cmpt Canadian microbiology proficiency testing

CMPT Clinical Bacteriology Program

Innovation, Education, Quality Assessment, Continual Improvement

Challenge PC241

May 2024

HISTORY

This paper challenge was sent to category A and C1 laboratories. The following scenario was presented to participants:

On a Wednesday, your laboratory receives a liver biopsy sample from the OR that has been mislabeled. The requisition that was sent along with the mislabeled sample is completed sufficiently.

Please choose the best option to describe how you would proceed?

□ A. Reject the sample and request a recollection.

□ B. Hold the sample and phone the surgeon/physician, when he/she is in the office the next day

□ C. Process the sample and add comment regarding the mislabeling of the sample.

□ D. Process the sample and contact the surgeon/physician promptly

□ E. Hold the sample until the paperwork has been completed on the same day

□ F. not applicable to this laboratory

CMPT QA/QC

The Committee considered answers "E" and "D" the best answers.

MAIN EDUCATIONAL POINTS from PC241

1. Lack of specimen labelling is a hazard for patients and carries the risk of incorrect attribution of results of testing.
2. Specimens collected in the operating room cannot be readily replaced and are collected at risk and discomfort to the patient, as well as the use of finite operative resources.
3. While the risk of mix up in patient of origin for specimens collected outside the OR requires strict application of labelling requirements, the risk of mix ups from the OR is reduced, but not eliminated, allowing more flexibility, but ideally these specimens should be properly labelled.
4. Specimens collected in the OR should be processed with minimal delay to avoid possible deterioration that might result in reduced sensitivity of testing.
5. Labelling errors in the OR are relatively common, and laboratory and operating room staff should work together to minimize them.[1]

SURVEY RESULTS

Reference labs: 12/13 (92%) labs reported D or E (7 reported E, 5 labs reported D), 1 lab did not report

Participants: 29/51 (57%) chose option D, and 18/51(35%) chose option E; one lab chose option B, 4 did not report and 1 indicated the scenario did not apply to the laboratory (Table 1).

Grading

Maximum grade: 4

Reporting options D or E was graded 4.

REFERENCES

1. Makary MA, J Epstein, P Provonost, E Millman, E Hartmann, J Freischlag. 2007. Surgery 141:4, 450-455. https://doi.org/10.1016/j.surg.2006.08.018

Table 1. Reported results

Option reported	Cat A	Cat C1	Total	Grade
D	28	1	29	4
E	16	2	18	4
Comment*	1		1	4
B	1		1	1
no report	3	1	4	0
F	2		2	ungraded
Total	**51**	**4**	**55**	

*comment - This specimen is considered irretrievable. A call would be made to the OR to inform them of the mislabeled specimen. An RN or physician is required to come to the laboratory to relabel the specimen and complete the relabeling form. The specimen would then be processed. A comment will be attached to culture report indicating that the specimen was relabeled in lab by "X" (RN or MD). A healthcare incident report will be completed for this sample.