Methodist Health Services Corporation & UnityPoint Health Methodist|Proctor Laboratory 7000 Administration	Page # 1 of 3	Section: UPPIA LA: Patient Services	Policy #: 03.010 Formerly: C-10
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	Reviewed: 2/8/14		
	Policy/Revision Submitted by: Rich Borge		
	CAP Standard: 20208, 41307, 41310, 40492		

POLICY GUIDELINE ON: **Error/Event Reporting**

I. POLICY:

All laboratory personnel will be able to respond to any event errors that occur during the pre-analytic, analytic and post analytic processor.

II. PURPOSE:

A. It is the goal of this laboratory to order tests, collect specimens, perform assays, and generate results in an event free manner; however, errors do occur.
B. This policy defines the necessary steps to be taken in the event of an error.

III. POLICY SCOPE:

The scope applies to all laboratory staff at both UnityPoint Health Peoria campuses.

IV. GENERAL INFORMATION:

A. Errors can be detected in the ordering, collection, testing, review, or reporting process.
   1. Legally Acceptable Documentation Guidelines:
      a. Utilize indelible black ink for written documentation.
      b. Write legibly utilizing correct grammar and spelling.
      c. Document clear, concise, objective, accurate and pertinent information.
      d. Correct errors on a written record by marking a single line through the written error, Initial, and date above the entry
      e. Document late entries by writing "Late Entry" and the actual date and time and the Date and time the record should have been recorded.
      f. For electronic documentation each employee must be logged in using their password.

   2. The following documentation practices **are not** acceptable:
      a. Erasing, obliteration or use of liquid paper correction fluid.
      b. Scribbling out or writing over entries.
      c. Arrows down and "Ditto" marks on logs indicating entry is the same as the above.
      d. Using a terminal when someone else is logged in.

B. The person making the error, the person detecting it, and the team leader/coordinator/manager notified of it are equally responsible for seeing that the necessary steps are taken to correct it. This may include leaving documentation for the lead to review.

V. PROCEDURE:

In the event of an error, follow the procedure below:

A. Any error detected during the procurement or testing, but before results are reported, should be corrected by the person detecting it.

B. When an error is detected after the result has been verified and it can be corrected without obtaining a new specimen, take the following corrective measures immediately.
   1. The person detecting the error must determine whether the difference between the incorrect and correct results is clinically significant.
      a. To make this decision, consultation with a colleague, lead tech, coordinator, Manager or Pathologist may be necessary.
      b. The person detecting the error must correct it or direct this responsibility to the person who made it.
   2. All clinically significant errors require notification of the physician, nursing unit, and physician's office and client hospital laboratory.
      a. If the change in results could affect treatment, **IMMEDIATE** notification is necessary.
      b. A comment for each analyte changed is appended. Document who was notified, the time and date.
   3. All error corrections involving client hospitals are phoned to that laboratory.
   4. Correct the report in LIS Results Entry. Remember to search for finalized results.
      a. Add a reportable comment to the corrected result indicating the name of the clinician notified, if applicable, the date and time of notification, and initials of the person making the correction.
      b. Any comments made during the original verification must be retained.
   5. Enter the event into RL Solutions by the end of the shift during which the problem was detected.

C. When a specimen is determined to be of questionable integrity (i.e. hemolysis, IV contamination) after the results have been verified and a valid specimen cannot be obtained, take the following corrective measures immediately.
   1. The CLS/CLT discovering the problem must notify the physician/nursing unit/physician's office and determine whether the patient was treated based on the erroneous result. Follow the steps for specimen rejection on Policy C-11 Laboratory Specimen Rejection.
   2. Using Result Entry substitute.
      a. a Reportable Comment stating the nature of the problem, the name of the clinician, the time he/she was notified, and your initials.
   3. Any footnotes made during the original verification must be retained in.
   4. Print a patient report, and leave it for Laboratory Billing to credit the patient account if warranted.
   5. It is the CLS/CLT's responsibility to let the patient's nurse or physician's office know that they need to re-order the test if it is still needed.
      a. The redraw testing will be performed using a new accession number.
   6. Enter the event into RL Solutions.

D. In the Microbiology section, the incorrect results should be replaced in results entry.

1. Add a reportable result comment stating the nature of the problem, the name of the clinician, the time he/she was notified, and your initials.

2. Enter into Peminic by the end of the shift during which the problem was detected.

E. For those results, which are reported on a separate report and not in the LIS, locate the original incorrect report, but do not remove it from the chart.
   1. Mark the incorrect result so it is clearly recognized as invalid and make reference to the corrected report (i.e. write in large block letters in black ink ERROR – SEE CORRECTED REPORT, and mark through the result with a single line without obliterating it).
   2. Record date, time, and initials of person correcting the report.
   3. A personal explanation to the nursing unit may be indicated.

F. If the patient's chart is not accessible (OP or Reference Lab), phone the physician's office, request that they disregard the original report and inform them that a corrected report will follow.
   1. A corrected report will be issued that reflects corrected values.
   2. Attach our copy of the corrected report to our filed incorrect report. (chart will show _____corrected from_____on 0/00/00)

G. UNDER NO CIRCUMSTANCES, SHOULD ANY HUMAN RESULT BE COMPLETELY DELETED FROM THE INFORMATION SYSTEM.

VI. MAINTENANCE AND STORAGE

A. All policies and procedures are reviewed every two years, (except for Safety procedures which are yearly) by Laboratory Administration and/or the Medical Director of the Laboratory or designee when there are changes in practice standards, or requirements.
B. All policies and procedures are reviewed every two years (except for Safety procedures which are yearly) by staff or at the time new or revised ones are put in effect.
C. All policies are retained 8 years after being discontinued or revised.
D. All procedures are retained 2 years after being discontinued or revised

REVISION HISTORY			
Rev	**Description of Change**	**Author**	**Effective Date**
0	Initial Release	N. Krakowiecki	12/15/14

Reviewed by

Designee	**Date**	Laboratory Director	**Date**
		Richard J. Barga	10/5/15
