TRAINING UPDATE

Lab Location:	SGMC and WAH	**Date Implemented:**	4.16.2018
Department:	Blood Bank	**Due Date:**	4.30.3018

DESCRIPTION OF PROCEDURE REVISION

Name of procedure:

Management of Data Entry Errors in the Blood Bank

Description of change(s):

1. Only designated staff members are allowed to change results in blood bank. Those staff members are outlined in the procedure.

2. ALL staff members must have approval of the manager to edit a result in the blood bank system.

3. If a result is edited, we must enter the proper "J" comment code (the one that opens on the right side of the screen) and result it with the appropriate code.

   "*List result* previously reported as *list* and changed to *list*. Called to and readback by *name and time.*"

Electronic Document Control System

Document No.: SGAH.BB55[6]
Title: Management of Data Entry Errors in the Blood Bank
Owner: LESLIE BARRETT
Status INWORKS
Doc Effective Date: 09-May-2018 **Next Review Date:**

Non-Technical SOP

Title	**Management of Data Entry Errors in the Blood Bank**
Prepared by	Stephanie Codina Date: 09/14/2010
Owner	Stephanie Codina Date: 09/14/2010

Laboratory Approval

Print Name and Title	Signature	Date
Refer to the electronic signature page for approval and approval dates.		

Local Issue Date: Local Effective Date:

Review:

Print Name	Signature	Date

TABLE OF CONTENTS

1. PURPOSE

To outline the steps that must be taken to correct an erroneous patient result (reaction grading, interpretation, or both) and document this action.

2. SCOPE

This procedure applies to any blood bank result that has been reported in the LIS system and is subsequently found to be incorrect.

3. RESPONSIBILITY

All members of the blood bank and management teams must understand how to correct errors in the blood bank system. Major blood bank interpretation errors (ABO/Rh) must be corrected within 10 minutes of detection to ensure incorrect blood products are not issued to any patient.

4. DEFINITIONS

BAD file—Blood bank administrative data file—A permanent history of critical information related to a patient's blood bank data. The items that automatically update to the BAD file include: ABO, Rh, number of red cell transfusions, date of most recent transfusion, antigen/antibody information, problems, comments, and transfusion attributes.

Clerical Error or Data Entry Error—Any result entered incorrectly into the Blood Bank LIS system. Clerical/Data Entry Errors can be incorrect entries for a reaction grading, interpretation, or both.

5. PROCEDURE

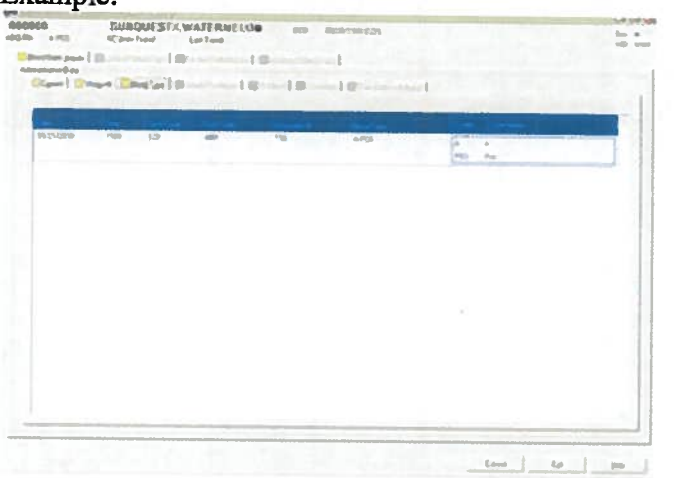
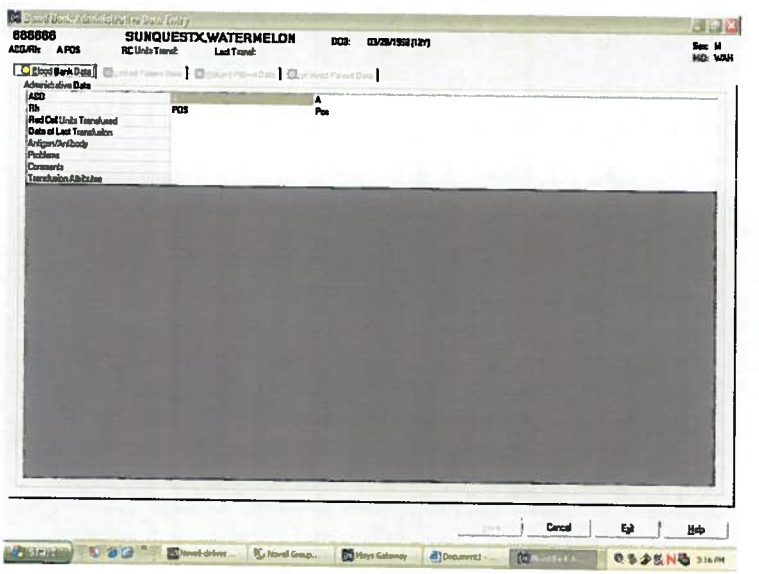
5.1 Investigation and Notification

Step	Action
1	When any error is noted, the tech must pinpoint the reason for the error and determine if the error needs additional confirmation testing. A. Clerical errors noted during the testing process by the tech that made the error may be corrected without retesting (except ABO/Rh errors). Examples include incorrect interpretation of the antibody screen (Ab screen entered as negative but antibody identification performed) or erroneous interpretation of antibody specificity. B. Errors noted by the same tech or a different tech at a later time will be reconfirmed by re-testing the original specimen on a downtime form. C. All ABO and Rh errors must be confirmed. a. Retest the ABO/Rh on any specimens that are available and can be used for testing (T&S specimen, ABO Retype specimen, and/or CBC specimen). If possible, have a different tech perform the retesting. b. Document all results on a blood bank downtime form. c. Verify the labeling of all tubes. If an LIS label was added to the tube, ensure the labeling of the LIS label is legible and matches that of the primary tube label by verifying name and/or medical record number. d. Determine the cause of the error. i. If the ABO/Rh of the primary tube was reported incorrectly (tech error), continue using this procedure. ii. If the ABO/Rh of the ABO retype or secondary tube does not match the ABO/Rh of the primary tube, refer to procedure "ABO Discrepancies with Historical Data." iii. If the ABO/Rh of the current tube does not match the ABO/Rh of the historical data, refer to procedure "ABO Discrepancies with Historical Data."
2	Immediately perform a lookback to assess the patient's transfusion status and the availability of blood products when the erroneous result can adversely affect patient care (as in ABO/Rh or antibody identification errors). Notify the patient care area immediately if incompatible blood products have been issued. A. Inform the MD or RN taking care of the patient of the situation. B. Verify whether the transfusion has taken place or is in process. a. Retrieve any issued blood products that have not been transfused. b. If the transfusion has been initiated. i. Instruct the MD or RN to stop the transfusion immediately. ii. Instruct the MD or RN to begin the transfusion reaction process. Refer to procedure, "Transfusion Reaction Investigation." iii. Notify the Blood Bank Medical Director or pathologist on-call immediately. iv. Release from allocation any other blood products that have been allocated or crossmatched to the patient.

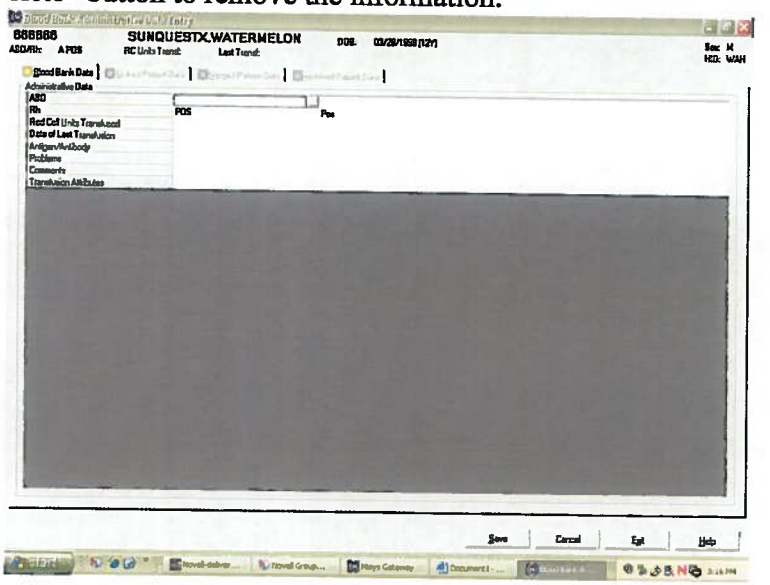
Step	Action
3	Notify the Blood Bank Manager or Lab Administrator On-Call that an error has occurred. **You must have the approval of a supervisor to edit a result in the blood bank module.**
4	Determine whether the error has crossed into the BAD file. Items that routinely cross into the BAD file include: ABO, Rh, number of red cell transfusions, date of most recent transfusion, antigen/antibody information, problems, comments, and transfusion attributes. To check the BAD file: A. Access Sunquest function "Blood Bank Administrative Data Inquiry." B. At the "Lookup by" prompt, select "Patient ID." C. At the "Value" prompt, type in the patient's medical record number and click on the "Search" button. D. Review the information to determine if the erroneous information has updated to the BAD file. a. If the error does not show up in the BAD file, proceed to step 5. b. If the error does show up in the BAD file, someone with supervisory access must correct the BAD file before the error can be corrected.
5	Determine who is available to correct the error in the BAD file. The correction must be made in Sunquest, so the person correcting the BAD file must be present in one of the laboratories. Determine if any of the following are in the laboratory using the following order: A. Blood bank manager. B. Blood bank lead tech. C. Blood bank lead tech from the sister hospital. D. Any other employee with LIS security access. Refer to appendix A for a list of approved personnel. E. The lead tech or tech-in-charge of the laboratory for the shift. a. This must be a technical person. Field operations lead techs do not qualify. b. This person will need to obtain a password from the security box located in the blood bank. Note: Any person changing a blood bank result must notify the Blood Bank Manager or Administration on-call **prior to** making the change.
6	Provide all paperwork associated with the error, including the downtime forms from step 1, to the person who will correct the BAD file. Fax paperwork to the other hospital if necessary.

5.2 Error Correction

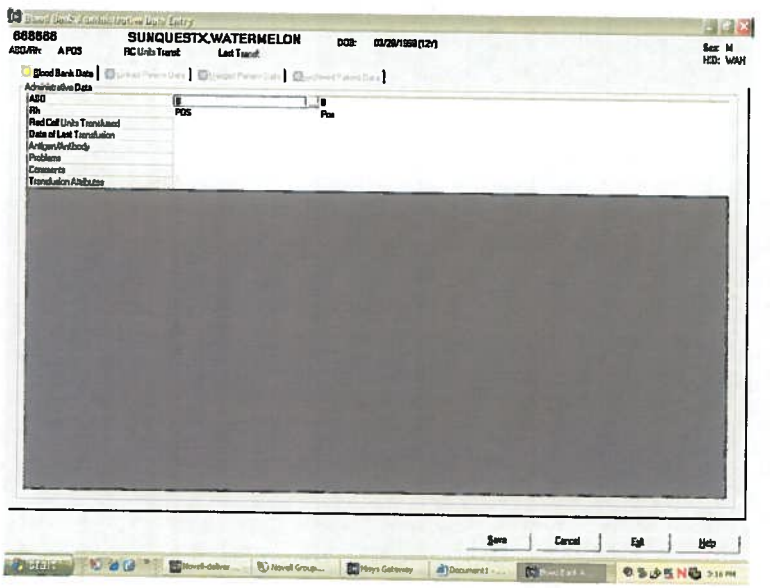
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Log into Sunquest using the username and password that will allow LIS security to change the BAD file.</td></tr>
<tr><td>2</td><td>Print an interim report with the current results.
A. Access Sunquest function "Laboratory Inquiry."
B.
<table>
<tr><th>Either…</th><th>Or…</th></tr>
<tr><td>At the "Lookup by" prompt, select "Patient ID."
And
At the "Value" prompt, type in the patient's medical record number and click on the "Search" button.
Then
At the "Number of days (1-9999)" prompt, select a number that will include the date on which the error was made.</td><td>At the "Lookup by" prompt, select "Accession Number."
And
At the "Value" prompt, type in the accession number on which the error was made and click on the "Search" button.</td></tr>
</table>
C. Click on the "Get Results" button.
D. Click on the "Blood Bank" tab.
E. Click the "Print Detail" button.</td></tr>
<tr><td>3</td><td>If the ABO/Rh was entered incorrectly, verify that only one result was entered.
A. Access Sunquest function "Blood Bank Administrative Data Inquiry."
B. At the "Lookup by" prompt, choose "Patient ID" from the dropdown menu.
C. At the "Value" prompt, type in the patient's medical record number and click on the "Search" button.
D. If more than one patient appears, select the correct patient by clicking on the name of the patient that you are selecting.
E. The patient's blood bank historical data will appear.
F. Click on the "Blood Type" folder. Every blood type entered into the blood bank historical data and the date on which it was entered will appear.
G. Review the data to ensure the patient only has one blood type on file (the erroneous data). Note: If the patient has multiple or different blood types on file, refer to procedure, "ABO Discrepancies with Historical Data."</td></tr>
</table>

Step	Action
3 Cont	Example:  H. Click on the "Exit" button.
4	Edit the BAD file. A. Access Sunquest function, "Blood Bank Administrative Data Entry." B. At the "Lookup by" prompt, choose "Patient ID" from the dropdown menu. C. At the "Value" prompt, type in the patient's medical record number and click on the "Search" button. D. If more than one patient appears, select the correct patient by clicking on the name of the patient that you are selecting. E. The patient's current blood bank data will appear. 

Step	Action
4 Cont	F. Click on the result to be changed (ABO, Rh, or both) and press the "Delete" button to remove the information.

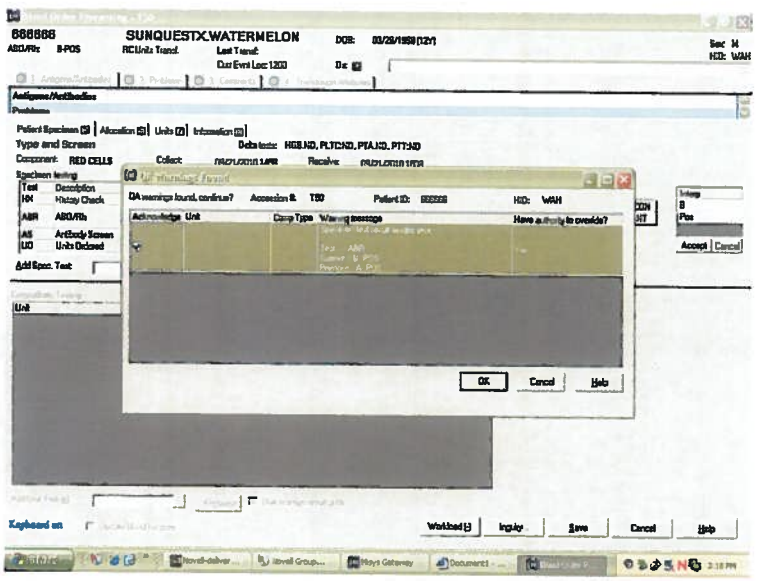


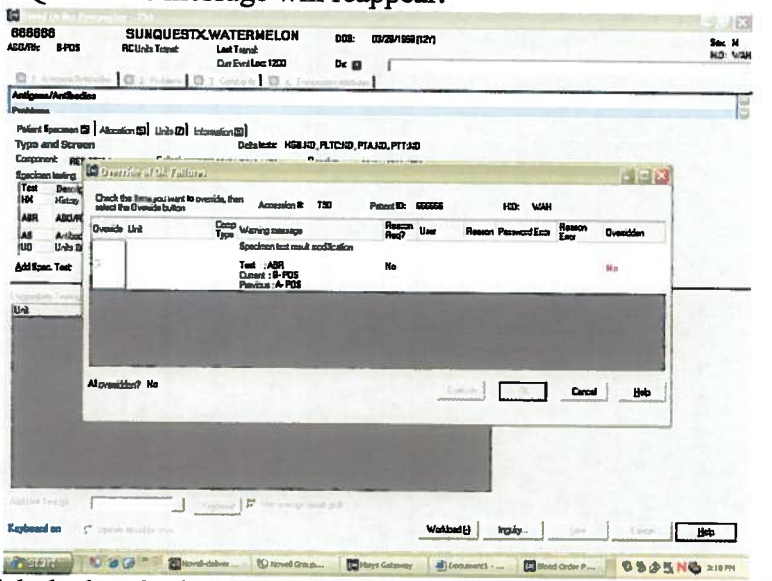
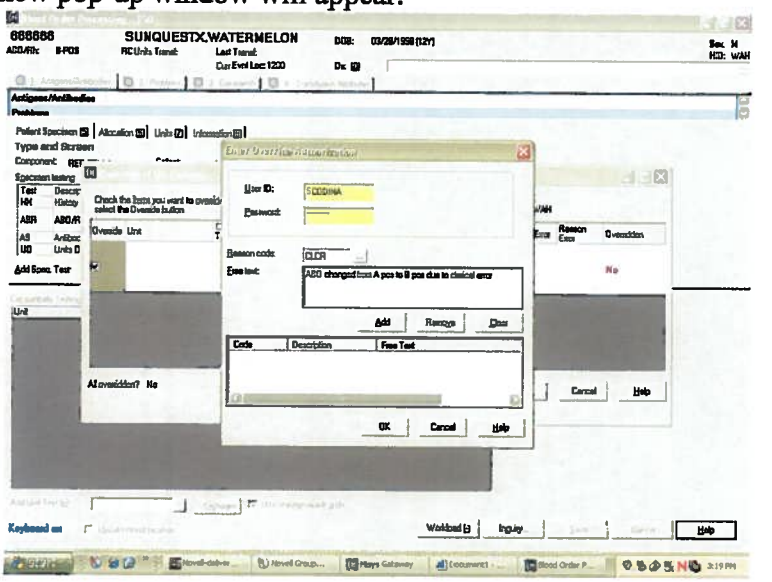
G. Replace the erroneous result with the correct result by typing the correct result in the appropriate location and pressing the "tab" key.



H. Click the "Save" button.

Note: The BAD file will not repopulate when the result is changed. The file will not show a blood type if the correct result is not entered at this step.

Step	Action
5	Change the result of the specimen. A. Access Sunquest function "Blood Order Processing." B. At the "Lookup by" prompt, choose "Patient ID" from the dropdown menu. C. At the "Value" prompt, type in the patient's medical record number and click on the "Search" button. D. If more than one patient appears, select the correct patient by clicking on the name of the patient that you are selecting. E. Select the correct specimen from the list by clicking on the most current accession. This is generally the accession number on top. F. Click on the test "ABR" and press the "Home" key. G. Change the result in the grids and correctly interpret the ABO. H. A QA failure message will appear.  I. Click on the "Acknowledge" box and then the "OK" button.
6	Add a comment denoting the changed result. A. Access the patient in Sunquest function "Blood Order Processing." B. In the "Add Spec Test" field, type "J" or type ";COMMT" and tab. C. The blood bank comment field will appear. D. Press the "Home" key to move your cursor to the comment field. E. Enter a free text comment. a. The proper format includes the test name, what the result was previously reported as, the old result, the corrected result, the name of the person the correction was called to, and the date and time that the correction took place. Example: ABO previously reported as A changed to O. Notified J. Doe, RN 11.1.10 at 1230. b. If the result was changed due to a compromised specimen noted **after** resulting, type the comment code "WPT" for wrong patient, please disregard results.

Step	Action
7	Save the information and override the QA failure message. A. Click on the "Save" button. B. The QA failure message will reappear.  C. Click the box in the "Override" column and click on the "Override" button. D. A new pop-up window will appear.  E. Type the user ID and Password in the appropriate boxes pressing tab after each. F. In the "Reason Code" box, type "CLCR." G. Type the reason for the change in the "Free Text" area then click on the "Add" button. H. Click on the "OK" button. I. The QA failure message will reappear. J. Click the "OK" button.

Step	Action
8	Print another interim report showing the corrected result with the comment(s). Refer to step 2 of this section.

5.3 Complete Paperwork

Step	Action
1	Complete a PI/Variance form documenting the result change. Refer to procedure, "Occurrence Management." Attach all paperwork associated with correcting the error.
2	If the results was erroneous due to a compromised patient specimen (labeling error, discrepancy between tubes, etc), re-order the test in the LIS and have the patient specimen recollected.
3	Perform a look-back of all patient specimens tested by the tech who made the error during the shift the error was made. Additional look-back may be necessary for some errors and will be determined by the management team. Immediate corrective action must be taken if another erroneous entry is noted.
4	Reportable Quality Incident (RQI) and FDA reporting will be at the discretion of the Blood Bank Medical Director per Quest Diagnostics policies and procedures.

5.4 Discipline

Step	Action
1	Blood bank data entry errors have the potential to cause great patient harm and even death. For this reason, the management team has the discretion to expedite disciplinary action. <u>Quest Diagnostics Disciplinary Tract</u>: 1. Summary of Discussion 2. Documented Discussion 3. Final Documented Discussion 4. Termination <u>Expedited Disciplinary Tract for Critical Errors</u>: A. Documented Discussion B. Termination If an employee is already on a disciplinary step at the time an error is made, he/she will be escalated to the next step appropriately per this guide.

Step	Action
2	Tech discipline will be automatically expedited when a serious data entry error that has the potential to cause patient harm or death is made. These include, but are not limited to, A. Data entry errors of ABO, antibody identification, antibody screen (when additional workup is not performed), antigen typing, and crossmatch that are not noted within 5 minutes of entry. B. Errors made in which the investigation revealed that the tech did not follow departmental procedures.
3	Clerical errors that are caught by the tech that made the error within 5 minutes of data entry will be disciplined per the routine Quest Diagnostics disciplinary tract.

6. RELATED DOCUMENTS

SOP: Transfusion Reaction Investigation
SOP: Occurrence Management

7. REFERENCES

N/A

8. REVISION HISTORY

Version	Date	Reason for Revision	Revised By	Approved By
		Supersedes WAH-SGAH B716.01		
000	11.18.11	App A: Replace Connie Buck with Maria Morris	SCodina	NCacciabeve
001	11.14.12	App A: Replace Rowena VinceCruz with Poan Wang; Removed David Singh	SCodina	NCacciabeve
002	12.17.13	App A: Removed Poan Wang and added Mona Patel Footer: version # leading zero's dropped due to new EDCS in use as of 10/7/13.	SCodina	NCacciabeve
3	11.16.15	Section 5.2: Changed comment type from "q" to "J" in procedure so information shows in patient chart. App A: Removed Mona Patel and added Yvonne Ngwa	SCodina	NCacciabeve
4	11.13.17	Header: Added WAH App A: Removed Sarah Delinger	SCodina	NCacciabeve
5	4.9.2018	Section 5.2: Removed instructions to enter the semicolons before the J comment	SCodina	NCacciabeve

9. ADDENDA AND APPENDICES

Appendix A: Employees with LIS Security to Edit the BAD File

Appendix A

Employees with LIS Security to Edit the BAD File

Utilize the following individuals first:

Name	Primary Location
Stephanie Codina	SGMC/WAH
Maria Morris	WAH
Yvonne Ngwa	SGMC

Utilize the following individuals if none of the above are available:

Name	Primary Location
Anne Rienks	SGMC
Marie Sabonis	WAH