It's 3am, "Excuse me Sir, Is this you?"

Cinthia Batista BSN, RN
Lehigh Valley Health Network, Cinthia.Batista@lvhn.org

Ismaela Cholula Lopez BSN, RN
Lehigh Valley Health Network, Ismaela_Y.CholulaLopez@lvhn.org

Jenna Marburger BSN, RN
Lehigh Valley Health Network, Jenna.Marburger@lvhn.org

Amber Trexler BSN, RN

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It’s 3am, “Excuse me Sir, Is this you?”

Cinthia Batista, BSN, RN; Ismaela Cholula Lopez, BSN, RN; Jenna Marburger, BSN, RN; Amber Trexler, BSN, RN

Lehigh Valley Health Network, Allentown, Pennsylvania

Significance/Background

- Hospital wide increase in mislabeled specimens, labeled with another patients label
- Potentially causing harm or even death to a patient(s).

LVH – CC/M Total Mislabeled Specimens (M4) FY ‘18 through April = 78

FY18	Events
July	9
August	5
September	8
October	10
November	10
December	4
January	4
February	16
March	6
April	6

PICO

For registered nurses and technical partners, would patient self verification of lab label compared to current practice increase registered nurses and technical partners recognition of patient misidentification prior to phlebotomy?

Evidence

- Encourage patients to be active participants in identification by verifying identification information to confirm that it is correct (World Health Organization, 2007).
- Misidentifying the patient can lead to harm or unnecessary treatments. (Lippi, G., Chiozza, L., Mattiuzzi, C., Phebani, M., 2017)
- Barriers to correctly labeling- workload and time spent with each patient. Many errors are not caught until after the blood is drawn (Lippi, G., Chiozza, L., Mattiuzzi, C., Phebani, M., 2017)

Implementation/Education

- Patient Inclusion/Exclusion criteria
  - Inclusion criteria - adult alert and oriented patient, who can see the label or have a visual aid that would allow them to see it, hearing intact.
  - Exclusion criteria - disorientation, blindness or vision impairment without aids, sedation, deaf.
- Pre/Post survey – “In the last 2 weeks, how many times did you identify that you had taken the wrong lab label into a patient’s room?”
- All registered nurses and technical partners educated on process at safety huddles and via email notification.
- Process instructions posted throughout unit as visual reminder.

PROCESS INSTRUCTIONS

1. Gather patient labels for specific room staff is entering and phlebotomy supplies.
2. Gloves are to be used for phlebotomy procedures.
3. The RN/TP is responsible to assure quality collection with the use of labels including:
4. Patient's identification using 2 patient identifiers prior to any blood draws.
5. Name and date of birth are the primary identifiers used: confirm identification on arm band and EPIC.
6. **RN/TP will hand labels to patient who meets criteria (Alert and oriented, non-sedated, vision and hearing intact), to self-verify that you have the correct patient.**
7. **Patient will then (√) the lab label.**
8. Draw lab specimen
9. Label lab specimen with RN/TP initials that physically collected lab. Re-time label, confirm correct date is on label; the specimen is to be labeled at the patient bedside
10. Place specimen in bag, confirm lab does not have special guidelines for sending to lab (i.e. send on ICE)
11. Send to lab via tube system

Results

Unit	Pre-Survey	Post-Survey
6K	Total of 21 responses 20 responded: “Zero mistakes” 1 responded: “One mistake”	Total of 13 responses 12 responded: “Zero mistakes” 1 responded: “One mistake”
6C	Total of 19 responses 17 responded: “Zero mistakes” 2 responded: “One mistake”	Total of 7 responses 6 responded: “Zero mistakes” 1 responded: “One mistake”
6B	Total of 11 responses 11 responded: “Zero mistakes”	Total of 3 responses 3 responded: “Zero mistakes”

Conclusion

- Patient self verification of lab label identified a potential for a lab error two times during 2 week pilot.
- Implementation of new process should be continued over a longer period of time to see benefits.

REFERENCES

1. World Health Organization. (2007). Patient Safety Solutions, Patient Identification.
2. Lippi, G., Chiozza, L., Mattiuzzi, C., Phebani, M. (2017). Patient and sample identification. Out of the maze?, *Journal of Medical Biochemistry, 36*(2):https://doi.org/10.1515/jomb-2017-0003