Stop & Check: Reducing Specimen Labeling Errors

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BACKGROUND

- Increased rate of preanalytical lab errors made by RN & TP on RHCM.
- Majority of errors involve identifying, labeling, and specimen handling.
- Specimen labeling errors threaten patient safety, are costly, and negatively effect patient satisfaction.
- Opportunity to create interventions that prevent lab errors and increase patient safety.

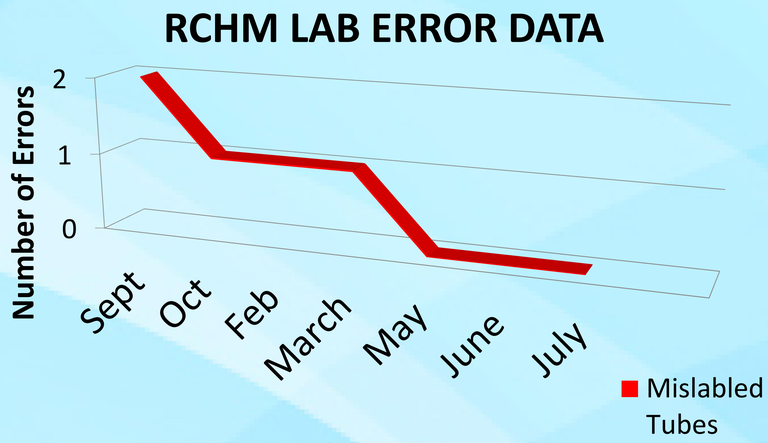
P I C O

- **P RNs & TPs who obtain labs on RHCM.**
- **I Visual prompts at tube stations (stop & check).**
- **C Current practice vs. visual prompts.**
- **O Preanalytical lab errors, increased patient safety and satisfaction.**

EVIDENCE

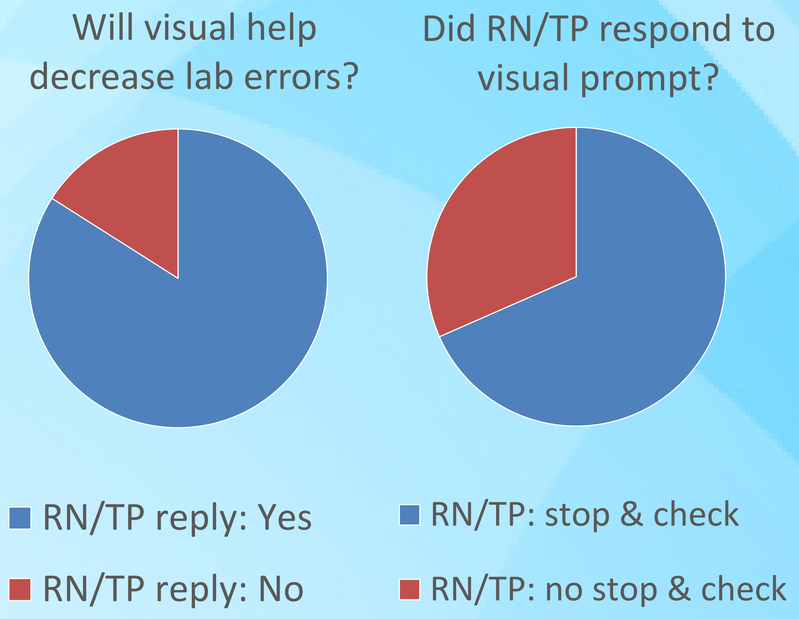
- Pre-analytical errors account for up to 70% of all mistakes made in laboratory diagnostics (Plebani & Carro, 1997).
- Mislabeled laboratory specimens can result in adverse patient outcomes (Wagar et al., 2006).
- Process-driven patient identification/specimen labeling protocols, including a low-cost crucial double check, reduces the frequency of specimen labeling incidents (Kim et al., 2013).
- The double check process reinforces a culture of safety in which processes improve and errors decrease (Kim et al., 2013).

OUTCOMES



Data reflects decrease in mislabeled lab specimens since April 2019

Survey results



IMPLEMENTATON

- Obtain lab error data from previous two quarters pre implementation.
- Survey RNs & TPs regarding perception of lab errors and if they thought a stop & check intervention would help reduce lab errors.
- April 2019 – Place large stop signs at tube stations.
- Post interventions (4-8 weeks later), obtain lab error data and compare.
- Resurvey RN/TP to evaluate if stop & check intervention created an opportunity to double check accuracy of laboratory specimens.

NEXT STEPS

- Educate staff on lab collection policies & procedures.
- Change signage quarterly to increase noticeability.
- Encourage collaborative efforts to reduce lab errors.
- Maintain culture of safety.

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