Solution: Keeping Patients Safe: Reducing Mislabeled and Unlabeled Laboratory Specimens

Organization: Sinai Hospital of Baltimore

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IDENTIFICATION:
Mislabeled and unlabeled specimens are a patient safety concern. These errors can place the patient at risk for receiving interventions that are not appropriate (mislabeled specimen) or delay treatment (unlabeled specimen). In 2004, Sinai Hospital of Baltimore had four hundred ninety-nine (499) mislabeled/unlabeled specimens reach the laboratory. The problem was identified through communication between the laboratory and patient care services. Since that year, Sinai Hospital has focused on this issue in an attempt to eliminate these problems.

PROCESS:
Collaboration with Patient Care Services, Laboratory Services, and Information Services (IS) was critical for identifying an innovative solution to this problem. Using the Plan-Do-Study-Act model, an Advanced Practice Nurse (Clinical Nurse Specialist) led an interdisciplinary team to assess the current system and develop innovative recommendations for improvement. The team consisted of point-of-service employees (bedside nurses), Nurse Managers, laboratory and IS leaders.

SOLUTION:
A comprehensive plan was developed and implemented in December 2004 to decrease the number of mislabeled/unlabeled specimens. The plan included a redesign of the laboratory label for specimens, a two-person verification of the labeled specimen against the patient’s wristband at the bedside. In addition, development of a required computer-based education module for all staff; a comprehensive communication plan to all nurses and physicians within the organization; and most recently in 2007, the implementation of a progressive disciplinary process for individuals who make multiple errors.

Results show a 50% (251 total errors) decrease in specimen errors in 2005 and an additional 35% (151 total errors) decrease in 2007 indicating that the strategies that were implemented have been successful in reducing the total number of mislabeled and unlabeled specimens.

The task force meets monthly to review all data related to specimen errors and to identify additional opportunities for improving the process and outcomes. The monthly mislabeled and unlabeled specimen numbers are disseminated to staff, unit managers, directors, advanced practice nurses, and the chief nursing officer.
Even though we have not met the desired outcome of zero mislabeled and unlabeled specimens, we have made a significant improvement in patient safety while instilling accountability for patient safety in the staff.