# Lab Event

## Investigation Prompts

<table>
<thead>
<tr>
<th>Causal Factor</th>
<th>Questions / Factors to consider</th>
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| **Communication / Teamwork** | - Was the patient correctly identified?  
- Does the medical record documentation adequately provide a clear picture of what happened?  
- Were there issues related to continuity of care?  
- Was communication between all team members (management/supervisors and front-line staff) adequate?  
- Was all necessary information available?  
  - when needed?  
  - accurate?  
  - complete?  
  - Unambiguous?  
- Were there methods for monitoring adequacy of staff communication?  
  - Were there methods for:  
    - "read back"  
    - confirmation messages  
    - debriefs  
- Are there barriers to communication?  
- How do front-line staff get results of lab tests?  
- When are lab results communicated directly to front-line staff from lab staff?  
- How is frontline staff notified of missing/unusable specimens? |
| **Environment** | - What controllable environmental factors affected the outcome?  
  - Was the physical environment appropriate for the process to be carried out?  
- What uncontrollable external factors influenced the outcome?  
- Were there any issues related to transportation of specimens?  
- Were there any issues related to storage of specimens?  
- How are specimens stored prior to being sent to reference lab? |
| **Equipment / Technology** | - Was the level of automation appropriate? (i.e., Neither too much nor not enough.)  
- Was available technology used as intended?  
  - Was the technology designed to minimize use errors or easy-to-catch mistakes?  
  - Did the technology work well with the workflow and environment?  
  - Was the technology used outside of its specifications?  
- Equipment maintenance/management  
  - Was the equipment functioning as intended?  
  - Availability and condition of equipment  
  - Staff knowledge of or education on equipment, including applicable competencies  
  - Correct calibration, setting, operation of alarms, displays, and controls |
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| Task / Process / Policies | • Were relevant policies/procedures clear, understandable, and readily available?  
• Were there any steps in the process that did not occur as intended?  
• Were specimens labeled correctly? |
| Staff Performance / Training | • Was staff properly qualified and currently competent for their responsibilities?  
• Were the results of training monitored over time?  
• Was the training adequate? If not, consider the following factors:  
  o supervisory responsibility  
  o procedure omission  
  o flawed training  
  o flawed rules, policy, or procedure  
• Did any human performance factor contribute to the event?  
  o Boredom  
  o Failure to follow established policies/procedures  
  o Fatigue  
  o Inability to focus on task  
  o Inattentional blindness/confirmation bias  
  o Personal problems  
  o Lack of complex critical thinking skills  
  o Rushing to complete task  
  o Substance abuse  
  o Trust |
| Organization / Culture | • Was staffing appropriate to provide safe care?  
• Did actual staffing deviate from the planned staffing at the time of the event or during key times that led up to the event?  
• Was there an overall management plan for addressing risk and assigning responsibility for risk?  
• Did management have an audit or quality control system to inform them how key processes related to the adverse event were functioning?  
• Had a previous investigation been done for a similar event?  
  o Were the causes identified?  
  o Were effective interventions developed and implemented?  
• Would this problem have gone unidentified or uncorrected after an audit or review of the work process/equipment/area?  
• Was required care for the patient within the scope of the facility’s mission, staff expertise and availability, technical and support service resources?  
• Is prevention of adverse outcomes considered a high priority? |