ELIMINATING SPECIMEN LABELING ERRORS IN POST ANESTHESIA CARE UNIT (PACU)

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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.

Identification of the problem: In a study conducted at our organization, all clinical areas achieved a significant decrease in mislabeled specimens except perioperative areas and labor and delivery which was attributed to multiple pathways in test ordering and lack of process uniformity in specimen labeling (Seferian et.al, 2014). A root cause analysis (RCA) done on five labeling errors in PACU for the fiscal year 2015 showed all cases used a downtime form with wrong patient labels.

Purpose of the Study: The purpose of the study was to understand if the implementation of a standardized process reduces or eliminates specimen labeling errors in PACU.

Methodology: PDSA (Plan, Do, Study, Act). A simplified visual guide "STOP & CHECK" was formulated. A standardized method was encouraged using the electronic 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. The project was piloted in two PACUs where mislabeling events happened. One on one education was given to all the nurses and compliance monitored through direct observation. The specimen labeling errors were tracked from the launch of the project in April 2015 to February 2017.

Results: One specimen error occurred in August 2015 after the launch of the project. An RCA confirmed deviation in the process when the nurse used a downtime form as the lab label printer was not readily available in the pre-op area. A dedicated lab label printer was installed in the area, and no mislabeling event has occurred since then. The mislabeling events for PACU has remained zero for 18 months.

Discussion: Standardization of specimen collection process reduces confusion among nurses during specimen collection.

Conclusion: Zero specimen labeling errors occurred with the use of the standardized process. An annual competency for staff will be conducted and the standardized procedure will be reinforced by the authors.

Implications for perianesthesia nurses and future research: The success of the project has encouraged the authors to standardize the specimen labeling process in other PACUs. The project has been disseminated to other PACUs with the aid of unit practice council.