources, and organisational performance targets were considered relative to the associated demand for care and interventions, as staff workload may influence the integrity and sustainability of safety checks in an outpatient setting.

Safety observation O/2021/111:
It would be beneficial if it was easier for trusts to find clear national guidance on what a good patient identification check looks like to assist the quality and consistency of trust guidance.

Safety observation O/2021/112:
It would be beneficial if the risks associated with patient identification in an outpatient department are considered within staff education and in the procurement and implementation of technical systems.

Safety observation O/2021/113:
It would be beneficial if there was national guidance on the principles for good design of tools to support the critical task of patient identification.

Safety observation O/2021/114:
It would be beneficial if trusts trained or employed suitably qualified and competent patient safety specialists to align with the national Patient Safety Syllabus currently under development.

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Further information

More information about HSIB – including its team, investigations and history – is available at **www.hsib.org.uk**

If you would like to request an investigation then please read our **guidance** before contacting us.

@hsib_org is our Twitter handle. We use this feed to raise awareness of our work and to direct followers to our publications, news and events.

Contact us

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We monitor this inbox during normal office hours - Monday to Friday from 09:00 hours to 17:00 hours. We aim to respond to enquiries within five working days.

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