



CASE STUDY

Large Hospital System Develops IV Labels to Reduce Medication Errors

“Make the right thing to do the easy thing to do.”

This was the guiding principle for a successful IV labeling project that came out of a cardiovascular intensive care unit (ICU) at a large West Coast hospital. Poorly labeled IV lines, especially in a higher acuity setting, made it difficult to properly identify medications which can directly impact patient care. Their Med-Surg Clinical Nurse Specialist and Clinical Educator knew there had to be a better IV labeling solution, and they turned to Shamrock Labels to design a custom label to reduce medication errors and improve patient safety.

Research & Development for Custom IV Labeling Project

Dissatisfied with the IV labeling they had, the CNS and Clinical Educator created a vision for what they wanted with the help of evidence-based guidelines and best practices from the Association for the Advancement of Medical Instrumentation (AAMI) and the Institute for Safe Medication Practices (ISMP).

But they still didn't know how to make their vision a reality: “Our staff had a concern and a solution, but they did not know how to get from their ideas to implementation and standardization.” That's where Shamrock Labels came in. Through Shamrock's custom labeling solution, they worked closely with Shamrock's Client Care experts to identify the appropriate customization options.

The customer and their team developed a solution consisting of pre-printed, flag-style labels that would be placed on both tubing and pumps. After some initial trial and error, they chose a 5/8” x 4” label size with capital lettering to ensure legibility. Shamrock's Client Care experts also encouraged them to use a removable adhesive, making the labels strong and durable, but also easy to remove when no longer needed. This saved staff members the time and frustration of scraping label residue off of IV pumps.

They also opted not to utilize color coding, a trend in healthcare. Instead, they made the labels white with black text because, according to the ISMP, people are more likely to read the labels this way. *(continued)*





Putting The New IV Labels to the Test

Once the customer and their team landed on the desired label design, they launched a trial of the new IV labels starting in February of 2018. In addition to using them in the high acuity cardiovascular surgery ICU, they also implemented them in a smaller adult ICU at another nearby hospital in their system. In this way, they were able to test the performance of the labels in a variety of settings, increasing the likelihood they could roll the new labels out system-wide and have a greater impact.


From comments about ease of use and visibility to the direct impact they have on patient safety, Shamrock’s custom IV labeling solution was met with resounding approval by the staff of both ICUs. The team attributes this to their guiding principle throughout the project: “Make the right thing to do the easy thing to do.”

“I think this is extremely pertinent to healthcare. The harder we make things, the less often they are done or are done correctly. Medication administration is such a high-risk process, that anything we can do to make it easier for the nurse to perform safely, the better.”

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So, What Is Your Labeling Need?

With over 50 years of experience in healthcare labeling and variety of stock and custom options available, we can help you find the right solution. **Start creating now** or call us at (800) 323-0249.



Share Your Story.

At Shamrock, we pride ourselves on partnering with our customers to provide solutions that increase efficiency and reduce errors in patient care. The IV labeling project spearheaded is just one example. Has Shamrock helped solve a labeling challenge in your organization? Share your Shamrock story with us!

SHARE

Sources: “Best Practices for Labeling of Intravenous Lines for Patients with Multiple Simultaneous Infusions” Institute for Healthcare Improvement, Improvement Stories, <http://www.ihl.org/resources/Pages/ImprovementStories/BestPracticesforLabelingofIntravenousLinesforPatientswithMultipleSimultaneousInfusions.aspx>