Specimen Identification Error Reduction: A Collaborative Interprofessional Approach

Denise Snyder BSN RN, Nursing Quality Program Manager
dsnyder@ccf.org 216.587.8234
Marymount Hospital, Cleveland Clinic, Cleveland, OH

Background

Specimen identification errors are patient safety issues which can result in adverse events such as diagnostic errors, inappropriate treatments, or potentially life-threatening consequences. In 2012, Marymount Hospital reported a total of 65 specimen errors. Correctly identifying and labeling specimens to prevent errors was identified as a hospital-wide quality & patient safety initiative, with a goal of zero errors. Interprofessional caregivers collaborated in an evaluation of current clinical practices to identify quality improvement strategies.

Methods

- Interprofessional Specimen Error Reduction Task Force met in June 2013 with membership including:
  - Patient Safety Manager
  - Laboratory staff
  - Direct care nurses
  - Nursing Leadership
  - Executive Leadership
  - Ancillary staff
- Guidelines and procedures for specimen collection were developed and distributed to hospital staff
- Nursing quality program manager and nurse managers developed educational references and established accountability guidelines based on a Just Culture philosophy
- Nurse managers educated staff in August 2013
- Remediation process for staff accountable for specimen errors was implemented
- Nursing Shared Governance decided that specimen error reduction was a priority goal for 2014
- The Nursing Clinical Practice Council received education regarding the Plan-Do-Check-Adjust performance improvement process to facilitate action plan development
- Nursing Clinical Practice Council Action Plans
  - Model behaviors for correct specimen collection by following established policies
  - Speak up when observing unsafe practices for specimen collection
  - Peer accountability when policy/protocol is not followed
  - Specimen errors discussed at unit meetings to increase staff awareness & develop unit based action plans
- “Clinician collect” function added to all caregivers patient lists to facilitate requisition printing by specimen collector
- Use of WOW at bedside during specimen collection
- Develop reminder signs for specimen collection protocol
- Strict adherence to dual signature process
- Visual Management tools were used to track progress for specimen error reduction
- Nursing Quality Dashboard posted on all units to increase staff awareness of monthly specimen error data and monitor trends
- Professional Practice Model (PPM) Huddle Boards include date of last specimen error

Outcomes

- Comparison of 2013 and 2014 August YTD data indicates a 61% reduction in specimen errors hospital-wide, with a 67% reduction in specimen errors for nursing staff.
- Number of specimen errors for nursing staff decreased from 48 in 2013 to 16 in 2014.
- Most significant improvement occurred after initiatives developed by the Specimen Error Reduction Task Force and the Nursing Practice Council were implemented.
- The CCIM Standardization process has resulted in sustainment of continued specimen error reduction by 67% in 2015.

Implications for Practice

The goal for specimen identification error reduction is in progress as the result of an interprofessional approach, with emphasis on involvement of direct care nurses and the Nursing Practice Council. Hospital and nursing leadership have provided education, oversight and adherence to Just Culture standards, including accountability for specimen errors. Quality improvement and patient safety supported by all caregivers are the organization’s core values that sustain continued efforts for specimen identification error reduction. Frontline caregiver involvement is vital in the sustainment of adherence to work practices that support quality improvement initiatives such as specimen identification error reduction. The Cleveland Clinic Improvement Model is a valuable tool for frontline caregivers to ensure success with continuous improvement projects.

References