

Objective 8: The team will secure and accurately identify all surgical specimens.

While there are considerable data on processing and diagnostic errors associated with surgical specimens, there is scant evidence about the incidence and nature of errors due to inadequate or wrong labelling, missing or inadequate information and 'lost' specimens, all of which can potentially hinder patient care and safety (1,2). An analysis of medico-legal claims for errors in surgical pathology revealed that 8% were due to 'operational' errors (2). Such incidents are accompanied by delays in treatment, repeated procedures and surgery on the wrong body part. Such incidents occur in all specialties and all types of tissue (3).

In a study of identification errors in laboratory specimens from 417 United States institutions, nearly 50% were due to labelling errors (4). Transfusion medicine has led the way in highlighting the importance of specimen labelling, but errors in laboratory tests can also result in patient harm. One in 18 labelling errors results in an adverse event, and, in the United States, it has been estimated that close to 160 000 adverse events occur annually because of mislabelling. Errors in labelling laboratory specimens occur because of mismatches between the specimen and the requisition and unlabelled or mislabelled specimens (5). Patient identification on specimens and requisition forms is critical in any attempt to prevent laboratory errors. The Joint Commission made 'accurate patient identification' one of their laboratory patient safety goals (6). Improved identification is crucial to preventing errors in laboratory specimen labelling. Rechecking wrist identification bands can decrease specimen labelling error rates and blood grouping errors (7-9).

Mislabelling of surgical pathology specimens can have more severe consequences (10) than other laboratory errors that occur before specimen analysis (7). A recent study by Makary et al. (3) showed that errors occur in 3.7 per 1000 specimens from operating rooms and involve the absence of accurate labelling, omission of details regarding tissue site and the absence of patient name. Several simple steps can be taken to minimize the risk of mislabelling. First, the patient from whom each surgical specimen is taken should be identified with at least two identifiers (e.g. name, date of birth, hospital number, address). Second, the nurse should review the specimen details with the surgeon by reading aloud the name of the patient listed and the name of the specimen, including the site of origin and any orienting markings. When required by a facility, the surgeon should complete a requisition form labelled with the same identifiers as the specimen container. This requisition form should be cross-checked against the specimen by the nurse and surgeon together before it is sent to the pathology department and should include the suspected clinical diagnosis and the site (and side or level when applicable) from which the sample was taken.

Recommendations

Highly recommended:

- The team should confirm that all surgical specimens are correctly labelled with the identity of the patient, the specimen name and location (site and side) from which the specimen was obtained, by having one team member read the specimen label aloud and another verbally confirming agreement.

References

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