



PATIENT SAFETY RESOURCES

DISCHARGED PATIENT WITH PENDING TEST RESULTS

By Kristin O'Reilly, Program Director

DESCRIPTION

A 68-year-old male suffered from septic shock after being discharged from an inpatient setting before any action was taken on a critical lab result.

KEY LESSONS

- Closed loop communication to the care team for all critical results is crucial to the safe care of patients.
- Review of pending or outstanding labs with a patient prior to their discharge is necessary to ensure appropriate follow up and symptom monitoring.

CLINICAL SEQUENCE

Day 1: A 68-year-old male was admitted to the hospital after falling on ice and feeling short of breath. The patient was found to have a right-sided pneumothorax. A chest tube was placed in his right lung. The patient was monitored and showed good clinical improvement. He was assessed by physical therapy for mobility and home safety.

Day 3: Two days after his admission, the patient was ready to be discharged to his home without any follow-up services recommended. The patient's discharge paperwork indicated that he had a pending result from a pleural fluid culture that had been collected on Day 2. The result of the fluid culture, which demonstrated gram positive cocci, was called from the lab to the care unit on the morning of discharge, but contact with a member of the care team was unsuccessful. The attending physician was paged, but did not respond. The culture result was not escalated to the patient's nurse or another member of the care team. The patient was discharged later that day, unaware of the positive culture.

Day 5: Two days after discharge, the patient was taken by ambulance to another hospital in septic shock. He required additional chest tubes and intravenous (IV) antibiotics to

manage the infection. After 10 days in the hospital, the patient was discharged home with a PICC line and required several more weeks of IV antibiotics. He was able to fully recover.

ALLEGATION

The patient filed a claim against the hospital alleging that the failure to communicate a critical lab result required admission for septic shock and several weeks of follow-up treatment.

DISPOSITION

The case was settled in the low range (<\$99,999).

ANALYSIS

The delay in notification about, and treatment of, the patient's infection potentially caused the patient to get significantly sicker than he would have had he begun antibiotics upon receipt of the critical lab value.

DISCUSSION QUESTIONS

- How can technology (e.g. smartphones) support/improve the communication of critical lab results amongst the care team?
- What steps in the discharge process would ensure the patient, the hospital care team, and the post-discharge providers are made aware of pending or unacknowledged lab results?

REFERENCES/HYPERLINKS

- [Quick Safety Issue 52: Advancing safety with closed-loop communication of test results](#)
- [Closed loop communication using provider team-specific smartphones improves the critical laboratory value notification process in pediatric inpatients](#)

