**PRACTICUM SUMMARY REPORT**

**Name:** Yumna Ahmed  

**Team Members:** Florentina Teoderascu, Aditya Martowirogo, Natasha Peters, Jeffrey Wong

**Project Title:** Reducing Rate of Mislabeled Specimens in Pediatric Intensive Care Unit (PICU) and Cardiac Critical Care Unit (CCCU) at the Hospital for Sick Children

**University/Organization Name:** UT IHI

**Health System Sponsor Name:** Sick Kids Hospital

**Aim of project (1-2 sentences)**
We will ensure that 100% of all specimens sent to the Rapid Response and Microbiology lab in CCCU/PICY are correctly labeled by April 1st, 2014. We will achieve this by ensuring all staff use the One-Person-Protocol (OPP).

**Planned changes tested (2-3 sentences)**
The first change was implementing the One Person Process, rewarding staff for following it, and educating the frontline staff about the issue of mislabeled specimens. The second change was labeling the blood access lines with patient identifiers.

**Predictions (2-3 sentences)**
We predicted that compliance rates with the OPP and with checking the ID band would increase significantly. We also predicted that in turn the number of mislabeled specimens would decrease to or below the hospital target value of 0.03 mislabeled specimens per 100 specimens sent.

**Results**
Present your results with a graph(s).

![Graph 1: OPP Results Post-PDSA1](chart1.png)

![Graph 2: Compliance with One-Person-Process](chart2.png)
Summary of results (3-4 sentences):
The One Person Process appeared to be effective in reducing the number of mislabeled specimens, but our compliance goal was not met. After looking at the data it showed a low compliance with the verification of the patient identification band during the sampling process. Adding ID identifiers to the blood access lines did lead to improvement as the OPP showed a 32% improved compliance over the 2 PDSA cycles. Thus it appears that these changes will lead to a reduction in the number of mislabeled specimens.

Learning (4-5 sentences)
Comparison of questions, predictions, and analysis of data:
It was seen that the nurses sometimes had difficulty keeping the process to one person as they could not leave the room, or due to other disturbances. However nurses understood the importance of the one person process. It was found that the labeling of the lines was well received by front-line staff and there was a general agreement by the staff that labeling the blood lines did reduce previously identified barriers. The change did lead to improvement as the OPP showed a 32% improved compliance over the 2 PDSA cycles. Lastly staff were excited for the change and agreed these changes should be implemented across the unit.
Impact on systems (3-4 sentences)
Discuss the project’s significance on the local system and any findings that may be generalizable to other systems:

| The project greatly impacted the local system as nurses were excited about and accepting of the one person process and ID bands on the blood access lines. Compliance with the OPP person process increased after intervention and most importantly, ID bands were being checked. This will greatly help in reducing mislabeled specimens. Thus the benefits these changes have are important and these changes can be implemented across different units. |

Conclusions (3-5 sentences)
Summarize the outcome of the project. Is this project sustainable? What are the requirements for sustainability?

| Overall the outcome of the project was successful. Compliance with the OPP rose to 73% and then to 85% after both PDSA cycles, with the largest improvement being in checking of the ID bands. This project is very sustainable, as it only requires the staff to complete the process alone and the addition of stickers with identification. The requirements for sustainability are staff agreement with the OPP and availability of ID stickers for the blood access lines. |

Reflections/Discussions (5-7 sentences)
Discuss the factors that promoted the success of the project and that were barriers to success. What did you learn from doing this project? What are your reflections on the role of the team?

| There were many factors that promoted the success of the team such as the willingness of the nurses to try the changes and the willingness of the unit to provide us resources we needed. The Sick Kids team we worked with was very helpful and front line staff promoted the initiative amongst themselves. Barriers we met were a restriction on what changes could actually be made and how long some changes would take. Any changes we wanted to make to the requisition layouts were not feasible due to software limits and a hospital wide standard printing layout. I learned that QI projects are dynamic and there are always new barriers or discoveries that arise and thus the plan is always changing. My reflections on the role of the team are that the team worked well together and were an instrumental part in helping to push forward the OPP to decrease the number of mislabeled specimens. |

By signing this document (electronic signature is acceptable), I attest that the information provided by the learners in this project is accurate.

LEARNER(S):

| Signature: 
| Printed Name: Yumna Ahmed 
| Area of Study: Pharmacy |
| Signature: 
| Printed Name: Aditya Martowirego 
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| Area of Study: Nursing |
| Signature: 
| Printed Name: 
| Area of Study: |
FACULTY SPONSOR:

Signature: ____________________________
Printed Name: ____________________________
Institution: ____________________________

HEALTH SYSTEM SPONSOR (if different from faculty sponsor):

Signature: ____________________________
Printed Name: Michael Hartman
Institution: The Hospital for Sick Children

AUTHORIZATION
Do the learners, faculty sponsor, and health system sponsor authorize this project for publication at www.ihi.org?

☐ Yes ☐ No