Fall 2012

Connections

ISSN 1496-3876

www.cmpt.ca | CMPT QUARTERLY ON-LINE NEWSLETTER | Volume 16 Number 3

CMPT's 2012 Annual General Meeting

CMPT's 2012 Annual General Meeting took place on October 16th, 2012 at the Holiday Inn, Vancouver. This was a special AGM as CMPT celebrates its 30th anniversary.

The meeting gathered CMPT staff and members of the different advisory Committees as well as members of accreditation bodies and CMPT's partners.

The meeting started with a word from Dr. Michael F. Allard, head of the Department of Pathology and Laboratory Medicine, UBC. He congratulated CMPT for its 30th anniversary and for providing a solid Quality program in laboratory medicine during all these years.

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CMPT's staff then followed with a report on different activities at CMPT such as the implementation of new quality programs, customer satisfaction surveys, finances, and product research.

The Annual General Meeting closed with Dr. Michael Noble's report on CMPT's programs, its activities, survey results, educational activities, projects in the last year, and goals and objectives for the coming year. (Please visit this year's Annual Report for a full Chair report - LINK).

Many thanks to our very generous vendors who provided door prices for our AGM participants!!

SARSTEDT - FISHER - VWR

Reporting Error in the Laboratory–Part I

The Institute of Medicine defines a medical error as a failure of a planned action to be completed as intended. [1]

As the total laboratory testing process includes the complete pathway from test selection to the correct interpretation of the final report, a laboratory error could be defined as any quality failure within this whole process.

Approximately 80 – 90% of all diagnoses are made on the basis of these laboratory tests. [2] Quality failures, even in very low rates, have a significant impact on patient care because of the large number of laboratory tests performed.

Only a small portion of laboratory errors results in actual patient harm and adverse events. This is because of the presence of defensive layers, intervention of individuals that identify the error before it reaches the patient, or because of fortunate evolution of circumstances.

However, 2.7 to 12% of laboratory errors result in adverse events while in a larger percentage (24.4 to 30%) they translate into a patient care problem. [3]

Most hospitals have some mechanisms for reporting incidents. These 'Incident Report Systems (IRS)' collect quantitative and qualitative data about safety events. The purpose of the IRS is to help identify weaknesses in policies or procedures in the system so that changes can be implemented.

Incident Report Systems classify the collected data using different taxonomies and quality indicators so the aggregate classified reports help determine areas that require deeper investigation.

The point in the testing process at which the error occurs is widely used because it is reproducible and easy to apply. Although this approach has the advantage of identifying the step in the testing pathway on which attention should be focused, it does not consider the causative nature of the quality failure.

"If diagnostic errors are seen as minor or trivial, it is unlikely that much attention is given to them."

Alternative classification systems consider additional factors that point to what initially cause the error, for example, if the error is cognitive or non-cognitive.

Cognitive errors are those where the incorrect choice was based on insufficient knowledge. Non-cognitive errors are unconscious lapses in expected automatic behavior.

The importance of classifying the events as cognitive or non-cognitive lies on the fact that the two types of errors call for the use of different responses.[5]

Many times the corrective action involves additional training for non-cognitive errors. However, it would be more appropriate to concentrate on improving the system by increasing error checking, increasing staff numbers and decreasing task complexity.[5]

Although this classification provides a more comprehensive picture of individual quality failures, it is more subjective and difficult to apply.

Classifying events according to the degree of harm is very widely used as it is usually the first factor used when prioritizing events.

It is important that any system of grading the seriousness of quality failures should consider not only the **actual harm** sustained, but also the potential worst case scenario - **potential harm** - for those events that did not cause harm.

In a study by O'Kane[2], when the events that caused no actual harm to the patient were scored, according to the potential harm, 68% were heavily skewed in favour of high potential adverse impact.

Those events that resulted in no harm to the patient because of the intervention of an individual or by a fortunate evolution of the circumstances are called "near misses."

Because "near misses" are more numerous than adverse events, and cause no harm to the patients, they are considered a cheap learning tool and offer advantages for risk identification and analysis.

It is essential then that ALL quality failures or safety events are reported. If diagnostic errors are seen as minor or trivial, it is unlikely that much attention is given to them.

One of the most important factors that affect the reporting of safety events is the prevailing culture within the laboratory. Fear of attracting blame, lack of feedback, or considering the error too trivial to be reported, are common barriers leading to under-reporting. [4]

On the other hand, a 'systems approach' that focuses on correctly designed systems to detect and prevent errors, the awareness of the impact of error detection on patient safety, together with positive feedback and corrective action, increase error reporting and participation by laboratory personnel.

A successful Patient Safety Incidents identification and reporting program

is possible only with management committed to a patient safety culture.

Management must resist the temptation to interpret a higher number of reports as a signal of more problems, but instead interpret it as a positive sign that incidents are recognized as an opportunity to learn and enhance patient safety.

Lastly, there must be tangible evidence that quality-failure reporting results in action in the form of improved policies, procedures, or to the laboratory environment.

Veronica Restelli

1. Kohn IT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. Washington DC: National Academy Press, 1999.
2. O' Kane M. (2009) The reporting, classification and grading of quality failures in the medical laboratory. Clin. Chim. Acta 404: 28-31
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4. Jeffs L, Berta W, Lingard L, Baker GR. Learning from near misses: from quick fixes to closing off the Swiss-cheese holes. *BMJ Quality & Safety*. 2012;21:287-294.
5. Astion ML, Shojania KG, Hamill TR, Kim S, Ng VL. Classifying laboratory incident reports to identify problems that jeopardize patient safety. *Am J Clin Pathol*. 2003;120:18-26.

In the next issue:

Reporting Error in the Laboratory - Part II: The BC Patient and Safety Learning System

Website Updates

Clinical Bacteriology

Gram stains photographs: as requested by participants more photographs of Gram stain challenges are being posted online. You can find these photographs on the final results page:

http://www.cmpt.ca/critiques/2012/critiques_2012.html

Photo-album: the photo-album has been updated. It is divided into two categories: Gram component (regular clinical bacteriology sendout) and Supplementary Gram Program and it is now sortable by challenge number and by site. Click on the "challenge" or "site" headers to sort the photographs and corresponding results. Big images can be accessed by clicking the "Big Pic" link.

Clostridium difficile

Results for the *Clostridium difficile* program are now posted on the following page:

http://www.cmpt.ca/survey_results_cb/cdiff_results_page.html

The page contains the latest results and the fact sheet for sample processing, methods, and results interpretation.

Critiques will only contain results and comments for each challenge and are available by clicking the challenge number.

Trichomonas vaginalis antigen

Results for the *Trichomonas vaginalis* antigen program are posted on the page:

http://www.cmpt.ca/survey_results_trich/trich_results.htm

The page contains the latest results and the fact sheet for sample processing, antigen test, and clinical significance.

There are no critiques for *Trichomonas vaginalis* antigen challenges.

Shiga Toxin

Results for the Shiga Toxin program are posted on the page:

http://www.cmpt.ca/survey_results_shiga/shiga_results.html

The page contains the latest results and the fact sheet for methods and clinical significance.

There are no critiques for Shiga Toxin challenges.

Get Connected

CMPT's OPEN HOUSE

CMPT would like to invite participants to its annual general meeting (AGM).

Every year, CMPT rounds up the year with an annual meeting during which we evaluate our performance during the year, receive suggestions from our committee members and accreditation bodies, present new ideas and programs, and discuss future directions.

For the first time, CMPT would like to extend the invitation to attend the AGM to participant laboratories.

We think that it would be of good advantage for both parties to increase communication and participation.

We will be sending a survey soon to find our if there is enough interest to make this happen.

Please stay tuned!!

Follow us on Twitter @CMPTUBC

Upcoming Events

December

SWACM Full Day Workshop: Basic Medical Mycology

December 14, 2012 University of Mary Hardin-Baylor, Belton, TX

More info: http://www.swacm.org/workshops/currentworkshops.htm

March 2013

5th Wastewater Management Conference & 48th Central Canadian Symposium on Water Quality Research

March 6-8, 2013 Hamilton, Ontario

More info: http://cwwa.ca/WastewaterConference_e.asp

April 2013

23rd ECCMID

April 27—30, 2013 Berlin, Germany

More info: http://www.congrex.ch/eccmid2013.html

ABOUT CONNECTIONS

"Connections" is published quarterly by CMPT and is aimed at the Microbiology staff.

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