Optimizing EHR for Quality: Reducing Lab Errors Through Streamlined Solutions

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DEFINE

BACKGROUND

The Department of Gynecology observed an upward trend in specimen errors reported by Laboratory personnel. The Gynecology department attempted several PDSA (Plan-Do-Study-Act) cycles to address reported lab quality events, but these efforts were unsuccessful. Consequently, a quality improvement project was initiated in collaboration with Quality and Education Laboratory leadership.

GAP IN QUALITY

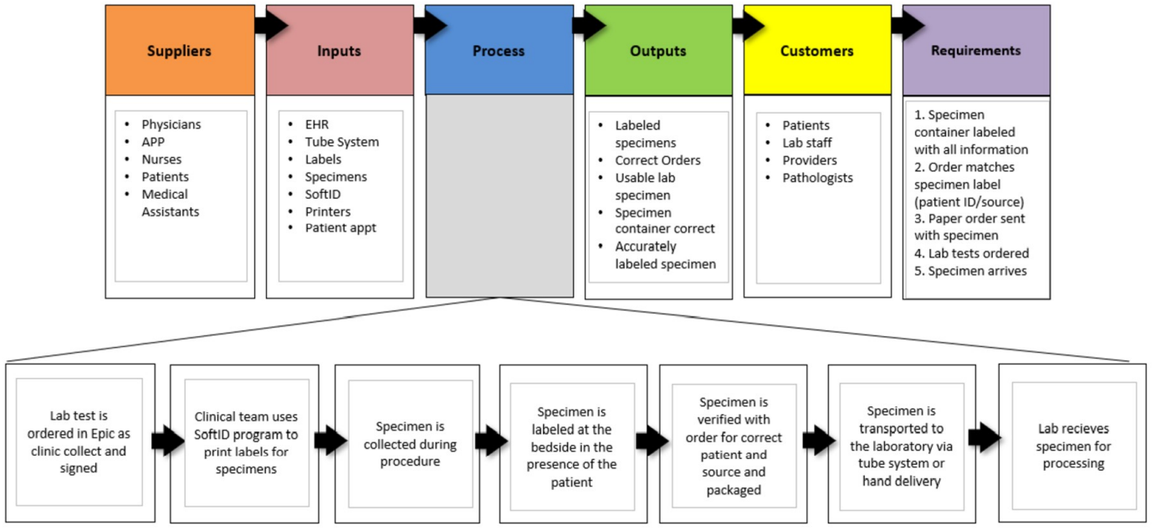
During the period from May 2022 to April 2023, 21 patient safety errors were reported and reviewed. These errors constitute the sample size for this project.

AIM STATEMENT

The aim was to identify the top two types of errors reported and reduce these errors by 50% in the post-improvement window without impacting the length of clinic appointment times.

ANALYZE

POTENTIAL CAUSES



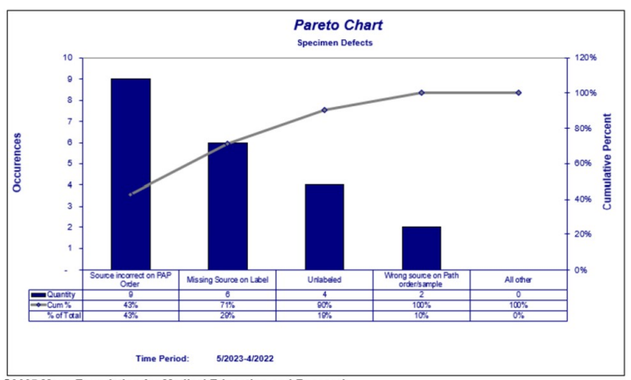
MEASURE

IMPROVEMENT MEASURE BASELINE AND SAMPLE SIZE

Patient safety errors were reported and reviewed in GYN.

Specimen Defects

Category	Quantity
Missing Source on Label	6
Source incorrect on PAP Order	9
Unlabeled	4
Wrong source on Path order/sample	2



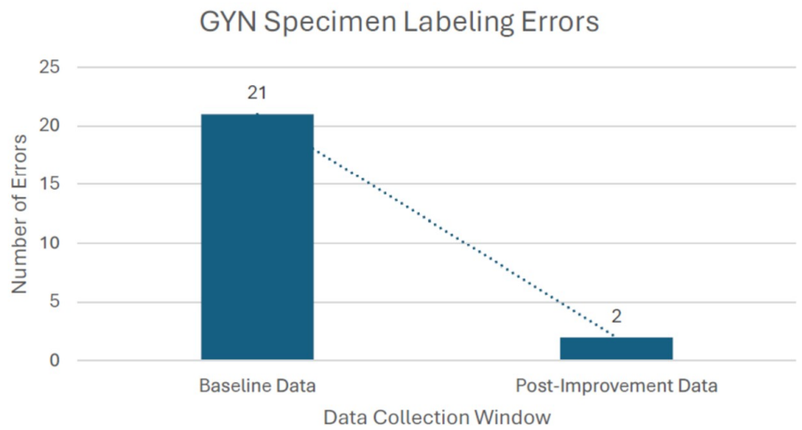
IMPROVE

INTERVENTIONS SELECTED AND TESTED

Interventions were selected based on the greatest impact at the lowest cost.

- Creation of standardized pre-saved orders in the EHR for all providers and staff.
- Creation of larger, pre-printed labels with the most common sources utilized in the department.

POST-IMPROVEMENT



CONTROL

LESSONS LEARNED

Employees expressed great satisfaction in no longer searching for lost specimens, decreased phone calls, and decreased order entry time.

Financial benefits included decreased non-billable patient care as well reduced re-work and overall improved interdepartmental communication.

Ancillary benefit was a decrease in incorrect diagnostic vs screening pap smear orders with standardized orders.

COMMUNICATION AND HANDOFF

Continue with provider education for efficacious use of EHR and guidance of pre-saved orders.

Continue with nursing bi-annual refresher, in-service regarding the new labeling system.

Continue to document patient safety errors for review and reporting to quality.

Plan for an annual audit to ensure there has not been a relapse.

ACKNOWLEDGEMNTS

Thank you to our Gynecology team for collaborating and adopting the recommended changes to workflow.

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