



1304 N. Old Hwy. 135 * Corydon, IN 47112
* phone (toll free): 866-657-9857 * fax: 812-738-5750 *
* Email: Phlebotomy@phlebotomy.com *
* Web: www.phlebotomy.com *

The Joint Commission
Division of Standards & Survey Methods
Standards Improvement Initiative
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

5/20/2009

To whom it may concern,

The Center for Phlebotomy Education would like to comment on the proposed revisions to the National Patient Safety Goals (NPSGs) for laboratories. We believe the proposed standard revisions are clear, but one specific deletion represents a dangerous reversal that jeopardizes patient safety.

We commend the Joint Commission for taking long-overdue steps in the 2009 NPSGs to strengthen its requirements for patient identification and sample labeling when collecting blood specimens. **However, we are dismayed that the first Element of Performance (EP 1) for NPSG.01.01.01 requiring active patient involvement in their identification is already being recommended for deletion.**

Until 2009's NPSGs were issued, the Joint Commission's sole requirement to obtain two identifiers prior to a venipuncture had not effectively protected patients from transfusion errors and other medical mistakes. By permitting those two identifiers to come from the same identification bracelet without requiring active patient involvement to confirm the bracelet was attached to the right person, patients could be misidentified without any deviation from the Joint Commission's requirements. Implementing the requirement for active involvement in the 2009 NPSGs eliminated the potential for those with an erroneous arm bracelet to be misidentified. To remove that critical provision is dangerous and ill-advised.

Statistics have shown that up to 16 percent of identification bands have erroneous information.(1) Another study showed 7.4 percent of wristbands are erroneous or missing, with missing bracelets comprising 70 percent of the total.(2) In the September 2005 issue of *CAP Today*, then chair of the CAP Quality Practices Committee estimated 160,000 adverse patient events occur each year in the US because of patient or specimen identification errors involving the laboratory. (3)

Without requesting the patient to state his or her name, bracelet errors go unnoticed, leading to transfusion deaths and other potentially catastrophic outcomes. Studies show that 11 percent of

all transfusion deaths occur as a result of the phlebotomist not properly identifying the patient or mislabeling the tube of blood.(4) A Joint Commission review of prior transfusion-related sentinel events is certain to unearth evidence of the necessity for healthcare professionals drawing blood to actively engage the patient as a component to identification, including these:

- In 2003, a patient admitted to Inova Fairfax Hospital in Falls Church, Virginia switched beds with her roommate in order to be closer to the window. When the technician came to draw her blood, she failed to identify the patient according to facility policy, and drew blood from her roommate instead. During surgery the next day, the patient received incompatible blood and died from the transfusion reaction. According to a hospital spokesperson, "The individual who made the error failed to follow our procedures for identification." At Inova Fairfax, the protocol for patient identification was to check the arm bracelet and ask the patient to state her name. The technician didn't recall if she conducted either check.(5)
- In December of 2007, a patient at Bert Fish Hospital in Florida died from a transfusion reaction after his roommate was drawn for the crossmatch by mistake. Hospital officials stated "the error was not a result of the hospital's failure to reasonably comply with all applicable statutory and rule requirements."(6) At the time Joint Commission did not require active patient participation for venipunctures.

The Clinical and Laboratory Standards Institute (CLSI) publishes standards for laboratory procedures. CLSI's specimen collection standards require specimen collection personnel to ask all patients to state their name prior to a venipuncture or skin puncture.(7,8) When not possible, a patient's caregiver or family member can be engaged for the active involvement. With the 2009 NPSGs, Joint Commission and CLSI were finally in harmony on this requirement creating a multi-agency standard. Patients have a right to be properly identified. Deleting EP 1 threatens patient safety and weakens the standard of care Joint Commission strives to maintain.

Additionally, we urge Joint Commission to retain Elements of Performance 6 (EP 6) for NPSG.01.01.01 requiring specimens to be labeled in the presence of the patient and to consider an additional EP.

While the statistics for patient misidentification are stunning, the statistics are much worse for specimen mislabeling:

- Three studies measured causes for specimen rejection and found that samples inadequately labeled account for 5.6%, 5.8% and 6.7% respectively. (9,10,11)
- Samples collected in the emergency department are ten times more likely to be mislabeled than those collected from all other hospital locations (0.36% versus 0.037%).(12)
- In one study, only 16% of the (non-laboratory) ward staff demonstrated desirable practices regarding tube labeling.(13)
- In Sarasota in 2004, an employee drew a specimen for crossmatch on a critically ill patient, but applied the wrong preprinted label on it. The patient died the day after getting the transfusion.(14)

When samples are not labeled at the patient's side, the potential for error and the sentinel events that can follow are enormous. Joint Commission has finally mitigated the risk of medical mistakes due to specimen mislabeling by including this important provision in the 2009 NPSGs.

We would like Joint Commission to not only maintain this provision, but to consider an additional safeguard.

Too often specimen collection personnel carry the blood collection labels for multiple inpatients from room to room. Even when patients are properly identified by active involvement, the wrong label can still be applied in the presence of the patient. Without confirming the tube is labeled properly before leaving the patient, errors and transfusion accidents will still occur. According to CLSI's venipuncture standard, those who collect blood specimens are not only required to label the specimen at the patient's side, but must also "compare the labeled tube to the patient's identification bracelet or have the patient verify that the information on the labeled tube is correct" whenever possible before leaving the patient.(7) We urge Joint Commission to not only maintain the provision to label samples in the presence of the patient, but to mandate the patient confirms the tube is properly labeled whenever possible as required by CLSI.

Patients need Joint Commission to be their first and last line of defense against medical mistakes. As the patients' advocate, attempts to erode the essential provisions discussed here must be met with resistance.

We urge Joint Commission:

- 1. not to delete the EP 1 for NPSG.01.01.01 as recommended;**
- 2. to retain EP 6;**
- 3. to add a new EP mandating a step to confirm a sample is properly labeled before leaving the patient.**

Thank you for your thoughtful consideration.

Respectfully,



Dennis J. Ernst MT(ASCP)
Director

References

1. Paxton, A. Stamping out Specimen Collection Errors. *CAP Today*. May, 1999.
2. Howanitz PJ, Renner SW, Walsh MK. Continuous wristband monitoring over 2 years decreases identification errors: a College of American Pathologists Q-Tracks study. *Arch Pathol Lab Med* 2002.
3. Ford A. Catching ID errors where it counts---in the lab. *CAP Today*, 2005;19(9):34-40.)
4. Sauer D, McDonald C, Boshkov L. Errors in transfusion medicine. *Lab Med* 2001;4(32):205-7.
5. State, Bert Fish Hospital Reach Settlement on Patient Death. www.news-journalonline.com. Accessed 7/16/08.

6. Patient Dies from Blood Mismatch. *Washington Post*. August 29, 2003. <http://www.washingtonpost.com>. Accessed 5/12/09.
7. CLSI. Procedures for the Collection of Diagnostic Blood Specimens by Venipuncture; Approved Standard—Sixth Edition. CLSI document H3-A6. Wayne, PA: Clinical and Laboratory Standards Institute; 2007.
8. CLSI. Procedures and Devices for the Collection of Diagnostic Capillary Blood Specimens; Approved Standard—Sixth Edition. CLSI document H04-A6. Wayne, PA: Clinical and Laboratory Standards Institute; 2008.
9. Wagar E, Tamashiro L, Yasin B, Hilborne L, Burckner D. Patient safety in the clinical laboratory: a longitudinal analysis of specimen identification errors. *Arch Pathol Lab Med* 2006;130(11):1662-8.
10. Dale J, Novis D. Outpatient phlebotomy success and reasons for specimen rejection. *Arch Pathol Lab Med* 2002;126:416-19.
11. Jones B, Calam R, Howantiz P. Chemistry specimen acceptability: a College of American Pathologists Q-Probes study of 453 laboratories. *Arch Pathol Lab Med* 1997;121:19-26.
12. Sandhaus L, Sauder K, Michelson E. Relative frequency of mislabeled laboratory samples from the emergency department (ED) compared to other hospital areas. Institute for Quality in Lab Med, 2005 IQLM Conference Poster Session. <http://wwwn.cdc.gov/dls/IQLM/2005Posters/Sandhaus-39-Frequency%20of%20mislabeled%20lab%20samples%20fm%20ED%20comapred%20to%20other%20hosp%20areas.pdf>. Accessed 5/12/09.
13. Wallin O, Soderberg J, Van Guelpen B, Stenlund H, Grankvist K, Brulin C. Preanalytical venous blood sampling practices demand improvement—a survey of test-request management, test-tube labeling and information search procedures. *Clin Chim Acta* 2008;391(1-2):91-7.
14. Mittle M, Pollick M. Patient who died had received wrong type of blood. *Herald Tribune*. <http://www.heraldtribune.com/article/20040717/BUSINESS/407170409#>. Accessed 5/19/09.