# Prevention of Intraoperative Specimen Errors

Maureen Bredbenner RN, CNOR
*Lehigh Valley Health Network*, Maureen.Bredbenner@lvhn.org



## Published In/Presented At

Bredbenner, M. (2013). *Prevention of intraoperative specimen errors.* Poster presentation.

# Prevention of Intraoperative Specimen Errors

**Maureen Bredbenner RN, CNOR**
Lehigh Valley Health Network, Allentown, Pennsylvania

## 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