IMPLEMENTATION OF POINT OF CARE SPECIMEN SCANNERS DECREASES EMERGENCY DEPARTMENT ERRORS

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Objectives:

- Describe advantages of clinical collaboration in system design
- Define go-live successes with quick roll-out of devices
- Evaluate project outcomes and lessons learned

The presenters have no conflict of interest or financial relationships to disclose.
Who We Are?

- Penn Medicine Lancaster General Health is a not-for-profit health system
  - Opened in December 1893
  - 9,200+ employees
  - Over 1.2 million physician office visits
  - 118,000+ ED visits

- Four hospitals with a total of 805 licensed beds:
  - Lancaster General Hospital
  - Women & Babies Hospital (WBH)
  - Lancaster Rehabilitation Hospital
  - Lancaster Behavioral Health Hospital
Background:

- Pre-implementation data showed an average of 4-5 per month reported mislabeled specimens
- Preparation for recertification from Healthcare Information and Management Systems Society (HIMSS) Stage 7 designation
  - LGH adopted standard bedside specimen scanners in the inpatient setting to provide positive patient identification
- LGH recognized the importance of technology as a driving factor to providing positive patient identification with specimen collection at the bedside
  - When reviewing ED quality data, leadership identified trends in increasing treatment errors affecting the patient’s care due to mislabeled specimens
- Phlebotomy team was using bedside specimen scanners
  - Missing extension of nursing
Goal:
Reduce the number of mislabeled specimens in the Emergency Department (ED).
Interventions:

• Created a Multidisciplinary Workgroup comprised of clinical nurses, nurse leaders, IT & lab leadership, and clinical informatics specialist
• Deemed an organizational project
  • Led by IT project manager
  • Acquisition of new hardware
  • Integrated lab orders with EMR
  • Testing and validation
  • Pilot units and rolling go live
• Clinical nurse superusers used a “train-the-trainer” approach
  • Superusers were tasked with training other clinical team members in the emergency department
    • Educational materials were provided to the superusers as additional resources to help with unit wide education.
    • Behavioral tip sheet created to help with clinical staff sign off
    • Distribution of an educational tip sheet of FAQ’s and helpful troubleshooting tips
Workflow:

1. Closed loop process for positive patient identification
2. 
3. 
4. 
5. 
6.
ED recognized Issue with Specimens being labeled correctly.

Multidisciplinary team was created to partner operational needs with IT solutions.

Training Completed using “train the trainer” approach.

**Timeline:**

- **March 2019**
- **April 2019**
- **May 2019**
- **June 2019**
- **July 2019**
- **August 2019**
- **September 2019**
- **October 2019**
- **November 2019**
- **December 2019**

- IT collaborated to review technology solutions available.
- IT Build /Testing completed.
- Pilot Units Live.
- Rolling Go Lives to bring Specimen Scanning Live to Organization.
- ED go Live.
Outcome:

‣ Maintained zero reported mislabeled specimens
‣ End user feedback remains positive concerning workflow and device
‣ Confident that specimens are being labeled appropriate at the bedside

Since Go Live in the ED

![NUMBER OF MISLABELED SPECIMENS](chart)

- Implementation
Conclusion:

- Emergency department staff were integral in the adoption of technology
- Implementing bedside technology provided positive patient identification in a closed loop process
- Anticipate a decrease in the number of treatment errors affecting patient care due to mislabeled specimens collected at the bedside