The laboratory approach to patient safety

Medical errors have a great impact on patient outcomes, since they can cause patients serious injury or even result in death. In 2000, in U.S. hospitals, medical errors were estimated to cause between 44,000 and 98,000 deaths annually, making preventable medical errors the eighth leading cause of death in the nation, with an estimated cost of $17 billion. Despite all efforts, it appears that the high quality of healthcare is not yet a universal reality; and further improvement is needed, as reported in the first National Health Care Quality Report, prepared by the Agency for Healthcare Research and Quality, using a variety of national data sources.

As part of the overall healthcare system, clinical laboratories are also vulnerable to medical errors. Considerable efforts were made by laboratory professionals and other stakeholders to decrease testing errors. Minimal quality requirements were set through regulations, both for laboratory testing and for manufacturing of safe and efficacious medical equipment and reagents. Also, nonregulatory approaches, such as laboratory standards, participation in various quality-improvement programs, voluntary reporting of adverse events, and introduction of successful approaches from other industries — like Six Sigma or Lean — have greatly impacted the quality of laboratory testing.

In order to facilitate further improvements in laboratory service — and better collaboration and coordination within the healthcare system — the Centers for Disease Control and Prevention (CDC) and nearly 40 partners (representatives from accrediting and standards-setting groups, diagnostics industry, healthcare providers, hospital administrators, laboratory professionals, patient advocates, payers/insurers, and policy makers) convened a Quality Institute conference in Atlanta in April 2003. Its goals were to develop: the framework and content for a national report on the quality of laboratory services; criteria for quality indicators of laboratory services and a process for ongoing collection; and analysis of data related to the quality of the U.S. laboratory services.

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At the conclusion of this meeting, it was evident that improvement in pre- and post-analytic areas is needed, as well as a core set of quality indicators that will assess the total testing process. Also, there was consensus regarding the need to enhance communications between the laboratory and clinical practice, to improve surveillance of the quality of laboratory practices and services, and to disseminate best practices.

To address these areas, CDC — working in consultation with numerous experts — developed plans to establish an independent public-private partnership. This partnership has been named the Institute for Quality in Laboratory Medicine (IQLM). The mission of the IQLM is to strive to promote improvements in labora-

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As has been the history of MLO’s “Washington Report,” this space will be devoted in 2004 to keeping readers abreast of ongoing issues and new legislation affecting the clinical laboratory and its professional managers and technicians. If there is a particular legislative question or a legislative topic of special interest to your organization, please e-mail: washingtonreport@mlo-online.com.