Improving the Identity Checking of Theatre Specimens

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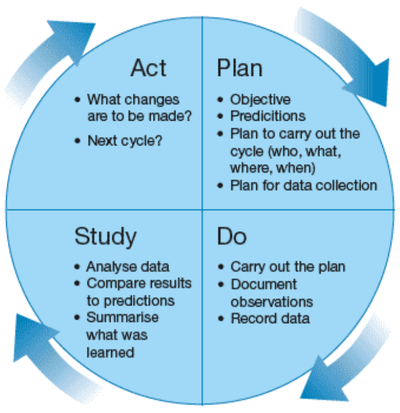
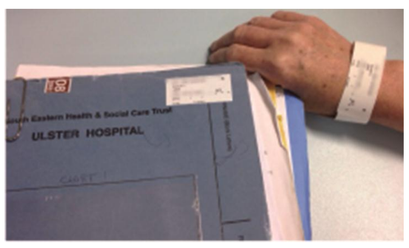
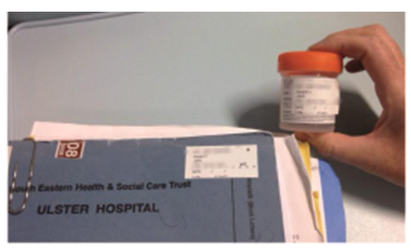
BACKGROUND
Within the South Eastern HSC Trust Theatres there have been several serious near miss incidents involving human tissue specimens where samples have incorrect patient details. Large studies confirm specimen mislabelling incidence is as high as 1 in 1150 specimens. Such errors are widespread within the NHS and can lead to serious harm to several patients. One patient may have a diagnosis made that is incorrect and may receive unnecessary treatment while another may not be diagnosed and go completely untreated. The lack of National regulation in the labelling of specimens leaves Trusts to formulate their own checking procedures.

AIMS
The aim of project was to identify and implement a process improvement for all theatre specimens to be safely checked prior to the patient leaving theatre by June 2013.

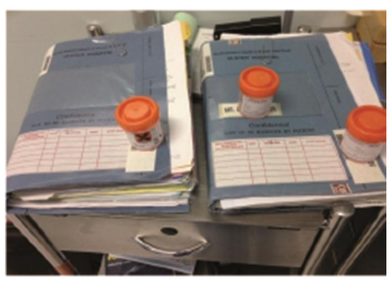


METHOD
A PDSA cycle was used to structure the project. We examined the original process of theatre specimen checking by observation of practice. We observed the notes were checked against the ID band and later specimens were checked against the notes.

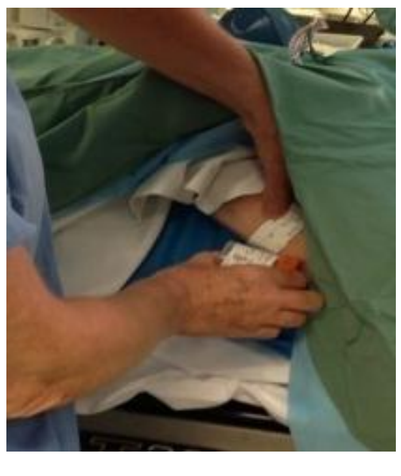




An analysis of this process revealed considerable weaknesses. We identified the potential for error when a second set of notes was in theatre or when incorrect identity stickers were within the notes.

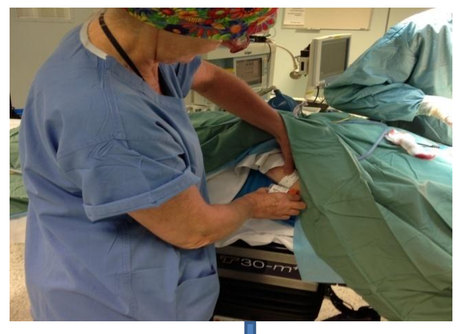


Mistakes were occurring due to the involvement of the notes in the checking procedure. Therefore a new standard of checking was proposed – checking the specimen immediately against the patient ID band.



Consultation with front line staff on the new standard of checking revealed potential problems with issues such as inaccessibility of the ID band and insufficient light to safely check during endoscopic procedures.

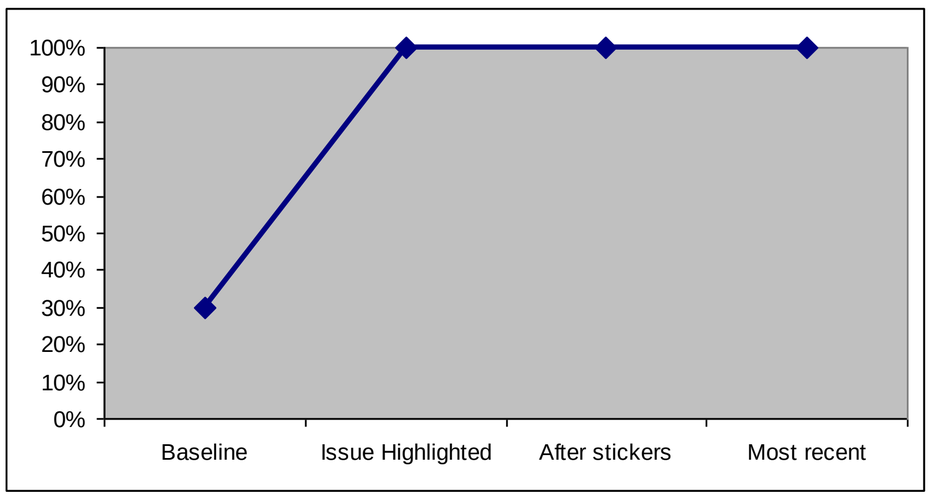
An additional innovation was required to allow staff to be aware that specimens that could not be checked immediately against the ID band needed checked at the end. The check sticker was introduced and is only placed on the specimen bottle when the ID check was completed.



The label is a high visibility indication of the correct specimen check and unchecked specimens are easily identified.

Other key actions in the project have included:
- Laboratory consultation on new labels
- Theatre specimen policy redraft
- Next Trust Surgical Safety Checklist will prompt sticker check.

RESULTS
- Staff are now totally 'bought in' to the new checking process – there has been a major culture change
- The new process of checking is significantly safer – notes have been eliminated from key specimen check
- The process has been cascaded out successfully to all main theatres on the Ulster site in May 2013
- Compliance with the new process is 100%. The most recent data was collected in September 2013.



An internet audit sample of 7 other Trust theatre specimen policies across the UK showed 6 directed the specimen ID check from the notes.

This project offers the potential for change across many other Trusts.