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Prevention of Intraoperative Specimen Errors

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Prevention of Intraoperative Specimen Errors

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Rationale for Change

Average percentage of specimen errors was 4%

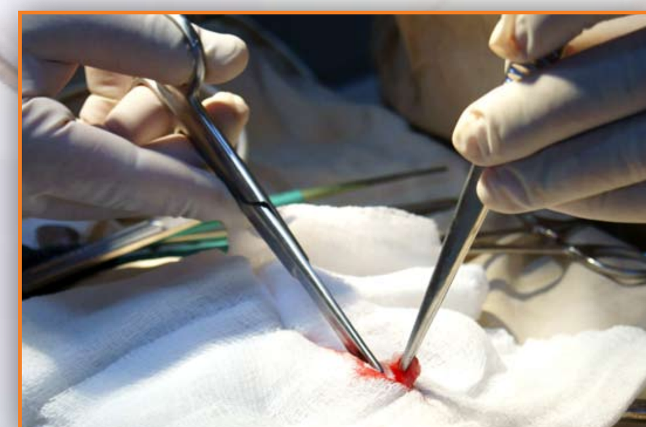
One specimen error is too many!

Common Specimen Errors

- Mislabeling specimens
  - Incorrect site
  - Incorrect patient
  - Incorrect laterality
  - No identification of specimen
- Mishandling specimens
  - Specimen placed in wrong solution
  - Specimen placed in no solution
  - Specimen sent to wrong department
  - Specimens discarded
- Empty specimen containers sent to lab
- Incorrect form
- Incomplete documentation

Challenges

- Effective handoff communication
- Documentation completed correctly



Recommendations of Task Force

- Create standard work
  - Preplanning for care and handling of specimen
  - Designated specimen "Drop Off Station"
  - Developed a chain of command protocol
    - *Two staff members verify the specimen*
    - *Specimen sign in and out of log book*
    - *Notify department receiving the specimen*
  - Labeling must occur at time of specimen collection
  - Verified with surgeon before specimen leaves the room
  - Double check documentation for completeness

Initiatives

- Developed a multidisciplinary task force
- Completed a Specimen Error Audit
- Revised Specimen Policy
- Raised awareness regarding specimen errors
- Re-educated staff
- Implemented recommendation of task force
- Evaluated and audited compliance of implementation

Outcome

- Specimen errors decreased from 4% to 1% over the following two years
- Positive patient safety outcome
- Improved team collaboration

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