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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