Administrative Closure December 13, 2010

Memorandum to the File
Case Closure

Improper Handling of Laboratory Specimens at the
VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi

(Project No. 2010-03463-HI-0353)

The Department of Veterans Affairs Office of Inspector General (OIG) Office of Healthcare Inspections received a request from U.S. Representative Jo Bonner to review allegations regarding improper handling of laboratory (lab) specimens at the VA Gulf Coast Veterans Health Care System (the system), Biloxi, MS.

Background:

The Mobile Outpatient Clinic (MOPC) routinely sends certain lab specimens to the system for processing. The specimens are accessioned[1], labeled, packed in a certified cooler, and transported by a VA courier daily by 3:30 p.m. Lab technicians at the system then unpack the cooler and check the integrity of the specimens prior to processing.

The alleged events took place on February 19, 2010, when (b)(6) received lab specimens from the MOPC at 4:30 p.m. (b)(6) considered the specimens to be contaminated and quarantined them. On February 23, he re-quarantined specimens labeled February 19, not knowing that the specimens were new, because the original labels were re-used. (b)(6) then notified the VA police to report this as a possible criminal act.

(b)(6) specifically alleged that:

- MOPC overloaded an ice chest with approximately 300 specimens.
- The temperature of the specimens in the ice chest was out of normal range.
- The specimens were delivered late.
- Staff re-labeled previously quarantined specimens.

[1] Accession is the process that marks specimens with the patient's demographic data for identification and tracking purposes.

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On March 3, 2010, the system chartered a Root Cause Analysis (RCA)[2] to investigate the incident. The system also conducted an Administrative Investigation Board (AIB)[3], which began on March 15.

The purpose of our inspection was to assess whether the RCA and AIB addressed the complaints and recommended appropriate corrective actions. Although (b)(6) mentioned being removed from his position and felt that the alleged incidents were criminal in nature, we limited our review to the clinical aspects of the case.

We reviewed the RCA, AIB reports, and other associated documents. We also interviewed the complainant and reviewed quality control checklists for shipping and receiving of lab specimens.

The RCA was (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705

The AIB, completed April 14, 2010, found that on February 19, (b)(6) failed to follow lab protocol, notify the supervisor in a timely manner, review the manifest log,[4] or check the viability of, and process the lab specimens. Leadership failed to respond appropriately when notified of the issue over the weekend, and delayed ordering new labels for re-collected specimens until February 23. Failure to order new labels for the specimens caused further confusion when the MOPC staff re-labeled the new specimens with the previously used labels from February 19. In addition, the AIB stated that staff did not take the initiative or feel empowered to act without guidance. AIB recommended that:

- Leadership training be provided for lab supervisors.
- Team building for lab staff be done.
- A binder of lab policies and procedures be available for staff use.
- An evening and weekend on-call roster for supervisors be implemented.
- Administrative actions be taken for lab supervisors and a staff member.

[2] Root Cause Analysis is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls.
[3] An AIB is a mechanism for review of patient and/or employee related incidents to collect information, formulate conclusions, and make recommendations for corrective action.
[4] A list of patients to validate the specimens transported to the lab for processing.

We found (b)(3):38 U.S.C. 5705 and AIB were thorough and (b)(3):38 U.S.C. 5705 were reasonable. (b)(3):38 U.S.C. 5705 and the AIB, the facility implemented corrective actions to: prevent recurrence of inappropriate transport and receipt of lab specimens; provide staff education; and correct management and personnel issues within Laboratory Services. Therefore, we consider that this matter be closed without further investigation or issuance of a formal report.

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