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Family Medicine-Primary Care Program

Safety Learning Summary

Occurrence Reporting Summary
Quarter 3 – Fiscal 2012/13

Category: Documentation – Lab Occurrences

Summary - What happened?

During Quarter 3 there were a total of 73 Occurrences reported to the Primary Care Program. Of those reported, there were a total 40 Occurrences (55%) specifically related to "Pt/Cl/Res Documentation" with the majority of these (88%) due to misdirected lab results.

What were the review findings?

- Nature of these occurrences were all related to mistakes in the reporting process by Lab Services. Lab Requisitions being generated by the provider would clearly identify the name of the ordering physician yet come back to the attention of different physicians. Misdirected lab results coming back to the clinic slow down the sorting and previewing process. Time is of the essence in the event of critical lab results – misdirected lab results have the potential of increasing the level of risk associated with patient safety.

What was recommended?

- The clinic worked directly with Lab Services to bring this issue to the forefront. As a result, the frequency of these events occurring has significantly decreased. A lower number of misdirected lab results also decreases the number of unmatched results that support staff have to sort through and reassign.

- Automation - Prior to implementation of Electronic Medical Record (EMR) the clinic could not demonstrate how the change in ordering provider was happening. The Lab Requisition walked out the door with the patient and Lab Services was sure that the clinic and its many learners were responsible. With EMR, the clinic is now able to print the Lab Requisition and corroborate that the event was a result of human error at Lab Services.

- Future events should continue to be reported by completing Occurrence Reports for both learning and tracking purposes.