

Category and Incident definitions and examples

Categories

The incidents are divided into 8 categories and follow the Request-Test-Report cycle. They indicate where the error occurs in the process (Figure 1)

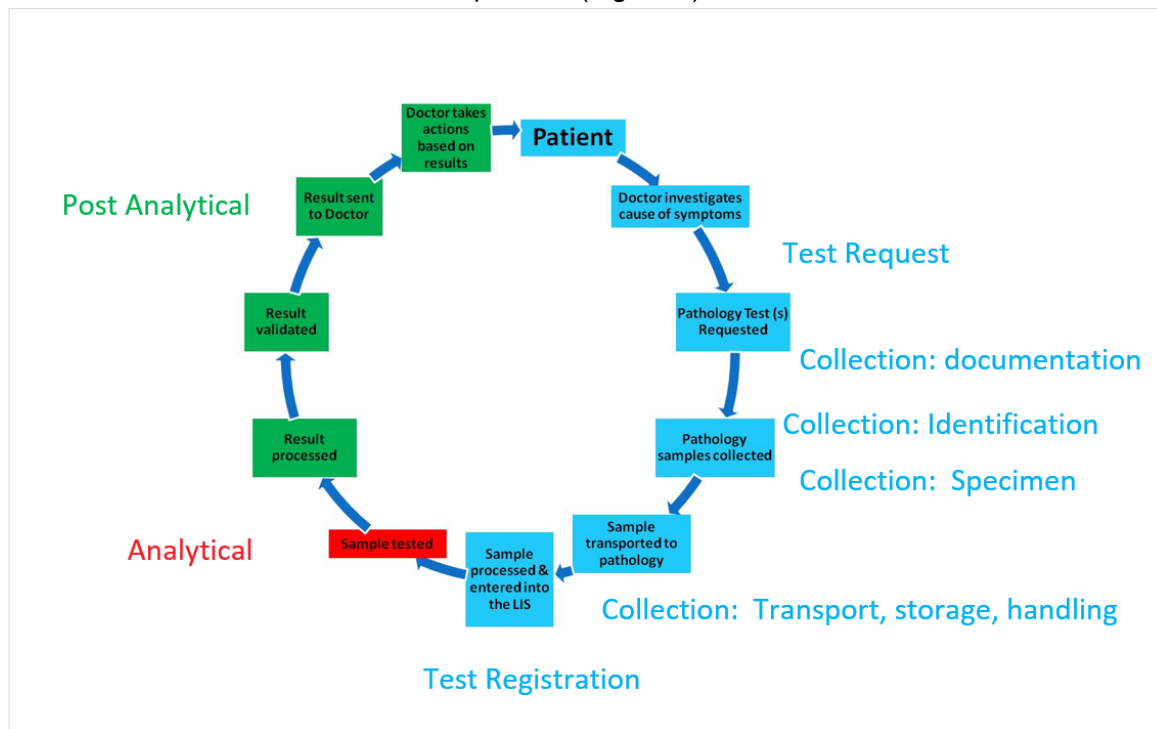


Figure 1: Request-test-cycle showing KIMMS categories.

Incidents

Specific incidents have been chosen based on discussions with KIMMS participants and input from the Advisory Committee. The table below illustrates the use of each of these and gives examples. The consequences are based on the consequences scale referred to in the RCPAQAP Data Analysis and Assessment Criteria Handbook.

Categories	Specific Incident	Consequences	Guidance on the use of this parameter in KIMMS:	Examples
Test request	Test request: Clarification of tests required	1	Collector or laboratory required to contact requestor to confirm test(s) requested as information not clear or illegible on request.	Examples: Information required to decide which tests or to interpret results (family history, medical history)
	Test request: Insufficient requester details or signature missing	2		
Collection: Identification	Collection: Unlabelled specimen and/or request	4	This is when sample or request has no patient identifiers.	Note: Totally unlabelled sample
	Collection: Insufficient patient ID specimen and/or request	3	Minimum identifiers are full name and DOB. 3 identifiers may be required E.g., transfusion samples.	Note: Less than 2 identifiers on the sample or request form, less than 3 for Transfusion samples. Examples: Missing Name, UR or date of birth, or unique laboratory number.
	Collection: ID mismatch between specimen and/or request	3	ID on specimen label does not match accompanying request form or electronic order	
	Collection: Specimen from	4	Labelling of specimen and	Example: It may be suspected or

	wrong patient (WSIT)		request are concordant, but the actual sample in the container is from a different patient.	known that this is the case E.g.: totally different results from previous results, which is not possible.
Collection: Documentation	Collection: Essential collection date and/or time not provided or discrepant between specimen and request	4	Specimen and form must align especially essential for a Transfusion request	Examples: Collection date and/or time incomplete or not recorded on specimen or request form. Discrepancy between those on sample and request form.
	Collection: Essential signature missing or discrepant on transfusion sample and/or request	3	This refers to collector and patient signature	Example: Unsigned label or request form for a transfusion sample
	Collection: Essential clinical indication for test not provided	2	Collector fails to record the clinical indication for the test that is required by the laboratory to aid in the interpretation of results.	Examples: Fasting status, relevant medication, time since last dose not recorded at the time of collection
	Collection: Essential specimen type/site not provided	4	Specimen type and/or site not provided when information is required to aid in appropriate testing and interpretation of results by the laboratory.	Examples: Site of swab or biopsy not provided
Collection: Specimen	Collection: Incorrect patient preparation	3	Patient not fasting, medication taken instead of being withheld, preparation procedure for test not followed	Note: This can be caused by patient not being given correct information or not following the information that was given.
	Collection: Incorrect specimen type or container or acid	3	Incorrect specimen type collected/submitted for test request	Examples: EDTA collected when LiHep required; urine with acid added vs urine without acid; fresh tissue vs formalin fixed; random urine submitted when 24 hour urine required.
	Collection: No specimen received	4	No sample received to do the test	
	Collection: Insufficient specimen	3	Insufficient specimen to do any or all tests requested.	
	Collection: Specimen incorrect fill leading to incorrect specimen:additive ratio	3	Under or overfilled Citrate (COAG) tubes.	Note: Usually citrate tubes, but any tube with a liquid additive could be affected.
	Collection: Specimen clotted or other clotting issues	3	Most commonly EDTA tubes, but any tube with anti-coagulant may be clotted.	
	Collection: Specimen contaminated – non microbiological	4	E.g: Diluted from IV drip; or order of draw incorrect.	
	Collection: Specimen contaminated - microbiological	3	Contaminated microbiology samples that require a recollection.	
	Collection: Specimen haemolysed	3	Sample is unsuitable for one or more tests due to the level of haemolysis.	Any sample with a haemolysis level of >50mg/dL or +.
	Collection: Specimen leaking	2	Any leakage should be recorded, even if there is still sufficient specimen to do the test.	
Collection: Transport, Storage and Handling	Transport and Storage: Incorrect transport/storage temperature/handling	3	Stored and/or transported at wrong temperature or handling not in accordance with documented procedure	Examples: Delayed separation of serum or plasma, specimen left too long in centrifuge; specimen not shipped frozen.
	Transport and storage: Transport delay leading to specimen being too old to test	3	Any delay in transport	Examples: being left in collection centre or at Drs surgery, or courier delayed for any reason Example: accident, cancellation of flight.
Test registration	Test registration: Incorrect unique specimen identifier	4	Also known as episode; laboratory or accession number. It is the unique identifier for that specimen from that patient collected/submitted on that	Incorrect barcode is read at test registration. It is NOT an incorrect Barcode being placed on the sample at the time of collection.

			date/time.	
	Test registration: Patient ID wrong patient	4	This occurs when the wrong patient is chosen at data entry from a list of patients with the same, or similar name. Request associated to incorrect patient demographics.	Specimen registered under the wrong patient details.
	Test registration: Error in transcription of patient demographic information	2	This occurs when information is incorrectly entered from a request. Registration data manually entered	Examples: Incorrect Name, DOB or address added at registration Note: Most likely to occur when registration done manually
	Test registration: Incorrect or missed tests	3	Test on request form not added at registration or incorrect test added.	This does not include add-on tests or tests that can't be interpreted at data entry.
	Test registration: Incorrect or missing specimen type, site, collection time	3	This is when the information is available on the request form or electronic order but is not entered into the LIS.	Examples: Specimen type not added. Incorrect collection time added
	Test registration: Incorrect requesting or copy doctor	3	Referring clinician or copy to clinician not registered to receive copy of the report	Examples: Incorrect Doctor selected at registration, copy to Doctor not added
Analytical	Analytical: Internal laboratory process incident - unfixable	3	This refers to any incident that happens after the sample has arrived at the laboratory that is not directly related to performing the test.	Examples: Irreplaceable sample spilt, formalin added to fresh specimen, samples thawed and not used; wrong test(s) performed and specimen volume depleted; specimen discarded prior to completion of testing, small sample placed on automation and not manually presented leading to inadequate sample for analysis
	Analytical: Within laboratory ID error	4	Error transferring patient Identification within the laboratory.	Examples: Pipetting incorrect patient into tube or well, mislabelling aliquot or block, not labelling aliquot or block
	Analytical: Intra or inter-laboratory specimen lost or misplaced - irreplaceable	5	Specimens lost/misplaced during intra and inter-laboratory transfer that are irreplaceable.	Examples: Irreplaceable samples are those that are deemed precious or difficult/impossible to recollect. E.g.: CSF, tissue and cytology samples; specimens that are collected as part of a series such as stimulation or suppression tests; pre-dose drug levels; specimens collected under sedation.
	Analytical: Intra or inter-laboratory specimen lost or misplaced - replaceable	3	Specimens lost/misplaced during intra and inter-laboratory transfer that can be recollected	Examples: Specimen recorded as received in Specimen Reception but did not reach department Specimen recorded as sent to another laboratory but not received
Post Analytical	Post analytical: Failure of clinical handover high-risk (critical) results	5	Failure to communicate high-risk results to the relevant party within agreed guidelines as documented within your organisation.	Result outside critical limits not communicated to Clinician
	Post-analytical: Failure of clinical handover non-critical results	3	Requests to re-send copy of report due to non-receipt by the requestor, including referring laboratories.	Note: More an issue in community patients than hospitals.
	Post Analytical: Amended report. Significant patient impact	5	This is amended report due to a diagnostic error or incorrect result being released.	Examples: Result incorrectly reported as Negative, found to be Positive so amended result issued with correct result. Missed diagnosis in AP or Haematology. Note: This does not include reports that have been amended due to more information becoming available, usually due to further testing or results of a second opinion