

# 1 Problem

<b>What</b>	Problem(s)	Pathology results switched; wrong care given
<b>When</b>	Date	Late April, 2013
<b>Where</b>	Different, unusual, unique	Recording error; pathology results switched
	State, city	Nova Scotia
	Facility, site	Cancer Center
	Unit, area, equipment	Tissue sample
	Task being performed	Oversight sample analysis

## Impact to the Goals

<b>Patient Safety</b>	Patient 1 received unnecessary surgery
	Patient 2 did not receive necessary surgery
<b>Employee Impact</b>	Staff devastated
<b>Organization</b>	Apology from health authority
<b>Patient Services</b>	Switch of patient tissue samples
<b>Property, Equip, Mtls</b>	Unnecessary procedure performed
<b>Labor, Time</b>	Investigation

Frequency	Previous unnecessary mastectomy in 2003 (related to different cause)
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# SAMPLE SWITCH Cause Map

**Patient receives unneeded mastectomy**  
**Delay in needed surgery for another patient**

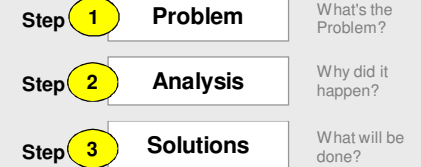
"Human error is always a possibility. But one of the things we strive for is to ensure there are appropriate controls in place to ensure that the risk of these things is absolutely minimized."

- Nova Scotia Premier Darrell Dexter

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

## CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis



For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

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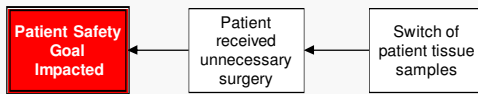
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# 2 Analysis

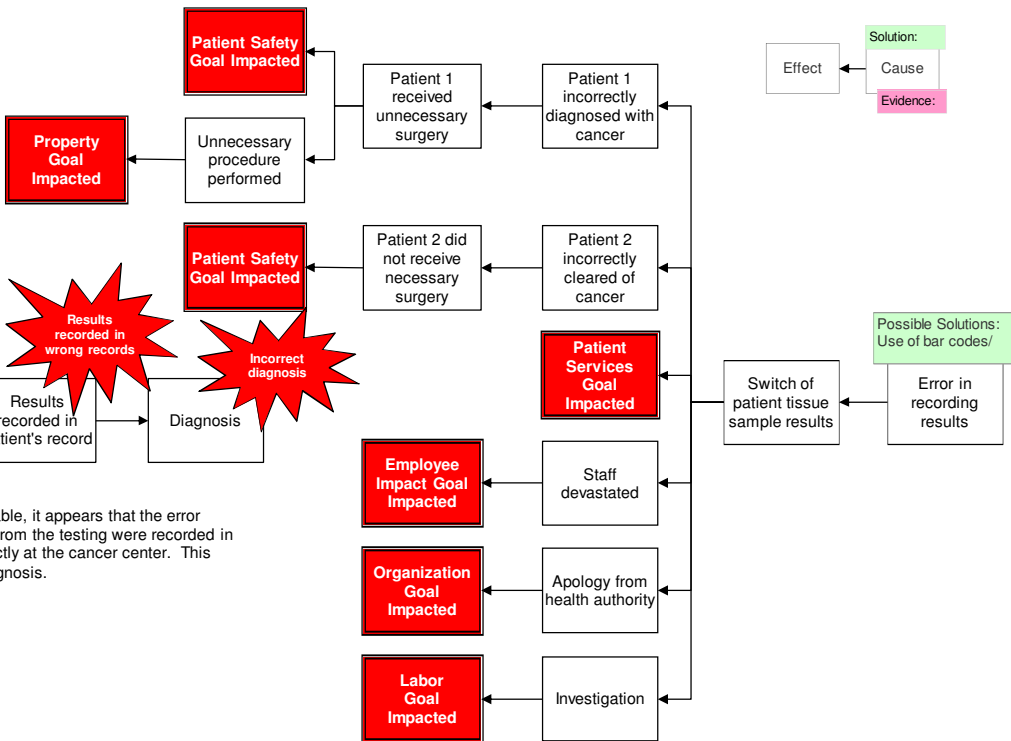
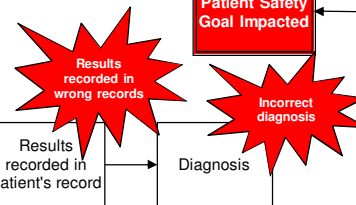
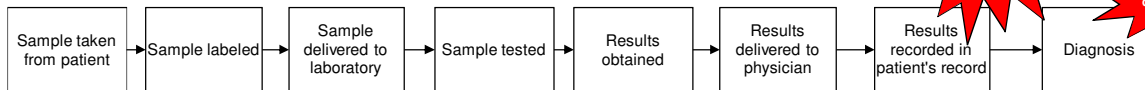
**Basic Level Cause Map** - Start with simple Why questions.

### Basic Cause-and-Effect

A patient received an unneeded mastectomy after her lab samples were switched with another patient's. A previous unnecessary mastectomy in the region occurred in 2003, and another sample identification error occurred the next month, resulting in an unnecessary biopsy.



## Process Map - Sampling Process



# 3 Solutions

The healthcare system involved in the error is in the process of instituting bar codes for sampling and an automated process. In general, a bar coding process is less prone to error because less entry of data is required.

From the information available, it appears that the error occurred when the results from the testing were recorded in the patients' charts incorrectly at the cancer center. This resulted in an incorrect diagnosis.

Possible Solutions: Use of bar codes/

Error in recording results