

Preventing Lab Label Errors

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Published In/Presented At

Cook, A., & Murray, E. (2016, July 20). *Preventing Lab Label Errors*. Poster presented at LVHN Vizient/AACN Nurse Residency Program Graduation, Lehigh Valley Health Network, Allentown, PA.

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BACKGROUND / INTRODUCTION

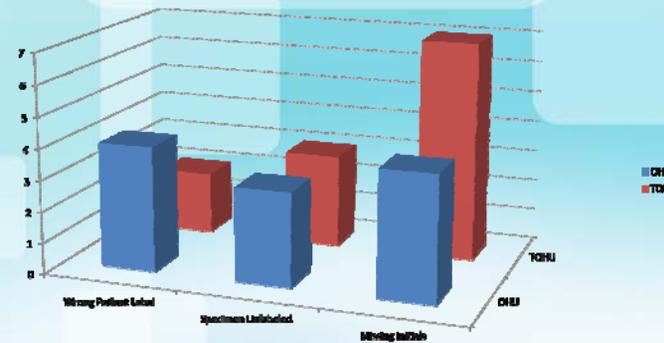
- Lab labeling errors throughout the network has become an issue that has compromised patient safety and overall patient satisfaction.
- Newer methods are being introduced to help reduce these errors, improving patient care and quality.
- With proper patient identification, a reduction in supplies, patient emotional strain, and employee frustration can help cut costs, improve network reliability, and promote timely and effective care.

METHODS

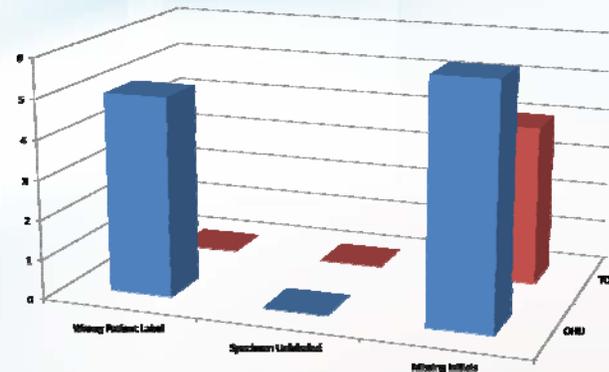
- Adding the patient's medical record number as a third patient identifier to confirm identity.
- Placing a yellow highlight mark on the lab label to signify the collectors initials location.
- Removing lab label books at nursing stations and placing label holders in the designated patient rooms.
- Initiating a double check in emergency situations.
- Dissemination of the new process regarding specimen collection and labeling through TLC for the employees involved.

OUTCOMES

Pre-Intervention



Post-Intervention



RESULTS

- From the data collection and analysis, pre-intervention (July 1st 2015 – January 3rd 2016) and post-intervention (January 4th 2016- June 1st 2016) both units showed various increases and decreases in the three types of errors outlined.
- While TOHU, a step down unit, showed marked improvement, CHU, an ICU unit showed worsening in the amount of errors.

CONCLUSIONS

- As a result of this study there is still much to be done concerning patient safety when it comes to specimen collection and identification.
- Revisiting the idea for the use of technology, specifically, bar code scanning of specimen labels may be the next step to improving patient care and satisfaction, all while reducing the cost of reprinted labels, specimen collection supplies, and the reagents and processes used to run duplicate tests.
- A cost benefit analysis, literature, and multiple studies will be needed to help support such claims.

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