Lehigh Valley Health Network

LVHN Scholarly Works

Identifying the Cause of Lab Errors (M4's)

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Identifying the Cause of Lab Errors (M4's)

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BACKGROUND

- Network wide increase in mislabeling during first quarter FY18.
- Providing safe quality care and making Sure our patients are not mistreated off of false results.
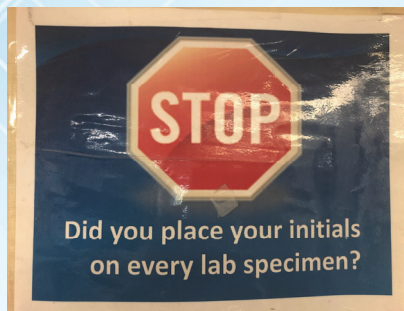- Through review of m4's if there is a commonality found, raise awareness.

P I C O

- P: ER Registered Nurses & Technical Partners
- I: Education (TLC Power Point)
- C: Yearly education
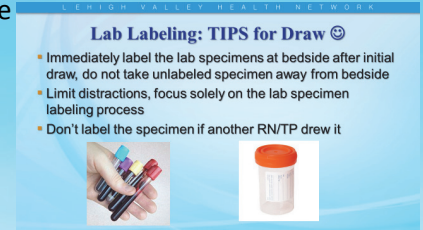- O: Decrease lab errors and missed intials

EVIDENCE

- One ED reduced major mislabeling events from 47% to 14%.Receive weekly updates on errors that occur so you can review them with staff while their memories are fresh.
- Of the 20,00345 specimens collected 1,023 were identified as having patient identification errors, compared with 58 errors among 37,61238 specimens collected, after serial interventions; this represents a 97% relative reduction
- Based on the evidence included in this review, the interventions that enhance the communication and collaboration between laboratory and healthcare professionals can decrease the specimen identification errors in healthcare settings.

OUTCOMES

- TLC completion:
  - 17th st- 86%
  - Muhlenberg- 74%
- M4 Occurrences:
  - 17th st-0
  - Muhlenberg- 0
- Missed initials:
  - 17th st- 0
  - Muhlenberg-3
- Overall education (TLC) is likely to decrease occurrence of M4's, however education did not affect occurrence of missed initials. Follow through study would be beneficial to gage if education helps over longer period of time.

IMPLEMENTATION

- Education Education Education
- TLC module

Lab Labeling: TIPS for Draw ☺

- Immediately label the lab specimens at bedside after initial draw, do not take unlabeled specimen away from bedside
- Limit distractions, focus solely on the lab specimen labeling process
- Don't label the specimen if another RN/TP drew it

- Barrier: could have used longer data collection time. Also, did not achieve 100% completion of TLC

NEXT STEPS

- Ongoing follow through with education and tracking errors even in ongoing FY's .
- Continue with more than just yearly education.

REFERENCES

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2. Level 1- Sandhu, P (+6 others), Effectiveness of Laboratory Practices to Reducing Patient Misidentification, J Appl Lab Med. 2017 Sep;

3. Level 3- Hsiao-Chen Ning, (+8 others) Reduction in Hospital-Wide Clinical Laboratory Specimen Identification Errors following Process Interventions: A 10-Year Retrospective Observational Study PLos One, 2016

Did you place your initials on every lab specimen?

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