Eliminating Specimen Labeling Errors in Post Anesthesia Care Unit (PACU)-Phase II
Lini Thomas RN MSN CCRN & Joey Yap RN BSN CPAN
Cedars-Sinai Medical Center, Los Angeles, California

Introduction
Inaccurately identified specimens can result in critical patient safety issues through delayed or wrong diagnoses, missed or incorrect treatments, blood transfusion errors, and the need for additional laboratory testing.

Background
A study at our organization identified multiple pathways in ordering tests, and lack of process uniformity in specimen labeling, which contributed to mislabeled specimens in peri-operative areas (Seferian et al., 2014). A pilot study in 7 & 8 PACU using a standardized process reduced specimen labeling errors from five in FY15 to one in FY16.

Quality Question
Does implementation of the ‘standardized specimen collection’ process from the pilot study eliminate specimen labeling errors in other PACUs?

Methods-PDSA

Plan
The simplified visual guide "STOP & CHECK" was introduced to the evidence-based practice (EBP) committee members. A standardized method was encouraged using the CS link label printer and discouraged the use of downtime forms. The nurses were instructed to perform a ‘final check’ at the bedside, verbalizing two identifiers (name & medical record number) with a second nurse before sending the specimen to the lab.

Do
The EBP committee members educated all PACU nurses, and the nurses completed a knowledge-skills-assessment tool on the standardized specimen labeling procedure.

Study
Specimen labeling errors were monitored for all PACUs from July 2016 to present.

Act
No mislabeled specimen events occurred for 17 months after project implementation in 2015. One specimen labeling error occurred in February 2017. The event occurred when Pre-Op RN and OR RN, working together, placed the wrong labels and failed to do the ‘final check’ while attempting to expedite the pre-op process.

Results

Conclusion
Standardization of specimen collection process reduces confusion among nurses during specimen collection. Since pre-op, PACU, and OR collaborate closely in the peri-operative areas, the standardized process needs to be disseminated to include OR RNs to prevent future mislabeling events in pre-op.

Implications
Standardized specimen collection process is an effective method to decrease mislabeling events. The process can be adopted by other areas who have mislabeling events.

Future Plans
The annual competency for staff will be continued to reinforce the standardized procedure. The project will be presented to OR RNs in the SCORE council and education provided on the standardized process.

Limitations
Standardized specimen collection process is an effective method to decrease mislabeling events. The process can be adopted by other areas who have mislabeling events.

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Reference

Magnet Model Components: New Knowledge, Innovations & Improvements
Professional Practice Model: Evidence-Driven Practice