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Texas Association for Clinical Laboratory Science

TACLS News

Wake Up! Our Errors Harm Patients

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The common belief that problems in laboratory services seldom affect patients is false. Preventable laboratory errors lead to patient dissatisfaction and poor outcomes, including patient injuries, which are known as adverse events. These errors are due to the incompetence of individuals and the failures and inadequacies of systems. A recent sample of laboratory related adverse events, taken from quality improvement studies and news headlines, show how serious these injuries can be:

•A falsely high INR result contributes to a patient's death by hemorrhage.

•Failure to detect malaria on a blood smear leads to 4 days of needless suffering and a life threatening experience for a traveler to West Africa.

•A lab error leads to a false positive maternal triple screen and a patient undergoes an unnecessary amniocentesis.

•A miscommunication of a blood culture result leads to severe infection in an elderly patient on dialysis.

These incidents are perceived as rare and isolated in the lab community, since only a small fraction of lab testing is associated with errors. But in light of the widely publicized and alarming Institute of Medicine Report "To Err is Human: Building a Safer Health System" (1999), which details the dangers posed by medical errors in the U.S., this complacency must be replaced by a realistic perspective that takes errors and adverse events much more seriously.

Although official error rates may be low, the absolute number of errors, both reported and unreported, is substantial. Many of these errors contribute to poor outcomes. Beyond the misplaced focus on low error rates, labs also do not consistently measure patient outcomes, including adverse events. This failure to document patient outcomes has contributed to the false belief that there are few adverse events associated with laboratory errors. The medical

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community, including laboratory medicine, is changing its views on the implications of preventable errors. For an individual laboratory, this means focusing on the absolute number of errors, and the reality that rigorous investigation of these errors will reveal poor patient outcomes, including adverse events. Coming articles in this series will focus on methods for investigating laboratory errors and methods for assessing competency of laboratory staff. Our overall goal is to understand all the implications of our preventable errors and identify appropriate responses, including error-proofing, competency assessment, and training.

Dr. Astion, what are some barriers to determining patient outcomes as it relates to injuries?

There are a few barriers. First, traditionally, the source of cases of injury come from incident reports. These are seldom submitted and investigated in a timely manner, and they often under-report injury. Second, when performing investigations of possible injuries related to laboratory care, you rely on the medical record as well as conversations with providers, such as physicians and nurses, to provide information about the injury. The medical record is notorious for under-reporting injury. I am aware of a number of cases at a variety of institutions in which laboratory errors were associated with significant injuries, and this was not reflected in the medical record. Providers also routinely underestimate injury caused by medical care. This is rarely an outright lie, but it is usually a subtle self-delusion fueled by overwork and the desire to avoid what is unpleasant once you admit that an injury has occurred. All these barriers that I have discussed can be overcome but it requires rigorous methods for identifying and investigating lab-related patient injuries.

Why do labs lack a culture of patient safety?

First of all, they have poor methods or no methods for detecting patient injuries related to problems in laboratory testing. Secondly, they have a misplaced emphasis on:

•The error rate rather than the number of errors
•Errors rather than injuries

Why are laboratory services not as safe as presently believed?

It's primarily because they lack a culture of patient safety. I think that any lab that gets serious about identifying cases of poor patient outcomes (including patient injury) due to laboratory problems will find more than they expected.

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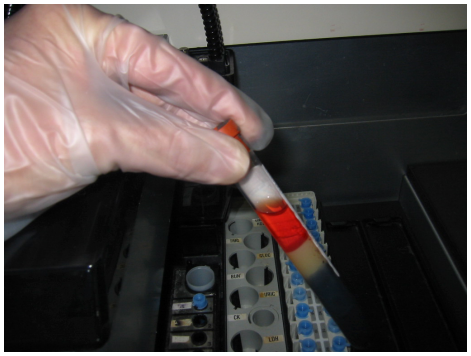
This is the first in a series of four articles by Dr. Astion about reducing laboratory errors. The second article will appear in the January issue of the TACLS News.



TACLS 2004 Is Coming!

Mark your calendar! You don't want to miss the TACLS 2004 Annual Convention. The Texas Association for Clinical Laboratory Science invites you to Houston Texas, April 1-3, 2004. Come hear great speakers including our keynote speaker, **Charles Lauer**, Editor of *Modern Healthcare*. Also speaking are **Dr. Kathleen Sazama**, President of the American Association of Blood Banks, and **Barbara Brown**, President of the American Society for Clinical Laboratory Science.

The meeting will be held at the Westchase Hilton. For more information, please contact Becky See, TACLS President and Convention Chair at bsee@giveblood.org or 713-791-6621 or go to the TACLS website, www.tacls.org.

Do you have a TACLS 2004 t-shirt? If not, here's your chance. Please contact bsee@giveblood.org. Prices including shipping are $12 for L & XL and $14 for 2X. Quantities are limited so don't wait too long. Send a personal check or money order to:

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HAPPY NEW YEAR
Becky See, TACLS President

As 2004 approaches and we all sit down and make our plans and resolutions for the New Year, why not include plans about your career? Why not put TACLS and ASCLS in your plans?

Come contribute your ideas and suggestions to the organization that represents and supports you. ASCLS and TACLS represent you in the Legislative arena, Healthcare arena and in the Public arena.

If you are not a member, why not join in 2004? Be a part of a fun group of people that care about Healthcare issues and the patients we serve.

If you are a member, thanks and please become more involved in your professional organization in 2004. We need your creative ideas, suggestions and support.

ASCLS/TACLS needs YOU. For more information about this GREAT organization and how you can help, please contact TACLS President Becky See at bsee@giveblood.org

HAPPY HOLIDAYS
From the
TACLS BOARD

Mark your calendar now

TACLS Winnter Board Meeting, San Antonio, February 7
Clinical Laboratory Educator's Conference, Milwaukee, February 26-28
Legislative Symposium, Washington DC, March 22-23
TACLS Annual Meeting, Houston, April 1-3
ASCLS/AACC Annual Meeting, Los Angeles, July 27-31

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