Hear ye! Hear ye! What's in an EERS?

How to complete an EERs and all things EERS-related

What's an EERs?

Safety is a top priority in St. Jude's mission of finding cures and saving children. Eliminating preventable harm and protecting the safety of our patients, employees and visitors is our goal. The first step to reach this goal is to identify opportunities for improvement of safety in all areas of the hospital.

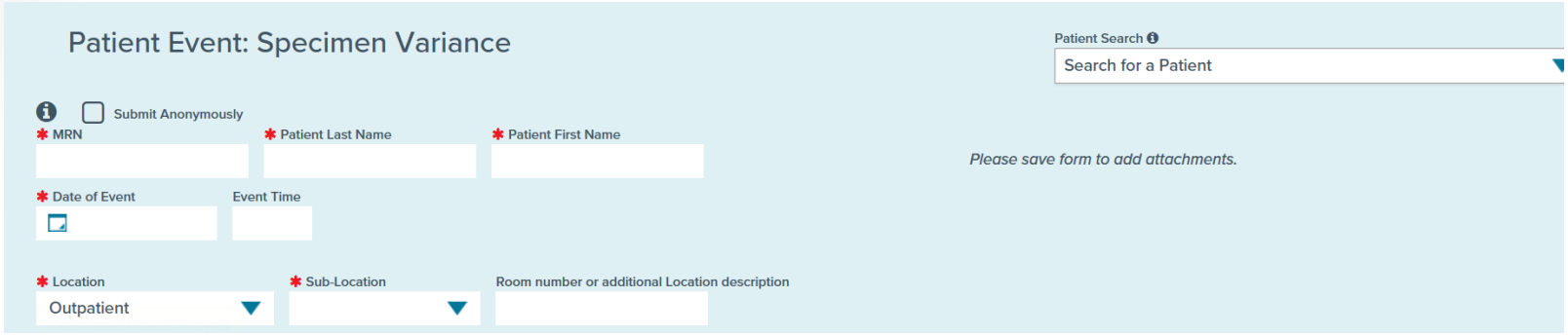
When properly filled out, an EERs is routed to the occurrence location for follow-up, education, training, and making patient safety our #1 priority.

CAP Regulation GEN.40499 Specimen Collection Feedback
There is a mechanism to provide feedback to the collectors of specimens on issues relating to specimen quality and labeling.

Points to Remember

- EERS are seen at the institutional level.
- Keep it professional. Always be respectful of your coworkers.
- Only provide the known information.
- The focus of EERS should be objective and policy/process-oriented.
- EERS should not be used as a method of reporting personnel issues; these events should be reported to your supervisor.
- Provide enough information so non-Pathology follow up personnel can understand what actually happened without being weighed down in lab terminology.
  - For example – Urine sample arrives in the lab with a BMP label on the container. The description should read “Urine sample labeled with BMP label. Wrong container for testing.”

Patient Information and Event Area

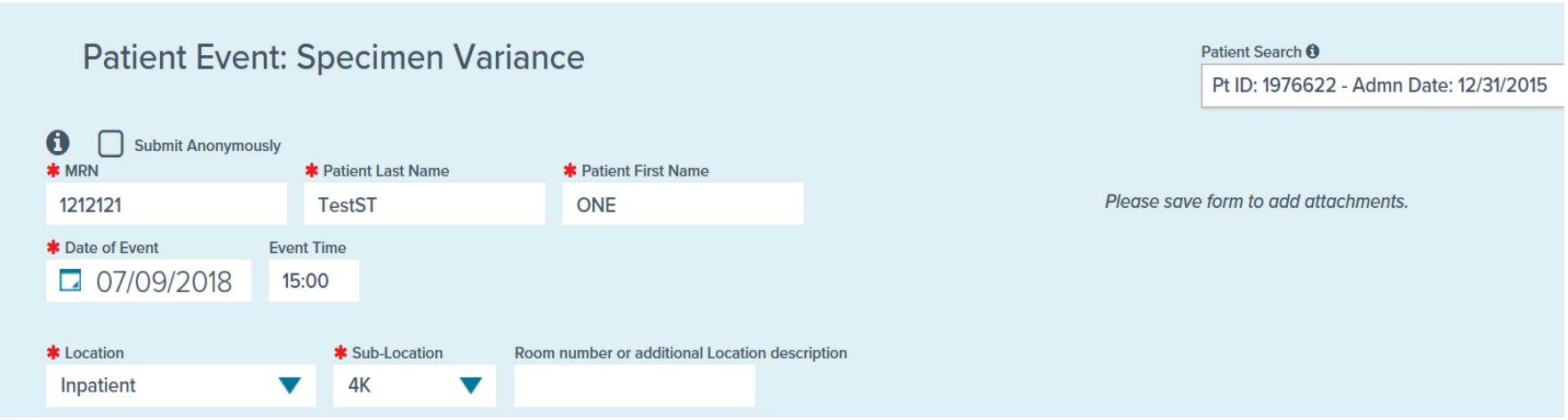


- Enter patient MRN in Patient Search field. Select top encounter.
- Patient Name will auto-populate based on MRN. Ensure correct patient is displayed
- Date of Event: Date event occurred.
- Event Time: Time event occurred.
- Location: The event area is based on **WHERE** the error occurred.
- Subcategory: Specific area event occurred.
- Room number or additional location description
- **Remember for outpatient collections from 7am – 6pm, the collection location will primarily be Assessment Triage, not the clinics. After 6pm, outpatients will be collected in the Medicine Room.**

Example #1

CMP from patient on 4KS is delivered to Chemistry. The technologist notices the sample is “cherry red.” The Serum Indices indicate the sample is 4+ hemolyzed. The sample is collected on 07/09/2018 @ 1500 by NRATCHET.

EERs – Example #1

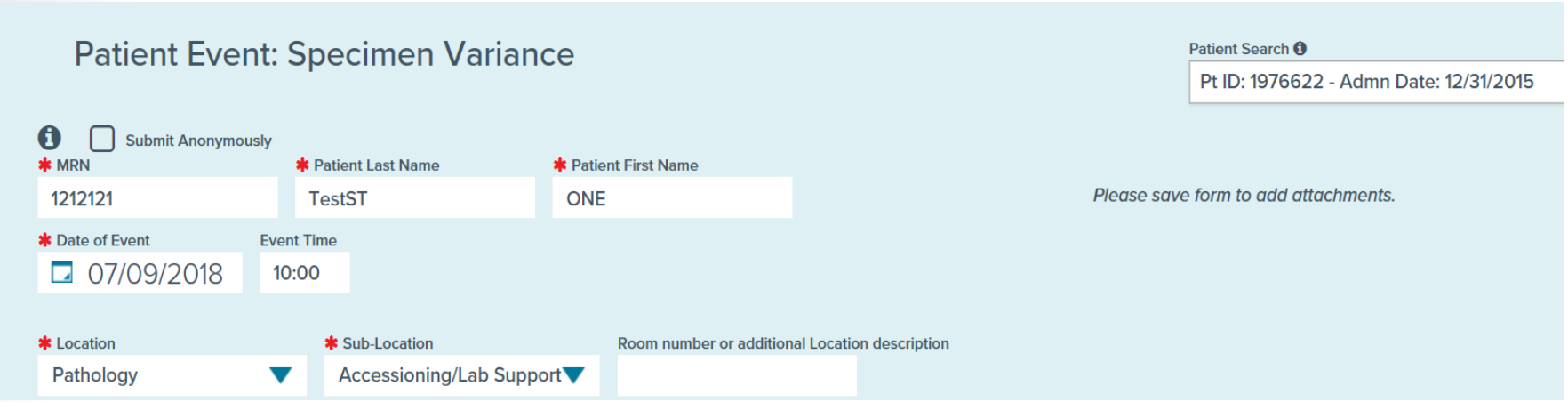


The Event occurred at the point of collection: Location - Inpatient, Sub-Location - 4K
The EERS will be routed to the nursing manager for 4K for follow-up.

Example #2

A sample for HIV 1/2 Ab and Ag testing is received in Lab Support on 07/09/2018 @ 1000 by CMELLOH. As the sample is being placed in the centrifuge, the tube is dropped on the floor and breaks requiring a recollect.

EERs - Example #2



The Event occurred when the sample was broken in Lab Support (where). The Location is Pathology, Sub-Location is Accessioning/Lab Support. The EERS will be routed to the Lab Support manager for review and follow-up.

* Describe Event/Concern

Dropped tube when loading in centrifuge. Tube hit the floor and broke.

* St. Jude Level of Harm

C - Event reached the patient but resulted in No Ha

Witness

Crystal Melloh

Family Aware

Accession Number 1

18-XXX-XXXX

Accession Number 2

Additional Accession Numbers

* Test(s) Ordered

HIV Ab/Ag

* Specimen Collected By

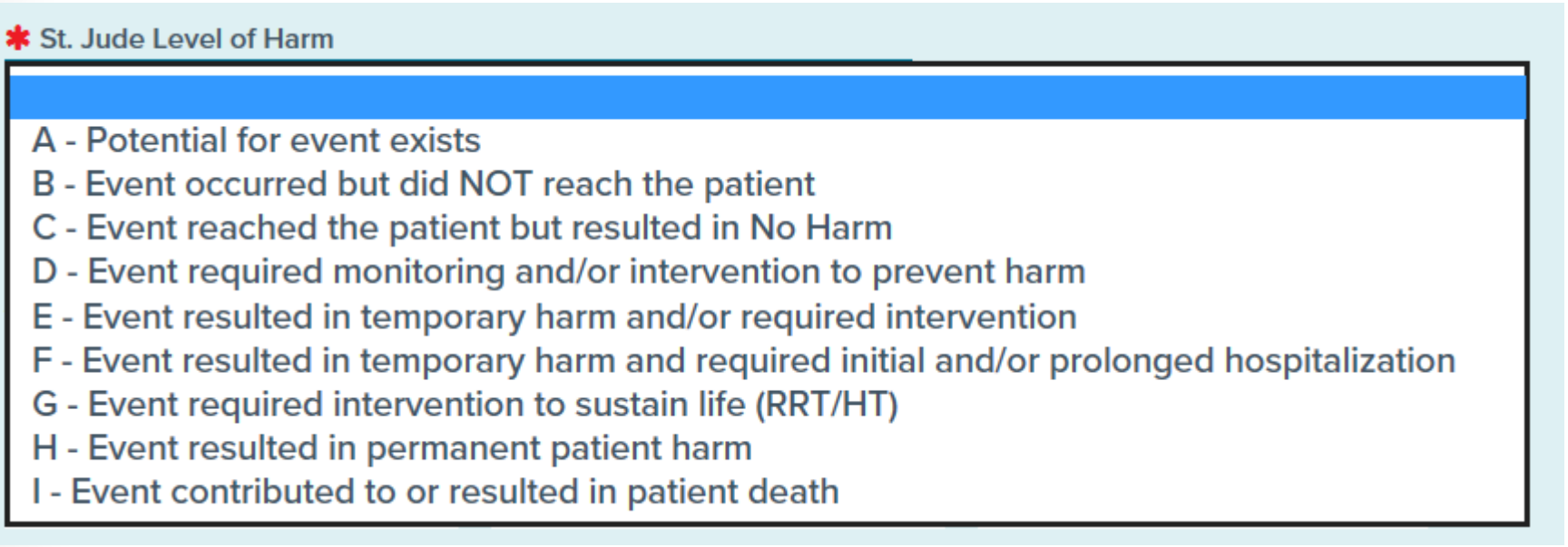
NRatchet

Specimen Type

Blood

Effect/Harm

The majority of Specimen events are typically A, B or C. See descriptions below. Any event rated D and above are serious events and trigger emails automatically to several key individuals to alert them of patient harm.



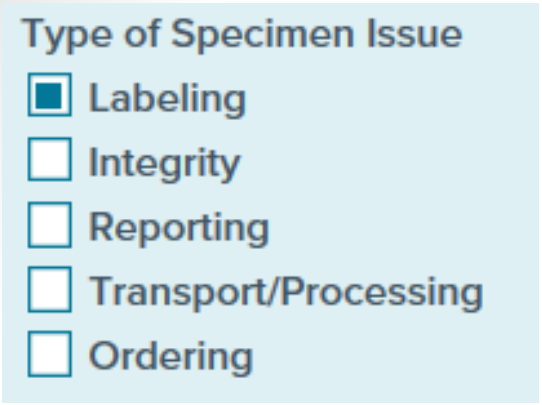
Effect/Harm

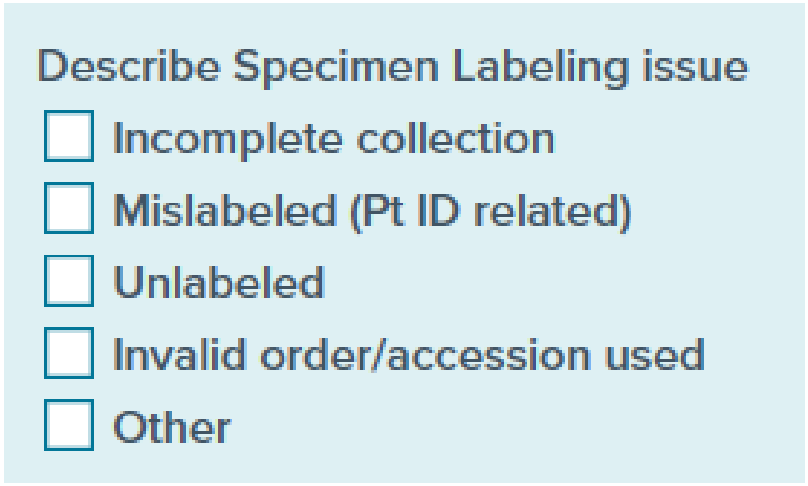
- A - Potential for event exists/No Harm – GOOD CATCH!
  - During the reconciliation of lab orders, for a pericardial fluid, a Molecular Micro order was discovered in Powerchart which had not been activated or label printed.
  - Testing error occurred but was caught prior to release of incorrect result.

- B - Event did not reach patient/ No Harm
  - No specimen site identification on blood culture, tissue, body fluid, etc.
  - Sample QNS but additional sample available in another laboratory.
  - Duplicate order, i.e. CMP and glucose
  - Invalid order: order already resulted or cancelled
  - Incomplete label: missing PPID
  - **Does *not* require recollect.**

- C - Event reached the patient/No Harm
  - Duplicate order where extra blood was collected (i.e. IGF-1). This does not require recollect but additional unnecessary blood was collected.
  - Clotted
  - QNS
  - Hemolyzed
  - Line Contamination
  - **Sample required recollect.**

Type of Specimen Issue





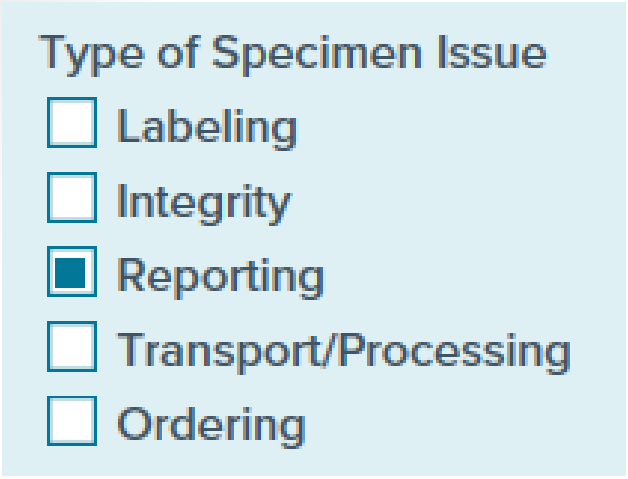
- Incomplete Collection: no PPID, no source on container, MRN cut-off.
- Mislabeled: Two different patient name's on specimen or incorrect patient.
- Unlabeled: No patient identifier's on specimen.
- Invalid order/Accession used: cancelled order or order already resulted.

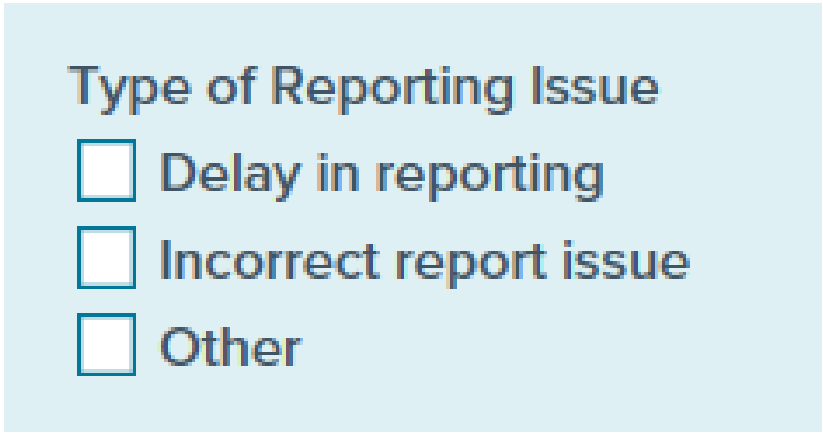
Type of Specimen Issue

- [ ] Labeling
- [x] Integrity
- [ ] Reporting
- [ ] Transport/Processing
- [ ] Ordering

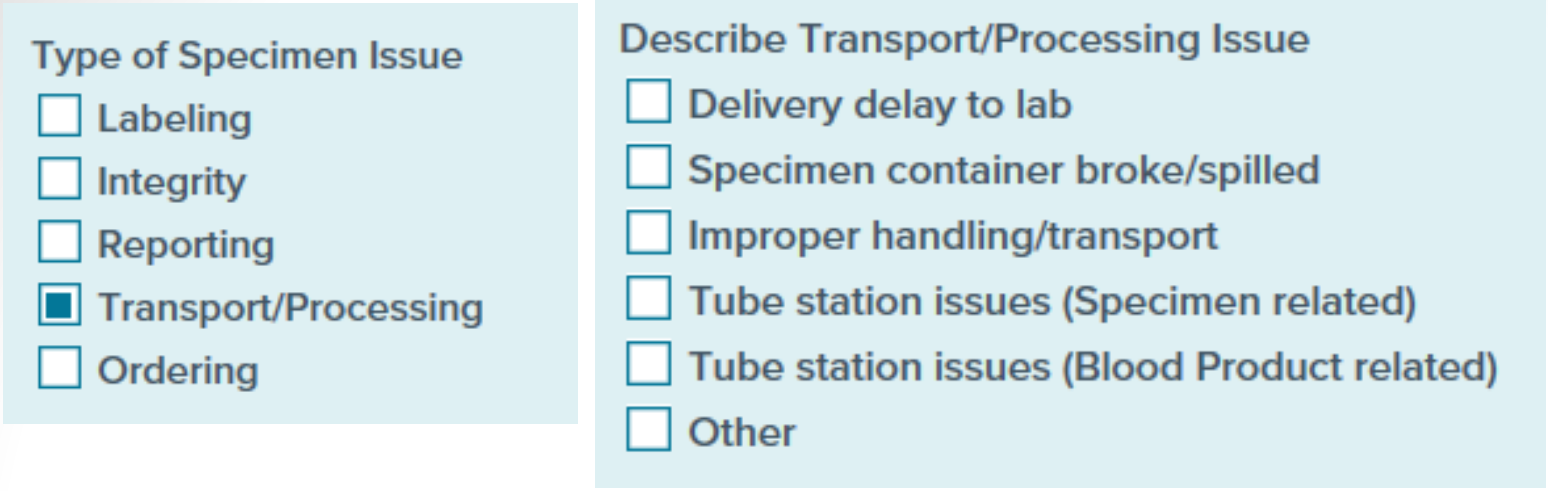
Describle Specimen Integrity Issue

- [ ] Hemolyzed
- [ ] Clotted
- [ ] Line contamination
- [ ] Quantity not sufficient
- [ ] Wrong container/Specimen for test
- [ ] Needle left on syringe
- [ ] Interfering substance
- [ ] Lipemia
- [ ] Other

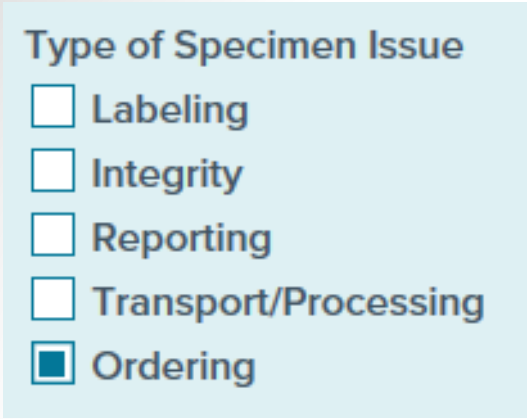


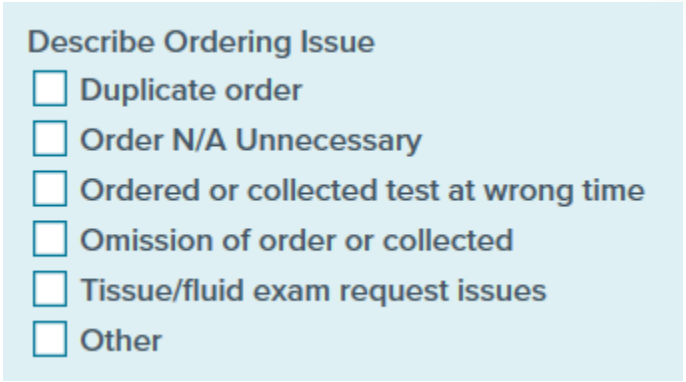


- Delay in reporting: Critical values/critical tests not called, major testing system shutdowns.
- Incorrect report issue: Significant incorrect results reported, i.e. D. Bili reported as 4.5 instead of 0.5.

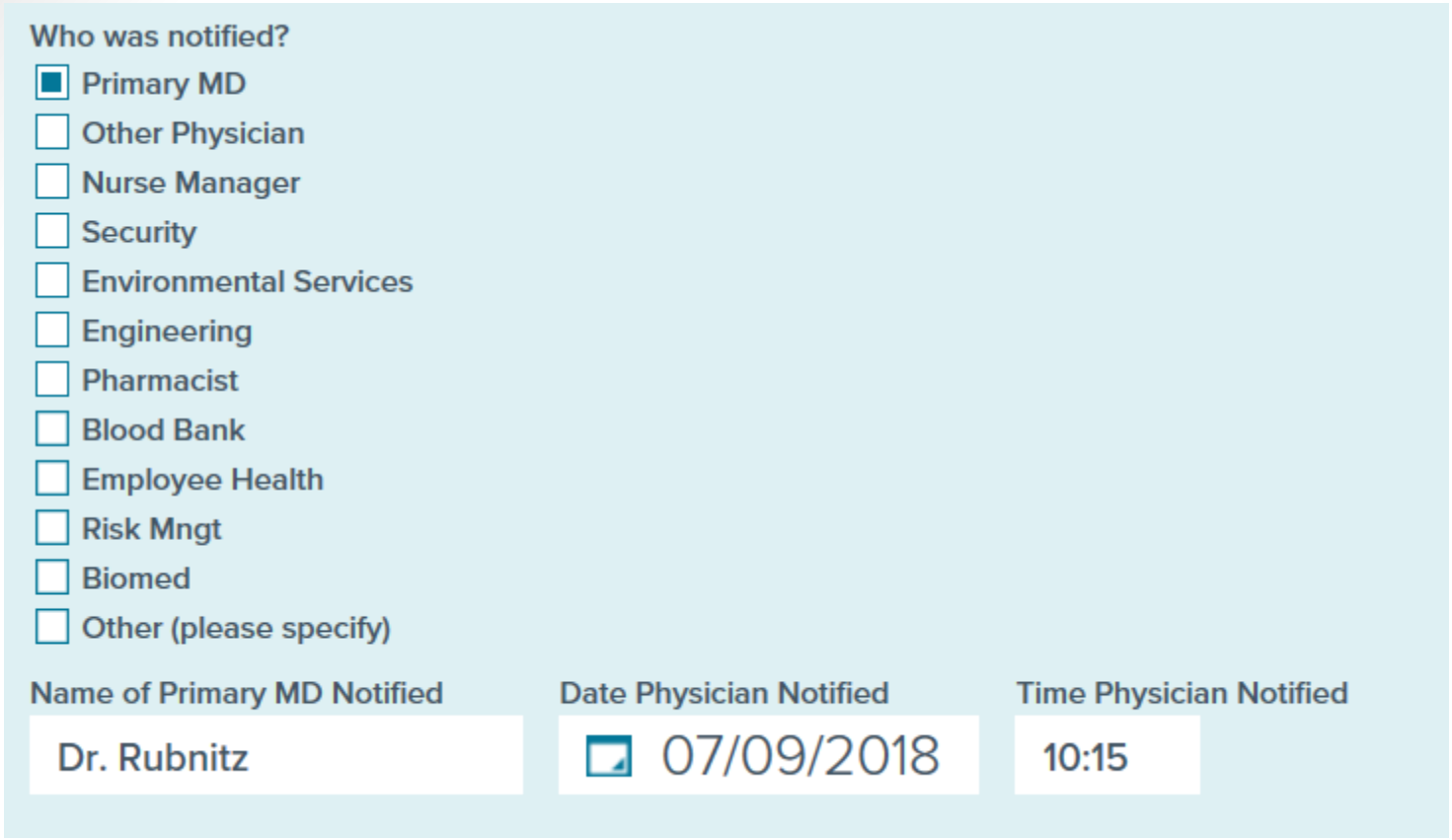


- Delivery delay to lab: Collect time to receipt exceeds pre-determined stability, ie. VBG >1 hour, Urinalysis >2 hours at room temperature
- Specimen container broke/Spilled: Sample leaked into/out of the biohazard bag.
- Tube Station Issue (Specimen Related) for spills contained to biohazard bag, spills resulting in shutdown, or a carrier is misdirected to the incorrect station.
- Improper handling/transport: Platelet Aggregation studies tubed to Lab Support
- Tube station issues (Blood Product related): Blood product lost due to issue with tube station.





- Duplicate Order: More than one of a test collected at the sample time.
- Order N/A Unnecessary: Call for invalid order to discover testing was not needed.
- Ordered or collected test at wrong time: Test has requirements to be collected Monday – Friday and is collected on Saturday.
- Omission of order or collected: Order not activated, label not sent with specimen.
- Tissue fluid exam request issues: Path Card- Tissue Fluid Exam Request or Procedure Note BMA not filled out or incomplete.

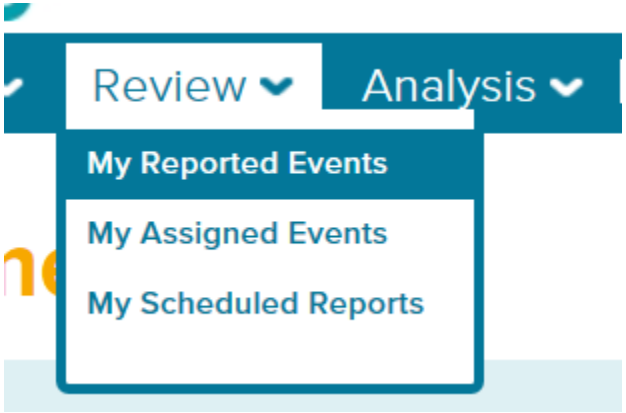


- Primary MD: Physician listed as Attending
- Other Physician: NP/PA
- Other: RN

Once all information has been entered, click Submit.

If interrupted during entry, click Save, but remember to go back and complete or the EERS will not be routed.

To review follow up on EERS you have submitted, click Review, My Reported Events.



Thank you for continuing to contribute to Patient Safety!