2011 Military Health System Conference

Labeling of Patient Specimens

The Quadruple Aim: Working Together, Achieving Success
Ms. Sandra Clark
26 January
## Title and Subtitle
**Labeling of Patient Specimens**

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## Abstract
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- **a. Report**: unclassified
- **b. Abstract**: unclassified
- **c. This Page**: unclassified

## Limitation of Abstract
Same as Report (SAR)

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Facility has identified an increase in number of patient lab specimens that are unlabeled, incorrectly labeled, or not ordered consistent with the specimens. These specimens have come from different clinics; 8 different value streams are in place with no standard work identified in the facility. **Trigger:** Decision to obtain specimen. **End Point:** Lab accepts specimen.
2. Break Down the Problem/Identify-OODA

Break Down the Problem

Performance Gaps:

1. The following specimen data was provided during the event.
   a. An average of 6000 specimens are obtained per month
   b. Incident labeling errors reported on 10-15 specimens per month (approx. 0.25% error rate)
3. Set Improvement Target -

**OOOA**

**Identify Target**

1. 100% of patient specimens are labeled correctly with a consistent order first time thru the implementation of a standardized process for label content, handling specimens and ordering in all section.
4. Determine Root Cause - OODA

Fishbone Diagram

Tech/Nurse
- Order/Label mismatch
- Specimen not labeled expeditiously
- Doesn’t prep room
- Multi tasked
- Attention to detail
- More spec. taken then scheduled/planned

Patient
- Don’t ID error
- Don’t know sponsor info.
- Don’t update data (records)
- Parent mixes up children data
- Patient unable to provide (sedated)
- Doesn’t divulge all info/need more than scheduled

Provider
- Leave without ordering
- Don’t comm. w/tech there is spec.
- Inconsistent handling of spec
- Multiple spec site in the container
- Patient unable to provide (sedated)

Sponsor
- Inconsistent labeling

Computer
- Don’t update DEERS
- Orders not always ordered in CHCS
- Limited print capability
- Patient doesn’t update DEERS

Training
- Goes down
- Orders not always ordered in CHCS

Uniform Standard
- Inconsistent training

Lab provides inconsistent guidance
- No standard requirements across all labs

Air Force Inspection Agency

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### Action Plan

<table>
<thead>
<tr>
<th>Description</th>
<th>Type</th>
<th>OPR</th>
<th>ESD</th>
<th>ECD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop Standard Process to label specimens</td>
<td>JDI</td>
<td>Capt Alaniz</td>
<td>14 May 09</td>
<td>14 May 09</td>
</tr>
<tr>
<td>Lab and Path processes (support staff - double check order before sent to lab, only handle specimens assigned, ask patient for name, DOB, last 4 SSN, ensure specimens never leaves label and if moved it is labeled), All orders in system and all near misses and errors reported to patient safety</td>
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</tr>
<tr>
<td>Purchase/Install printers in each clinic to print labels</td>
<td>JDI</td>
<td>Capt Cutter</td>
<td>14 May 09</td>
<td>22 May 09 (proposal)</td>
</tr>
<tr>
<td>Research compatible printer, Cost, Time Frame</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Develop standard training for all clinics</td>
<td>JDI</td>
<td>SSgt Ally</td>
<td>15 May 09</td>
<td>29 May 09</td>
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<tr>
<td>Develop standard label content for all clinics</td>
<td>JDI</td>
<td>Mr Haynes</td>
<td>14 May 09</td>
<td>15 May 09</td>
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<tr>
<td>Develop Visual Management Sheets</td>
<td>JDI</td>
<td>SSgt Cole</td>
<td>14 May 09</td>
<td>19 May 09</td>
</tr>
<tr>
<td>For Providers, support staff (reminders)</td>
<td></td>
<td>SSgt Ellis</td>
<td></td>
<td></td>
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<td>Steps at computer for labeling (exit doors in clinics)</td>
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<tr>
<td>Develop labeling instruction for all Clinics</td>
<td>Project</td>
<td>SSgt Kim</td>
<td>15 May 09</td>
<td>5 June 09</td>
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<tr>
<td>Attachment to MDGI 44-10</td>
<td></td>
<td></td>
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<tr>
<td>Notify change to clinic orientation checklist</td>
<td></td>
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</tr>
<tr>
<td>Team members meet 1/4ly for feedback and review results</td>
<td>Ongoing</td>
<td>Maj Favero</td>
<td>14 Aug 09</td>
<td>Aug 10</td>
</tr>
<tr>
<td>Meeting 14 Aug 09, 1400 in lab break room</td>
<td></td>
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<tr>
<td>Develop TICK sheet to track near misses</td>
<td>JDI</td>
<td>Ms. Clark</td>
<td>15 May 09</td>
<td>19 May 09 (sheet)</td>
</tr>
<tr>
<td>Clinics will provide to PS 1st working day of month</td>
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<td></td>
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</tr>
</tbody>
</table>
6. See Countermeasures/Action Plan Through - Follow Through:

1. Team Members implement the following:
   a. Standardize labeling process, mistake proof at the source
   b. Standardize label content, automate with inkless printers once process is proven
   c. Place visual reminders for providers and support staff

2. Event countermeasures were presented/approved by the 10 MDG Executive Staff 21 May 2010

3. 15 July 2009 no change in results - new personnel not receiving training. Added to clinic unit orientation. Reported as completed to Executive Staff 28 Aug 09.
Tracking & Trending:

1. PS Manager will track and review specimen near miss/incident report monthly.
   a. Email monthly summary to clinics for review and follow-up as needed.
8. Standardize Successful Processes - OODA

**Standardization:**

1. Rewrote MDGI ECD post-sustainment
2. Updated event into CPI-MT as results available
3. Contacted SAF/SO for AF integration of countermeasure result w/ significant improvement

**Lessons learned:**

1. Need for active patient involvement - assure accuracy of their information: Patients are KEY!
2. Standardized work is essential: Visual Cues
Visual Cue #1  In Exam Rooms

SPECIMEN COLLECTION & LABELING
Visual Reminder

- ACTIVE QUESTIONING USED?
  (Ask the PT to state name, DOB, & sponsor’s last four)

- STANDARD LABEL COMPLETED AND INITIALED?
  (Staff member and PT verify label * & initial)

- SPECIMEN COLLECTED AND IN CONTAINER?

- APPLY LABEL TO THE SPECIMEN CONTAINER
  (IN PATIENT’S PRESENCE WHEN POSSIBLE)

- SPECIMEN ORDER IN SYSTEM
  - Pathology in CHCS
  - Lab in either AHLTA or CHCS

- VERIFY LABEL ON SPECIMEN WITH ORDER IN SYSTEM*

- TAKE SPECIMEN TO PATHOLOGY/LAB

- NOTIFY PATHOLOGY/LAB OF ANY VARIANCES THAT CANNOT BE CHANGED

*CORRECT ANY ERRORS DOCUMENT FINDINGS ON TICK SHEET
Visual Cue #2  At Provider’s Desk

- Locate the slide containing the video and right click on it.
- Click on EDIT MOVIE OBJECT
- Click on the “SOUND VOLUME” button and adjust as necessary
- Click OK when finished

STOP
ARE ALL YOUR SPECIMENS ORDERED AND SIGNED??
ARE THOSE SPECIMENS ORDERED???

DO THOSE SPECIMEN LABELS MATCH THE ORDER???