2011 Military Health System Conference

Labeling of Patient Specimens

The Quadruple Aim: Working Together, Achieving Success

Ms. Sandra Clark

26 January

USAF Academy/10 MDG

Report Documentation Page

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Tools Page 1 of 2 View Options Close

Team Leader: Capt Cutter
Team Members: Mr. Cleland (FPC), SSgt Ally (AMDS), SSgt Kim (Derm), Ms. Clark (PS Manager), Capt Alaniz (OR), TSgt Bluemer (Int Med), SSgt Cole (WHC), SSgt Ellis (ACC), Mr Hayes (Histo/Cyto).
Facilitators: Mr Pyeatt, CMSgt Simmons Observers: Ms. Robbins & Col Ness, Ms. Woolley

USAFA
10MDG Specimen Labeling

Approval Signatures:
Process Owner: Major Favero
Champion: Col Ness
Event dates: 12-14 May 2009

1. Clarify & Validate the Problem

O O D A

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

O O D A

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)

Note: It was noted during the event that the actual number of near miss incidents reported monthly was low due to laboratory personnel performing rounds each morning to collect the laboratory specimens. When an error was found by the laboratory technician the specimen was left, reported to staff and not collected until after correction, delaying patient care and treatment.

3. Set Improvement Target

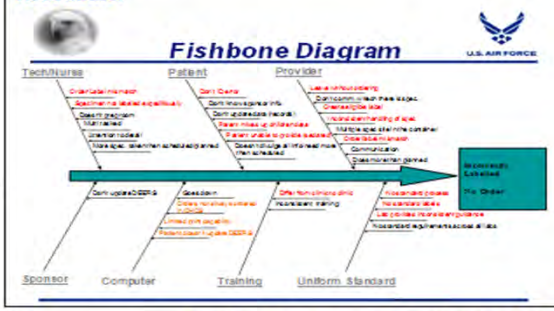
O O D A

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. Start Point: decision to obtain specimens. End Point: Properly labeled specimen accepted by the laboratory.

4. Determine Root Cause

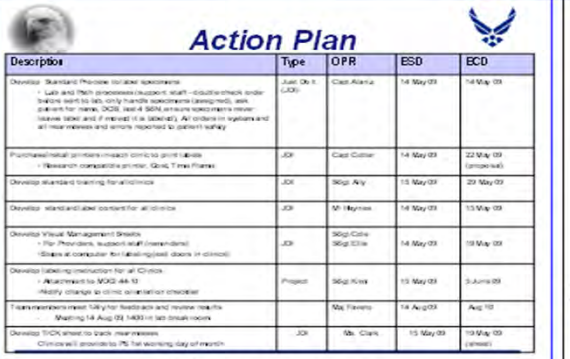
O O D A

Root Cause:



5. Develop Countermeasures/Action Plan

O O D A



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6. See Countermeasures/Action Plan Through

O O D A

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 and approved by the 10 MDG Executive Staff 21 May 2010.

3. CPI - 15 July 2009 no change in results -found new personnel were not receiving the training. All clinics added training to newcomers unit training. Reported as completed to Executive Staff 28 Aug 09.

7. Confirm Results & Process

O O D A

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.

a. Breakthrough goal achieved Oct 09. *Zero Defect Management in progress.
b. Found training of new staff not part of orientation-added to clinic orientation checklist
c. Learned signage not in appropriate areas post moves-clinics revisited & educated on need/purpose for visual cues
d. Confirmed inkless printers not working appropriately nor connected in all clinics-Systems contacted clinic NCOIC/OICs & placed/connected as appropriate
e. Provided retraining to all clinic POCs, confirmed staff knowledge of printers and rounded clinics to confirm placement of visual cues
f. Developed standardized label with Systems for use on all specimens, with room to hand print any unusual pertinent information.

8. Standardize Successful Processes

O O D A

1. Rewrote the MDGI ECD post-sustainment.
2. Logged event into CPI-MT update as results are available.
3. Contact SAF/SO for AF integration if countermeasure result if significant improvement occurs.

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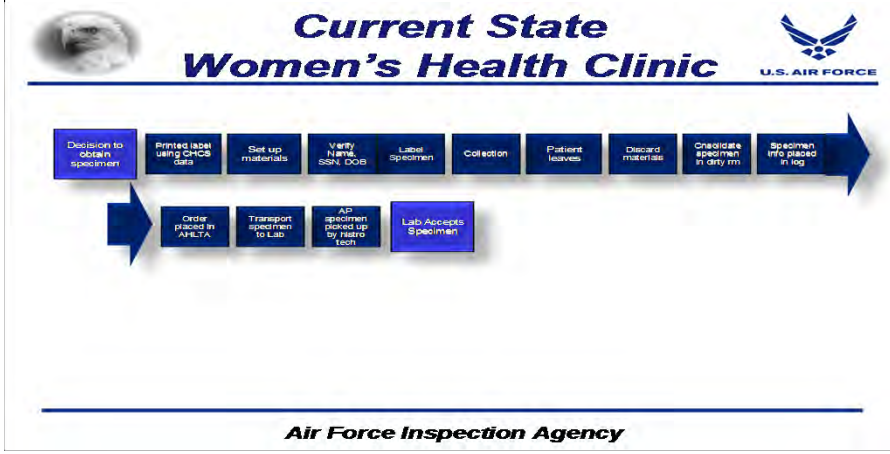
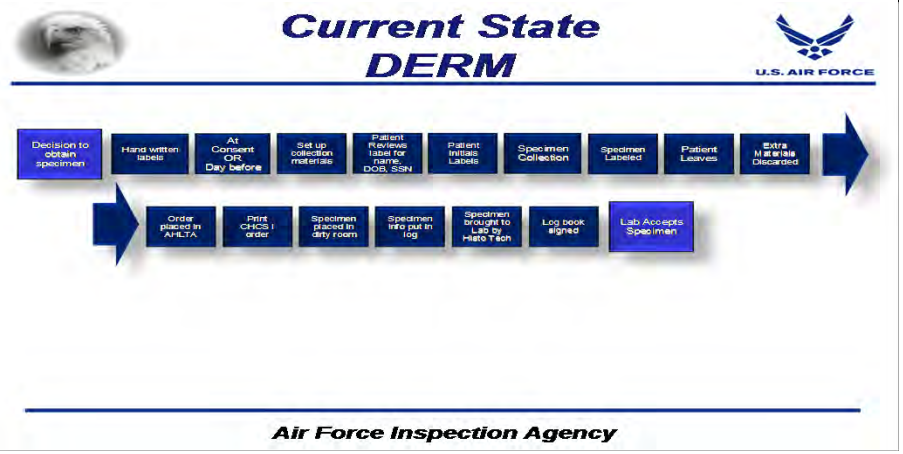
1. Clarify/Validate the Problem-

OODA

Assure all Understand Same Issues:

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:

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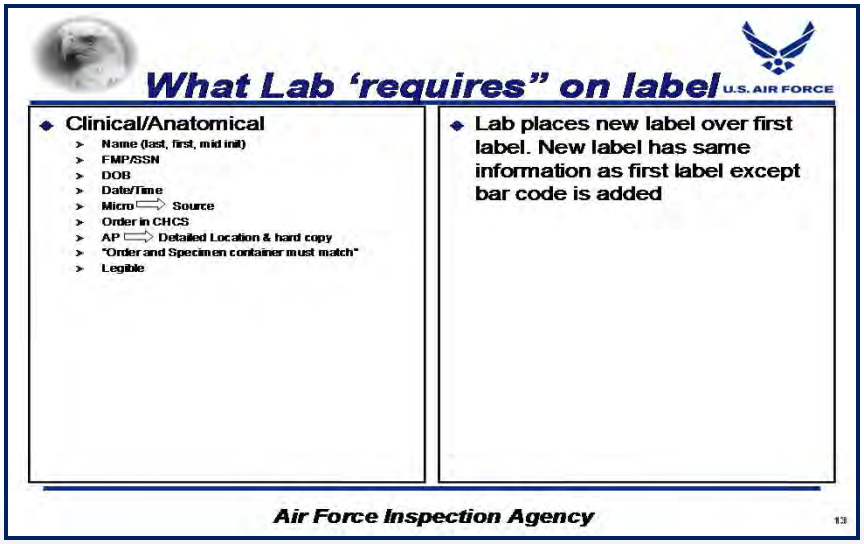
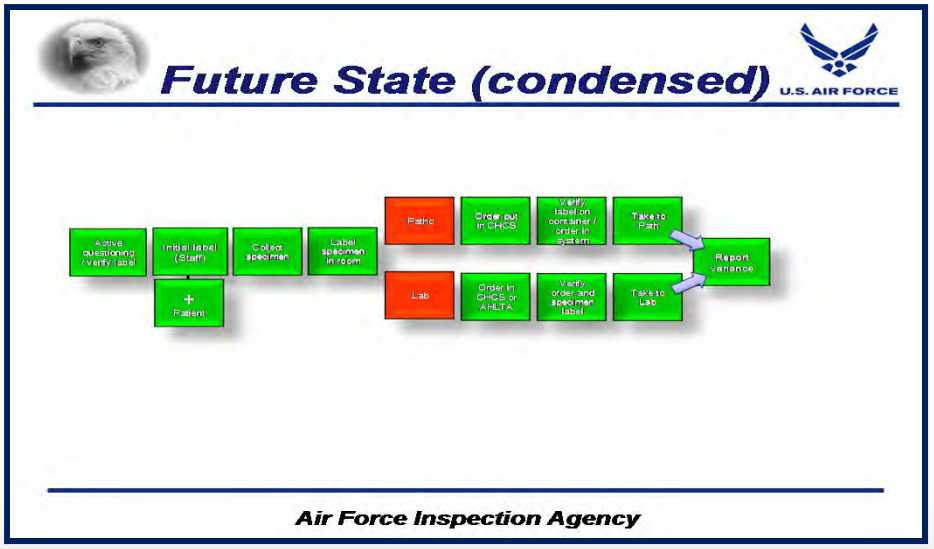
   b. Incident labeling errors reported on 10-15 specimens per month (approx. 0.25% error rate)

3. Set Improvement Target- OODA

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

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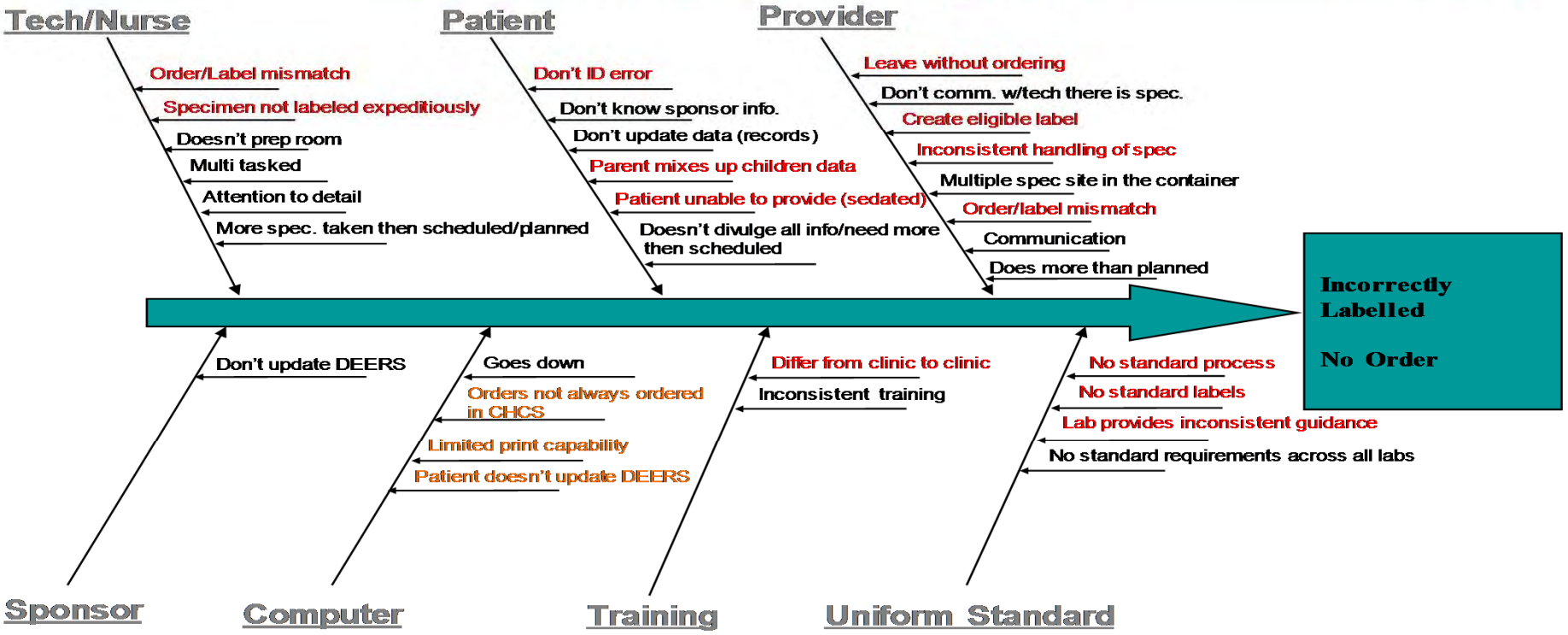
Fishbone Diagram



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5. Develop Countermeasures & Action Plans- OODA

Action Plan

Description	Type	OPR	ESD	ECD
Develop Standard Process to label specimens 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	Just Do It (JDI)	Capt Alaniz	14 May 09	14 May 09
Purchase/Install printers in each clinic to print labels Research compatible printer, Cost, Time Frame	JDI	Capt Cutter	14 May 09	22 May 09 (proposal)
Develop standard training for all clinics	JDI	SSgt Ally	15 May 09	29 May 09
Develop standard label content for all clinics	JDI	Mr Haynes	14 May 09	15 May 09
Develop Visual Management Sheets For Providers, support staff (reminders) Steps at computer for labeling (exit doors in clinics)	JDI	SSgt Cole SSgt Ellis	14 May 09	19 May 09
Develop labeling instruction for all Clinics Attachment to MDGI 44-10 Notify change to clinic orientation checklist	Project	SSgt Kim	15 May 09	5 June 09
Team members meet 1/4ly for feedback and review results Meeting 14 Aug 09, 1400 in lab break room	Ongoing thru out	Maj Favero	14 Aug 09	Aug 10
Develop TICK sheet to track near misses Clinics will provide to PS 1st working day of month	JDI	Ms. Clark	15 May 09	19 May 09 (sheet)

6. See Countermeasures/Action Plan Through- OODA

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.

7. Confirm Results & Process-
OODA

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

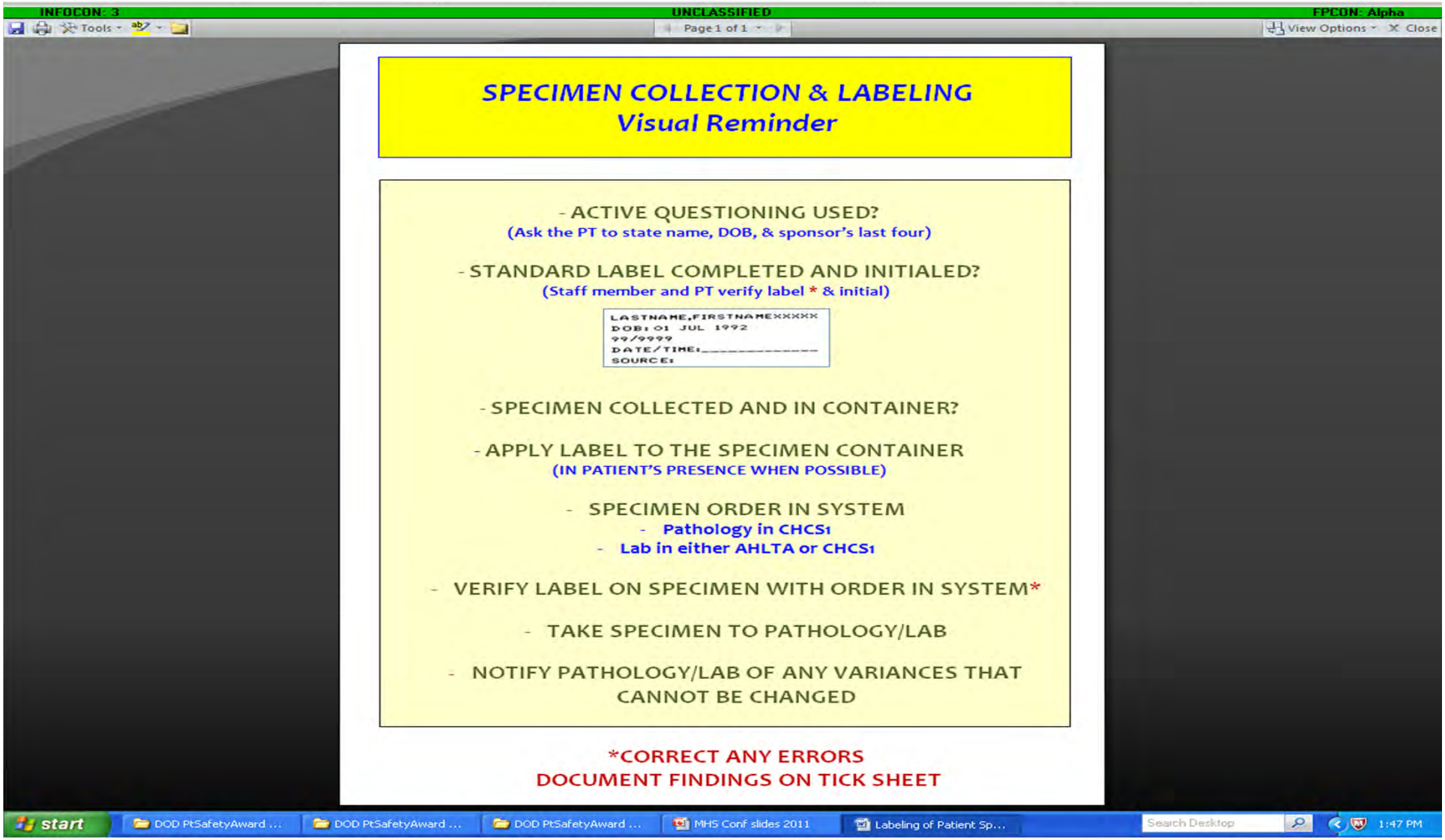
Standardization:

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
3. Visual Cues decrease risk.

Visual Cue #1 In Exam Rooms



Visual Cue #2 At Provider's Desk

Visual Cue #3 Clinic Specimen Room Exit Door