Lehigh Valley Health Network

Patient Care Services / Nursing

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

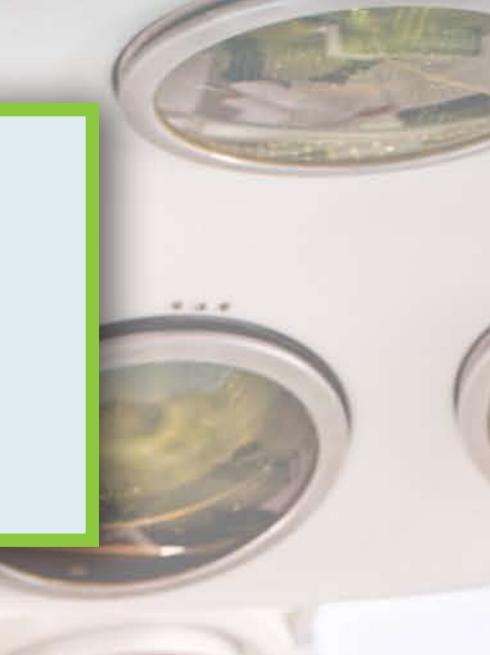
- Specimen placed in wrong solution
- Specimen placed in no solution
- Specimen sent to wrong department
- Specimens discarded
- Empty specimen containers sent to lab
- Incorrect form
- Incomplete documentation

<u>Challenges</u>

- Effective handoff communication
- **Documentation completed correctly**



Prevention of Intraoperative Specimen Errors Maureen Bredbenner RN, CNOR Lehigh Valley Health Network, Allentown, Pennsylvania



Recommendations of Task Force

- Create standard work

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

- following two years
- **Positive patient safety outcome**
- Improved team collaboration



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



Specimen errors decreased from 4% to 1% over the

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