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Patient's Excluded from Self-Identification of Lab Errors

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BACKGROUND

- Hospital wide increase of mislabeled specimens, labeled with another patients label.
- Potentially life threatening, causing harm or even death to patients.
- LVH- CC-M Total Mislabeled Specimen (M4) from January 2018-Septemeber 2018=91

PICO

- P- Patients that are excluded from the selfidentification lab label protocol
- I- Dual verification with Epic Work list and wrist band
- C- Compared to only wrist band verification
- O- number of mislabeled specimens, labeled with another patient's label

EVIDENCE

- "STOP & CHECK" PACU members check blood specimen using name and medical record number with second nurse before sending it to the lab. Outcome: No specimen errors were found using standardize method of care.
- Two patient identifier with use of automated system to decrease the potential for identification errors.
- Increase education and training of healthcare staff responsible for specimen collection.
- All identifying labels must be attached to specimen containers at the time of collection rather than at a later time. Misidentified specimens not only adversely impact patient care but also increase the cost of healthcare delivery. ID errors can have serious consequences for patients, including missed or delayed diagnosis; incorrect or unnecessary treatment; patient injury; and severe transfusion reactions

OUTCOMES

 The amount of specimens mislabeled with the wrong patient label was zero for the months of June, 2019 and July, 2019 on units 6C, 6B, and 5K which is a decrease from FY 18.

FY 18	Events
January	14
February	16
March	9
April	9
May	8
June	7
July	12
August	8
September	8
Total	91

IMPLEMENTATON

- April 16th: Identify PICO Question
- April 16th- May 15th: Create education for TLC
- End of May: Attend trial unit staff meetings
- June 7th: Disseminate education via TLC
- June 17th: Trial begins
- July 17th: Trial ends
- July 17th- August: Analyze trial outcome data
- August 12th: Finalize presentation

NEXT STEPS

 More data should continue to be collected to identify if the policy needs to be changed in the future.

REFERENCES:

•Thomas, L., & Yap, J. (2018). Eliminating Specimen Labeling Errors in Post-Anesthesia Care Unit (PACU). Journal of Perianesthesia Nursing, 2018-08-01, Volume 33, Issue 4, Pages e31- e32

•Abdellatif, A., Barajas, J., Ruelas Cohen, E., Cousins, M., Denham, D... (2007) Joint Commission Journal on Quality and Patient Safety, Volume 33, Issue 7, 434 – 437. Retrieved from

https://www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf

•J Appl Lab Med . (2017) Effectiveness of Laboratory Practices to Reducing Patient Misidentification Due to Specimen Labeling Errors at the Time of Specimen Collection in Healthcare Settings, 2(2): 244–258. doi:10.1373/jalm.2017.023762.

•NingH-C,LinC-N,ChiuDT-Y,ChangY-T, WenC-N,PengSY,etal.(2016) Reduction in Hospital-WideClinicalLaboratorySpecimen IdentificationErrorsfollowingProcessInterventions: A10-YearRetrospectiveObservationalStudy.PLoS ONE11(8):e0160821.doi:10.1371/journal.pone.0160821

