

## Challenge PC092

August 2009

### HISTORY

This paper challenge was presented as a common community based problem where throat swabs are received from two siblings.

Unfortunately it becomes apparent upon receipt in the laboratory that while the two requisitions are labelled appropriately with two separate and discrete names, the two samples both carry the same name, indicating that one of the two throat swabs has been mislabelled.

Four choices were given for possible resolution:

- A) reject both specimens, but phone the physician to re-label;
- B) set up both specimens;
- C) set up both specimens, but with a disclaimer;
- D) reject both specimens, but contact the physician to recollect the samples.

### CMPT QA

The paper survey was submitted to all laboratories including 15 reference laboratories. Since 14 (93%) of reference laboratories agreed upon a single response (D), which was consistent with the committee consensus, the paper challenge was deemed appropriate for grading.

### COMMENTS ON RESULTS

The purpose of current interest in patient safety and systems approaches to reducing through improved standardization and continual improvement is to increase awareness of significant medical laboratory errors that can cause inconvenience or harm to patients as a result of delayed or misdirected therapy or medical decisions.

Studies have demonstrated that significant medical laboratory error may occur as often as 4 of 1000 laboratory specimens, with the majority occurring during the pre-examination phase before the sample reaches the medical laboratory. Of pre-examination error, the most commonly identified category is associated with mis-identification of the sample of patient, or both.

While by convention, these errors are designated as medical laboratory error, identification pre-examination errors commonly occur outside of the management or control of laboratory staff. That being said, the laboratory is charged with the responsibility of catching the error, correcting the immediate problem (remediation), correcting the underlying factors that lead to the error (corrective action) and developing strategies of preventing their occurrence (preventive action).

#### Grading

#### Maximum grade: 4

Answer D was considered the only acceptable response.

Laboratories reporting D were given a grade of 4.

Laboratories reporting any other option were graded zero.

### REFERENCE

Plebani, M. 2006; Errors in clinical laboratories or errors in laboratory medicine? Clin Chem Lab Med 44(6):750-759

**Table –1:** PC092 challenge – results reported and grades

Laboratories	Total	Grade
<b>Category A</b>		
Answered D	77	4
Answered C	1	0
<b>Category B</b>		
Answered D	29	4
Answered A	1	0
Answered C	1	0
<b>Category C</b>		
Answered D	15	4
<b>Category C1</b>		
Answered D	13	4