Letters to the editor

Readers respond

Never too safe

In their article, “Quality Collection: the phlebotomist’s role in pre-analytical errors” [MLO, September 2006, p.30], Dennis Ernst and Lisa O. Ballance address the many possible errors that may occur before, during, and after the blood collection process. I applaud the authors for including information in the article that addresses important information for all staff phlebotomists, supervisors, and educators. We must all recognize that our mission is to educate and then monitor for compliance in following the rules and protocols for safe phlebotomy. I would like to remind the authors of the importance of promoting only safety-engineered products. There are two photographs of needles on pages 30 and 34 with no safety-engineered guard in sight. We must not promote the concept that it is okay to use non-safe products — this is unthinkable!

—Helen Ogden-Grable, MT(ASCP) PBT
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Editor’s reply: Thanks to Helen Ogden-Grable of DSI Labs, south of our offices, for her astute observation. The truth is that Dennis Ernst and Lisa O. Balance did not choose the artwork for their manuscript. The artwork available from a battery of aging stock photographs included half a dozen that did not reflect safety standards. Unfortunately, these two were selected and used without the benefit of their counsel. MLO apologizes for this error and takes Ms. Ogden-Grable’s critique to heart. New stock photography for the laboratory is being ordered for our Production Department.

Saved by a sliver

Here are some thoughts on the September 2006 MLO article entitled, “Quality collection: the phlebotomist’s role in pre-analytic errors.” The authors state that “up to 16% of identification brace-lets contain erroneous information.” While this may be true and we should strive to update and correct these errors, they should not compromise the identification process as long as it remains consistent through the process of specimen collection, analysis, and reporting. Unconscious and John Doe patients are two examples where the identification might be erroneous and yet such identification should be effective. Old identification bands should not be removed until the need to use them to identify the patient prior to transfusion has passed. The option is to re-cross match the patient with a new, properly identified specimen.

A major issue in pre-analytic errors is that many individuals who submit specimens for lab analysis are not lab employees and the lab has little, if any, leverage to educate and/or provide feedback on improperly collectioned specimens. Pre-analytical manipulation of specimens can go undetected by the lab with potentially serious consequences to the patient. I recently saw specimens where the caps had been removed, the tubes filled manually, and the green cap replaced on the citrate tube while the blue cap was put on the heparinized tube. The patient’s calcium was critically low, and the coagulation testing was greatly prolonged. One of our techs in coagulation noticed a tiny sliver of the manufacturer’s green label that was not covered by the label identifying the patient. Redrawing the patient yielded normal values. Unfortunately, the nurse phlebotomist did not appreciate the gravity of the situation when I explained it.

This is just one example of improper specimen manipulation I have seen. I am sure every lab professional could add their own scary stories. There is a real need for hospital administrators and the various regulatory agencies to take very seriously the ramifications of these kinds of interdepartmental interactions.

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