

## **ELIMINATING SPECIMEN LABELING ERRORS IN POST-ANESTHESIA CARE UNIT (PACU)- PHASE II**

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**Introduction:** Inaccurately identified specimens can result in critical patient safety issues through delayed or wrong diagnoses, missed or incorrect treatments, blood transfusion errors, and the need for additional laboratory testing.

**Identification of the problem:** A study at CSMC identified multiple pathways in ordering tests, and lack of process uniformity in specimen labeling, which contributed to mislabeled specimens in peri-operative areas (Seferian et.al, 2014). A pilot study completed in 7 and 8 PACU using a standardized process reduced specimen labeling errors to one in FY16 from five in FY15.

**EP Question/Purpose:** Will implementation of the 'standardized specimen collection' process from the pilot study eliminate specimen labeling errors in other PACUs?

**Method/Evidence:** Plan-The simplified visual guide called "STOP & CHECK" formulated in the pilot study was introduced to the evidence-based practice (EBP) committee members of each PACU. A standardized method was encouraged using the CS link label printer and discouraged the use of downtime forms. The nurses were instructed to perform a final check at the bedside, verbalizing two identifiers (name & medical record number) with a second nurse before sending the specimen to the lab. Do-The EBP committee members provided education to all PACU nurses, and the nurses completed a knowledge-skills-assessment tool on the standardized specimen labeling procedure. Study- Specimen labeling errors were monitored for all PACUs from July 2016 to present. Act- No specimen labeling errors have been reported since the project implementation in all PACUs and has remained zero for the last 18 months.

**Significance of Findings/Outcomes:** No specimen labeling errors occurred when the standardized specimen labeling procedure was followed.

**Implications for perianesthesia nurses and future research:** Standardization of specimen collection process reduces confusion among nurses during specimen collection. The annual competency for staff will be continued to reinforce the standardized procedure. The authors will continue to monitor the mislabeled specimens to ensure that the results are sustainable.