College of Medical Laboratory Technologists of Ontario

CMLTO Interprofessional Collaboration (IPC) Case study

Case study #6: Misplaced specimen puts patient at risk

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Introduction

As one of Ontario's self-regulated health professions, medical laboratory technologists (MLTs) are governed by the *Regulated Health Professions Act, 1991* (RHPA). The RHPA was developed to protect the public's right to safe, competent, and ethical healthcare. The RHPA requires each health regulatory College to develop and maintain Standards of Practice that outline the expected level of quality and safety for professional services provided by its members. Legislation, regulations, bylaws, Standards of Practice, practice guidelines, and the Code of Ethics collectively establish a framework for medical laboratory technology practice.

The Ontario government, through the RHPA, defines CMLTO's objectives. These expectations include promoting and enhancing interprofessional collaboration (IPC) among MLTs, and with other members of the healthcare team. Further, the CMLTO is expected to support MLTs' abilities to respond to changes in the healthcare environment.

What is a case study?

A case study describes a relevant professional practice scenario or issue to enable MLTs to critically analyze a situation and identify opportunities for learning and development. Members can apply these learnings when faced with similar situations in their own practice. Expanding current professional behaviours empowers MLTs to share their knowledge and expertise with other health professionals to support improved patient care.

How can I use this case study in my professional practice?

CMLTO's professional practice resources are intended to support, not replace, an MLT's professional judgment. Reading through case study materials, and reflecting upon the professional practice issues or opportunities supports an MLT's ability to develop effective strategies and skills for handling similar situations in the future. MLTs reading this case study may not experience the exact same scenario in their own workplaces. However, similar key themes may exist locally making the case study useful in identifying issues and opportunities for improving their professional practice.

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Case study reflection and discussions may be done independently, or as a group. In either situation, MLTs should reflect on the scenario's enablers and barriers to identify both personal and organizational opportunities to improve their professional practice. Thinking about case studies from both perspectives and articulating those reflections will enable MLTs to develop successful strategies and solutions.

Case study 6: Misplaced specimen puts patient at risk

Case study highlights

- A laboratory receives a STAT sample and processes it as a routine sample.
- A newly-hired staff member is feeling overwhelmed by the volume of specimens which leads to an error.

A busy community laboratory that handles thousands of specimens a day hires a new medical laboratory technician in their specimen processing area. This area is supervised by an MLT who monitors various items including turnaround times, specimen tracking and workflow, and inquiries from referral clinics. One afternoon the supervising MLT receives a phone call from a referring clinic inquiring about the status of a STAT specimen that was sent earlier that day. The MLT looks up the specimen in the Laboratory Information System (LIS) and finds that two specimens were received from that patient, and both were processed as routine specimens. The MLT tells the referring clinic they will look into the progress of the testing and will call them back.

Upon further inspection, it is clear that one specimen was for routine testing and the other for STAT testing. However, the newly hired technician did not notice the STAT request and placed both specimens in the routine testing queue. The supervising MLT brings this to the attention of the technician who apologizes and states that they are feeling overwhelmed by the volume of specimens.

The supervising MLT calls the referring clinic back and reports that the patient's test results will be ready by the next day. The referring clinic expressed anger at the laboratory for not handling the STAT specimen appropriately. They state that the patient is now at risk, as the clinician requires the result to make an urgent decision about their care.

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Enablers and barriers

	Institutional/organizational	Personal
Enablers	• The laboratory has an LIS system that efficiently monitors and tracks patient samples. • The referring clinic has a direct mechanism to contact the community laboratory.	• The MLT supports the newly-hired technician in identifying and resolving the error. • The technician takes responsibility for the error.
Barriers	• There was no automatic detection or visual cue that the sample required STAT testing. • The laboratory's orientation and training program may not be comprehensive enough.	• The technician did not express they were overwhelmed leading to an error that could have been avoided.

Individual reflection and group discussion questions

The following questions are meant to guide individual reflection and/or group discussion. Writing responses down may be helpful in preparing an action plan for a specific professional practice issue.

1. How would you communicate with the technician to foster a collaborative working environment while addressing the error?
2. What suggestions would you make to ensure this does not happen again? If applicable, how would you plan and implement these changes?
3. If this situation occurred in your professional practice setting, what personal and organizational enablers or barriers would be similar? What would be different?
4. Do you think the outcomes would be similar in your institution? Why or why not?

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Conclusion

CMLTO's role includes a legislated requirement to promote the ability of members to respond to changes in the healthcare system including IPC. The CMLTO develops case studies to prepare MLTs to effectively analyze and reflect on professional practice scenarios involving IPC.

Please contact CMLTO at memberrelations@cmlto.com to discuss this case scenario, other professional practice IPC scenarios, and to share your own experiences.

Additional resources for MLTs

CMLTO provides additional resources for MLTs that may help address local professional practice issues. Please visit the Members section of www.cmlto.com for the most recent professional practice resources for MLTs.