The Problem
Over the course of 2 years 11/2011 to 11/2013 we noticed that the unit was having a consistent spike in specimens in our dirty lab being mislabeled/mismatched.

- Collected the data provided by the hospital on lab errors
- Changed standard practice and put a dual check system in starting November 2013 and collected data for 1 full year
- The project consisted of review of our practices i.e. collection of specimens in exam rooms and how specimen collection was done.
- The problem was tough on many areas, and had direct impact on patients who were called and asked to come back to leave another specimen/exam.
- The Quality of Care for patients was directly linked to an increase in patient satisfaction.

Aim/Goal
The goal for this initiative was to decrease our mislabeled and mismatched lab errors by 50%-75% in our first year of implementing our new protocol for specimen collection on the unit. We looked at both 11/2011-11/2012 and 11/2012-11/2013 lab error data. We looked at the causes of the errors and our standard process. We found that in the 11/12 data we had 42 total lab errors and 33 of those were mislabeled/mismatched. In the 12/13 data showed we had 59 total lab errors and 41 of those were mislabeled/mismatched. In this last year 13/14 after we implemented new process we had 34 total errors and only 11 were mislabeled/mismatched.

The Team
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The Interventions
- We looked and studied the data over 3 years.
- We looked at our busiest clinic days and found this was our spike in errors.
- Compared Data to other large units, Spoke directly to patients when they would have to return to clinic.
- November 2013 we implemented new process for the collection and bagging of specimens. We eliminated bagging in batches and 2 staff had to sign off.
- We have lab fax all requisitions directly to a Nurse or Ops Manager when an error occurs as well as daily spot checks in labs.

The Results/Progress to Date

Lessons Learned
During a project, unexpected opportunities and challenges arise that positively or negatively impact an improvement effort. In our transition from one individual processing specimens to having a mandatory second person check. We ran into some situations where different personal processes would cause confusion. So setting a standard for processing and labeling specimens had to also be implemented to make the new system work.

Next Steps/What Should Happen Next
- We will continue to improve on this and sustain a goal of no more than 10% lab errors consisting of mislabeled/mismatched specimens
- We would like to expand this process to our other units in OBGYN both in Boston and at our Off-Sites in Milton, Chelsea, Needham, Chestnut Hill, Lexington, and Bowdoin Street.
- While continued work on our current lab error we are working to set up a better process for getting all lab errors down.

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