



Eliminating Specimen Labeling Errors in Post Anesthesia Care Unit (PACU)-Phase II

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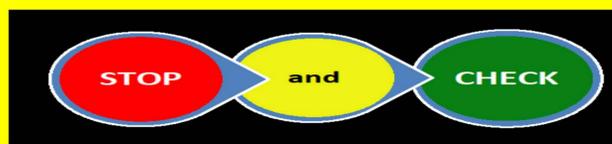


Introduction

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.

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.



ZERO MISLABELED SPECIMENS IN PACU STOP!!!

- ✓ Check MD's orders in CS link **and** print label
- ✓ Check printed label **against** patient's name band
- ✓ Collect specimen
- ✓ Second RN checks Primary RN's
 - specimen label
 - patient's name band **and** MRN
- ✓ IF Downtime Form needed . . . Do steps above **and**
 - Second RN **and** Primary RN check
 - patient's name **and** MRN
 - **against** downtime form

Acknowledgements

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Reference

Seferian, E.G., Jamal, S., Clark, K., Cirricione, M., Burnes-Bolton, L., Amin, M., & Klapper, E. (2014). A multidisciplinary, multifaceted improvement initiative to eliminate mislabeled laboratory specimens at a large tertiary care hospital. *BMJ Quality & Safety*, 23(8), 690-697. doi:10.1136/bmjqs-2014-003005

Key words-mislabeled specimens, specimen labeling

Quality Question

Does implementation of the 'standardized specimen collection' process from the pilot study eliminate specimen labeling errors in other PACUs?

Methods-PDSA

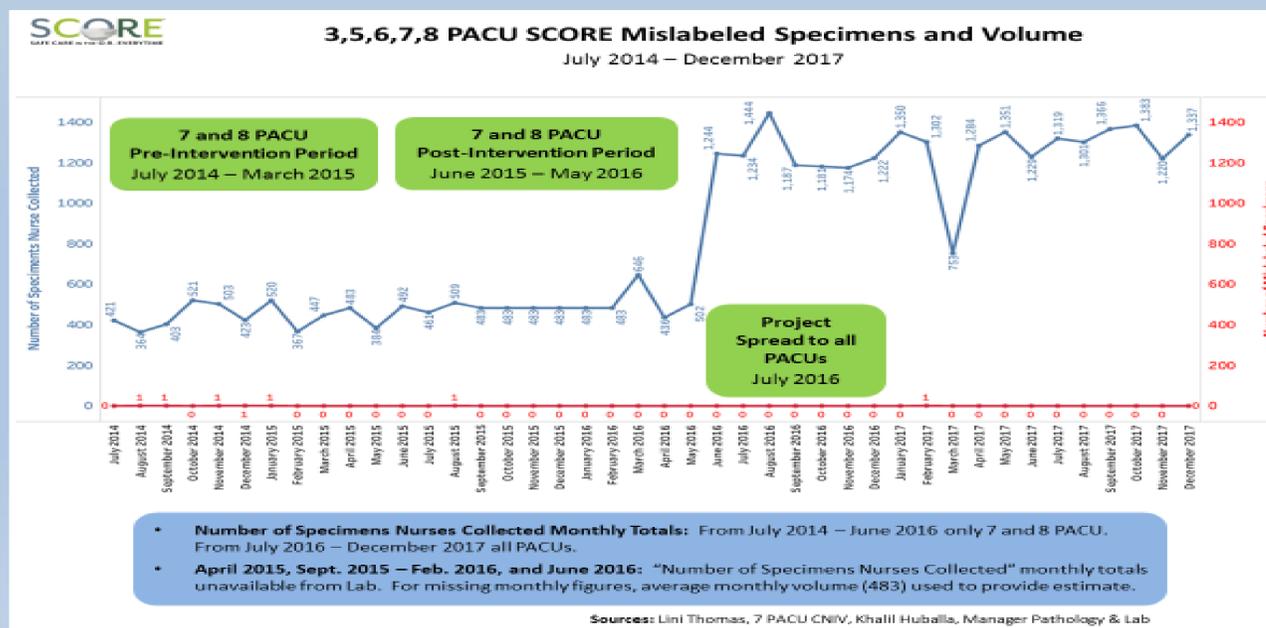
Plan-The simplified visual guide "STOP & CHECK" was introduced to the evidence-based practice (EBP) committee members. A standardized method was encouraged using the CS link label printer and discouraged the use of downtime forms. The nurses were instructed to perform a 'final check' at the bedside, 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.

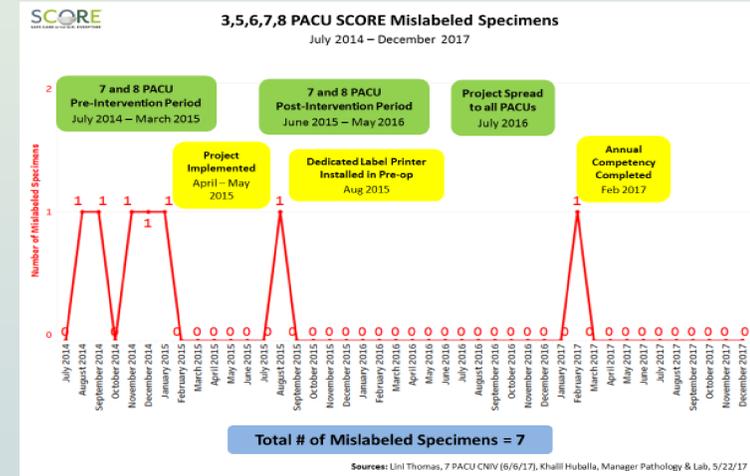
Study- Specimen labeling errors were monitored for all PACUs from July 2016 to present.

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



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



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

To ensure results are sustainable, the mislabeled specimens data needs to be monitored for longer period. The 'final check' with a second nurse at bedside may not be feasible in some areas like OR and ICUs with high volume of specimens.