

# DESTINATION: REDUCING SPECIMEN LABELING ERRORS

## Our Journey to Improve Patient Safety at Pella Regional Health Center

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### OBJECTIVE

The purpose of this project was to improve patient safety and satisfaction by accurately labeling specimens in accordance with national patient safety goals. In 2022, PRHC had 70 mislabeled or unlabeled specimens arrive at the Main Lab for processing. The goal of this project was to reduce the number of mis/unlabeled specimens by 50% or no more than 35 in 2023.

### ANALYSIS

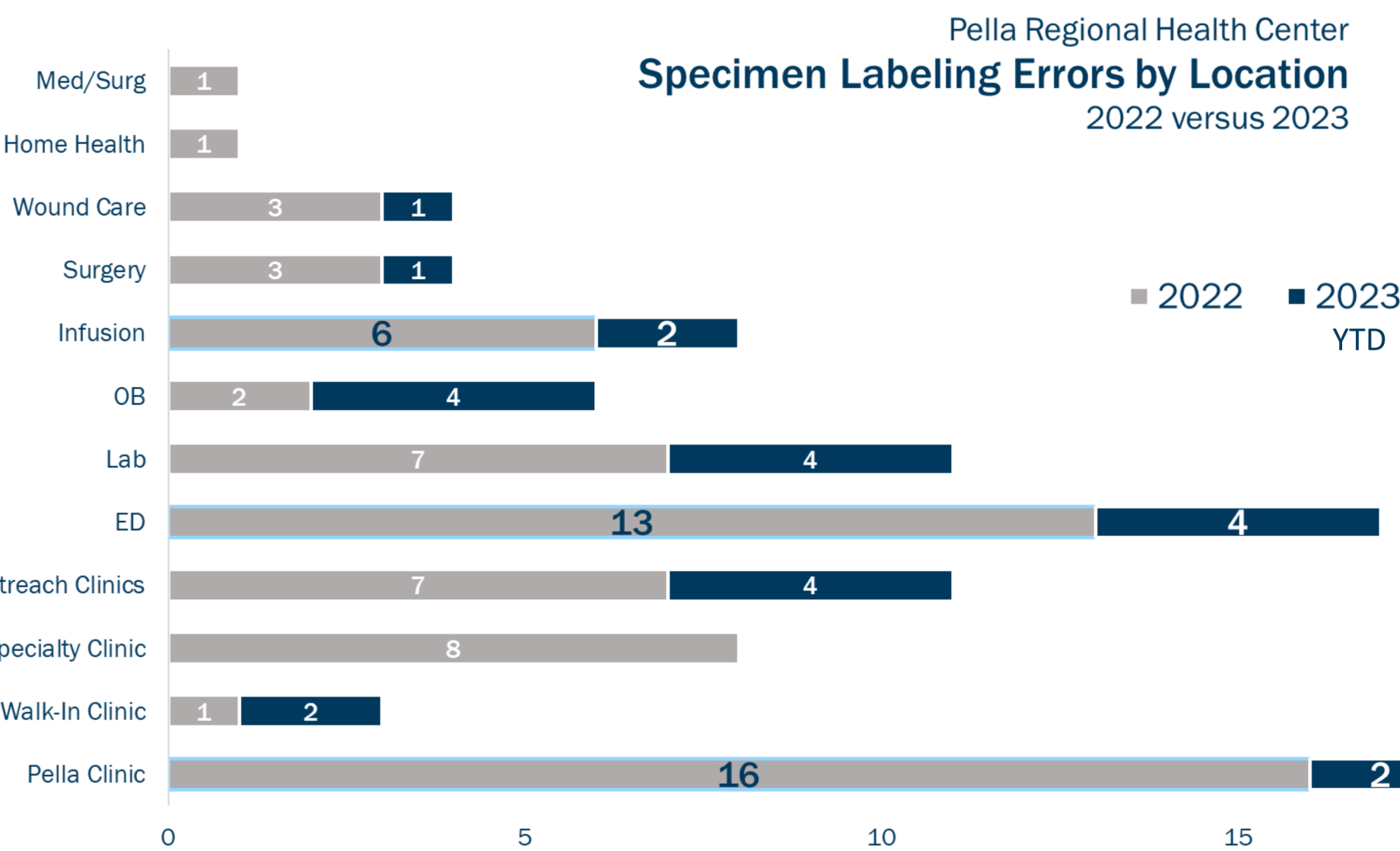
- A multi-disciplinary subcommittee evaluated our current processes and policies and identified four different areas of opportunity:
- Emergency Dept.: Lab labels had multiple originating sources resulting in overlapping sets of labels, which could cause confusion
  - Clinics: Staff did not have access to labels generated from our EHR system for send-out specimen testing
  - Infusion Dept.: Multiple sources of order input locations from inpatients, outpatient clinics and external providers caused layers of processes to become inefficient and discordant
  - Current Policy: PRHC's current policy states "all specimens are to be labeled in the presence of the patient with a label that has been verified by two patient identifiers"; analysis of specimen labeling errors showed that errors were occurring when specimens were being labeled at the nurse's station or desk and often resulted in missing labels when the specimens arrived at the lab for testing.

### ACTIONS TAKEN

- Emergency Dept.: A blank label was inserted between sets of patient labels to create a visual barrier between the sets of labels
- Clinics: IT modified our current label printers to create an Ambulatory Patient Label that included all patient identifiers and could be printed at any time from the EHR.
- Infusion Dept.: Org. Exc., Lab and Infusion leaders are working on a new process for lab order entry that will increase communication between the departments for more efficiency and safety for our high risk patients
- Current Policy: Leaders in all departments have been completing Specimen Labeling Audits to increase adherence to policy. Staff-requested visual reminders have been displayed where staff retrieve the specimen collection supplies to remind them to collect their patient labels before collecting their specimens
- Continuous Monitoring & Reporting: Current data from safety reporting of specimen labeling errors has been distributed to department leaders
- Staff Ideas: Additional visual reminders at locations of both the specimen collection supplies and collected specimen drop-offs to have labels on specimens at correct times

### BACKGROUND

In quarter three of 2022, the Organizational Excellence team identified an increasing trend of safety reports for specimen labeling errors being submitted into Pella Regional's (PRHC) electronic reporting system, KaiNexus. Based on that trend, PRHC included reducing specimen labeling errors in the organization's Quality and Process Improvement (QAPI) plan for 2023 as an opportunity for improvement and to increase our compliance with national patient safety goals.



### NEXT STEPS

- Finalize the standard work for improving the Infusion order entry process, followed by training and implementation.
- Reassess and update our new hire training and on-boarding education to include the proper way to follow our policy for specimen labeling.
- Ensure that the education included in our yearly nursing competencies is current with our policy.
- Meet in the fourth quarter for follow-up and resolution of project, with the option of meeting sooner if trends or occurrences warrant the need.
- Continued surveillance and monitoring of errors with expanded evaluation of circumstances by Org. Excellence through the end of 2024.
- Finalize and distribute "Best Dressed Tubes" flyers to enhance education surrounding proper label placement on blood tubes for Lab Department.

