| UnityPoint Health PEKIN | Page 1 of 3 | Section: UPP HEMO | Policy #: UPPK GEN-0621 |
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| | Approved by: see signature block at end of document | | Date: 11/16/18<br>Review by: 11/16/20 |
| LABORATORY | Policy Created: 3/12/18<br>Supersedes: 3/12/18 | | |
| | Primary Responsible Parties: Cindy Schroeder<br>Secondary Responsible Parties: Dana Spears | | |
| | CAP Standard: NA | | |
| SUBJECT: DETECTION AND CORRECTION OF ERRORS | | | |

## I. PURPOSE:

A system of multiple checks, review and verification of abnormal results is used in the Pekin Laboratory to assure accurate test results. In the event of a corrected result, timely correction and notification is imperative for good patient care.

## II. POLICY SCOPE

The scope of this policy applies to all Laboratory staff that prepares or performs testing on laboratory specimens at UnityPoint Pekin.

## III. POLICY

A. A system of multiple checks, review and verification of abnormal results is used in the all sections to assure accurate test results. In the event of a corrected result, timely correction and notification is imperative for good patient care.

B. Technical personnel check visually for abnormalities like short volume, hemolysis or clotting. Clotted or short draw samples must be redrawn. Hemolyzed samples may affect patient results. Check the procedures for the limitations.

C. Each procedure lists causes for rejection of a sample and limitations of the procedure (causes for inaccurate results).

D. Results from the analyzers are screened for plausibility and instrument printouts are marked with a series of flags explained in the procedures. Technical personnel will refer to these directions on how to handle each flag or word message. Results from the Hematology, Coagulation and Chemistry analyzers autoverify if there are no instrument flags, results are not critical or fail delta and the results are within the linear limits of the analyzer. Screen results for plausibility and abnormalities are marked with flags.

E. Sunquest will alert the technologist to changes from a previous specimen by Failed Delta ●Flags for those tests that are deemed necessary. Investigate the plausibility of the results before turning out. This may include any or all of the following:

1. Repeating the test.
2. Finding out if the patient received a blood transfusion or had a procedure or medication that would affect test results.
3. Checking Sunquest for previous specimen results. You can branch to results right from the Result entry screen in two ways. Click on the MRN to branch to the full

Result Inquiry Function. Also, click on Specimen and choose from the drop down menu- previous results to display results of a single test lined up by date.

4. Reviewing with the phlebotomist the site or ease in obtaining the blood sample, as well as identity of the patient.
5. If it is a line draw, was a proper amount of blood wasted. What type of a line was used?

F. Technical personnel recheck the name and accession number on microscopic slides with the analyzer print out and Sunquest screen before performing a differential or Urine Microscopic. Automated results are checked against microscopic findings for compatibility.

G. All critical values (failed verify) must be verified (see above failed delta) and called to the floor or physician's office. Document the full name of the person reading back the time and date. See the Critical Value Policy in Lab Administration.

H. Abnormal CBC results and differentials are left for Pathologist review according to the criteria outlined in this manual.

I. Abnormal results (failed delta, failed verify, failed technical) are screened again for possible error when the Quality Assurance report is checked the following morning.

J. The department leads in will also sign off/investigate any corrective action sheets/corrective action logs each day.

K. When a technologist, lead or designated person in charge becomes aware of a technical error he/she will take the following actions:

1. Immediately notify the nurse in charge of the patient or the Doctor's office of the erroneous results reported.
2. Correct the report. Do not delete the old results. Do not credit the report before allowing Sunquest to put in the corrected comments. See the policies for cancelling results in Sunquest.in the LIS Procedure/Policy Manual.
3. Immediately call the correct report to the patient's nurse or Dr office.
4. Fill out the Unity Point Health Occurrence Report on line. The report will be directed to the Laboratory Manager for follow up. Leave any documentation for the follow up.

L. Errors on log sheets are to be crossed out with a single line and the correction written above the result. No white out. Errors on manual laboratory requisitions should be handled the same way as steps 1,3,4 in K above. New results should be sent on manual requisitions that say "Corrected Report" in bold letters and delivered immediately to the floor. No white out is to be used on laboratory requisitions, start fresh with a new requisition.

M. If nursing makes an error, document the error by the Unity Point Health Occurrence Report online. Handle any laboratory result error caused by the incident as above in K. If necessary, refer the problem to the Nursing Supervisor and/or Pathologist.

## V. **MAINTENANCE AND STORAGE**:

A. All policies and procedures are reviewed every two years by Laboratory Administration and or the Medical Director of the Laboratory or designee.

B. The Laboratory Administration and Medical Director review policies and procedures when there are changes in practice standards, or requirements.

C. All policies and procedures are reviewed every two years by staff or at the time new or revised ones are put in effect.

D. All policies are retained 8 years after being discontinued or revised.

E. All procedures are retained 2 years after being discontinued or revised.

MMCI Laboratory is a CAP accredited facility, as of 7/1/11 the responsibility of new and/or substantially revised policies and procedures will be restricted the Laboratory Director whose name appears on the CLIA certificate, whose signature appears below. The biennial review will be completed by the Administrative Director.

| ***POLICY CREATION :*** | | ***Date*** |
|---|---|---|
| ***Author:*** | ***Cindy Schroeder, MT (ASCP)*** | ***11/16/2018*** |
| ***Medical Director:*** | ***Kathryn Kramer,, MD*** | ***11/16/2018*** |

| ***MEDICAL DIRECTOR*** | | |
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| DATE | NAME | SIGNATURE |
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| ***SECTION MEDICAL DIRECTOR*** | | |
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| **REVISION HISTORY (began tracking 2011)** | | | |
|---|---|---|---|
| Rev | Description of Change | Author | Effective Date |
| 1 | Initial Release | Cindy Schroeder | 11/16/18 |
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| **Lead** | **Date** | **Coordinator/ Manager** | **Date** | **Medical Director** | **Date** |
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