



Specimen management is critical for safe patient care.



GYNECOLOGY Anatomic Locations	
Source	Appropriate Anatomic Location Description
Fallopian Tubes	Right or Left Fallopian Tube
Ovary	Right or Left Ovary
	Right or Left Ovarian Cyst
	Right or Left Ovarian Fossa
Uterus	Right Uterine Adnexa
	Left Uterine Adnexa
	Right or Left Adnexal Mass
Fallopian Tube or Ovary	Right Fallopian Tube and/or Ovary
	Left Fallopian Tube and/or Ovary
	Right Uterine Adnexa
	Left Uterine Adnexa
	Right or Left Round Ligament
	Right or Left Broad Ligament
Uterus, Tubes or Ovaries	Uterus, Right/Left Fallopian Tubes, and Right/Left Ovaries
Cervix	Endocervix (Orientation on towel)
	Ectocervix (Orientation on towel)
Vagina	Anterior or Posterior Vagina
	1:00/2:00/etc. Vagina Biopsy
Vulva	Vaginal Polyp
	Right or Left or Midline Vulva Biopsy
Clitoris	1:00/2:00/etc. Vulva Biopsy
	Clitoris
Cul de Sac	Cul de Sac or Rectouterine Pouch (of Douglas)
	Posterior Cul de Sac
	Anterior Cul de Sac or Vesicouterine Pouch
Abdomen	Ileal Serosal Biopsy
	Right or Left Colic Gutter
	Right or Left Pelvic Sidewall
	Right or Left Uterosacral
Small Bowel	Small Bowel Serosa
	Small Bowel Mesentery
Diaphragm	Right or Left Diaphragm
Large Bowel	Large Bowel Serosa
	Large Bowel Mesentery
Bladder	Bladder Peritoneum
Endometrium	Endometrial Curettings
Endocervix	Endocervical Curettings
Colon	Sigmoid Epiploic

Using a Specimen Resource Aid to Reduce Perioperative Specimen Errors

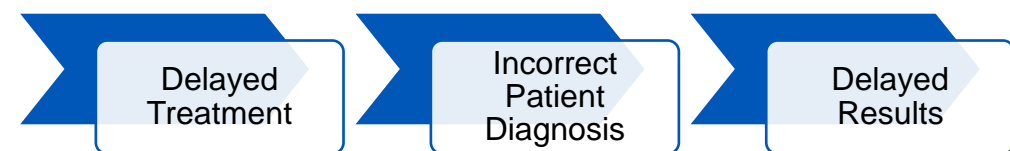
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INTRODUCTION

BACKGROUND

Specimens are a critical component when it comes to the care and safety of patients. Incorrect results or misdiagnoses can result in:

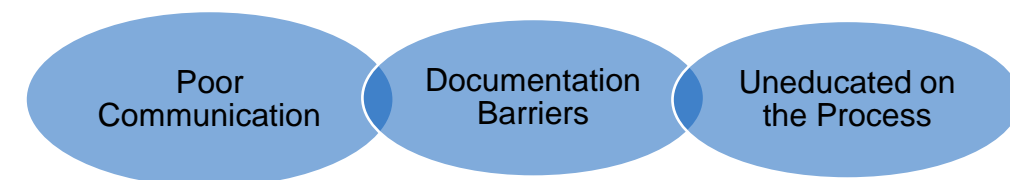


All these outcomes put undue stress and frustration on patients. Specimen errors can occur for several different reasons such as mislabeling, unlabeled specimens, and fixation delays to name a few.

GAP IN QUALITY

In 2019, 60% of the unit's specimen errors were in the gynecology (GYN) specialty. Within a two-month analysis timeframe in 2020, this unit had 14 specimen errors with eight of those errors being in the GYN specialty. The errors ranged from fixation delays to incorrect sources and an inaccurate requisition.

POTENTIAL CAUSES



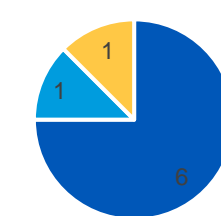
AIM STATEMENT

Gynecology-related specimen errors will decrease by 25% from 8 errors to 6 errors by 08/30/2020.

METHODS

IMPROVEMENT MEASURE BASELINE

Number of Specimen Errors Pre-Intervention



■ Fixation delay ■ Source Error ■ Requisition Error

Graph 1: The pre-intervention analysis consisted of 256 specimens that were sent to the pathology department during an eight-week period. Of the 256 specimens, there were a total of eight errors. This accounted for a 3.13% error rate.

INTERVENTIONS SELECTED AND TESTED

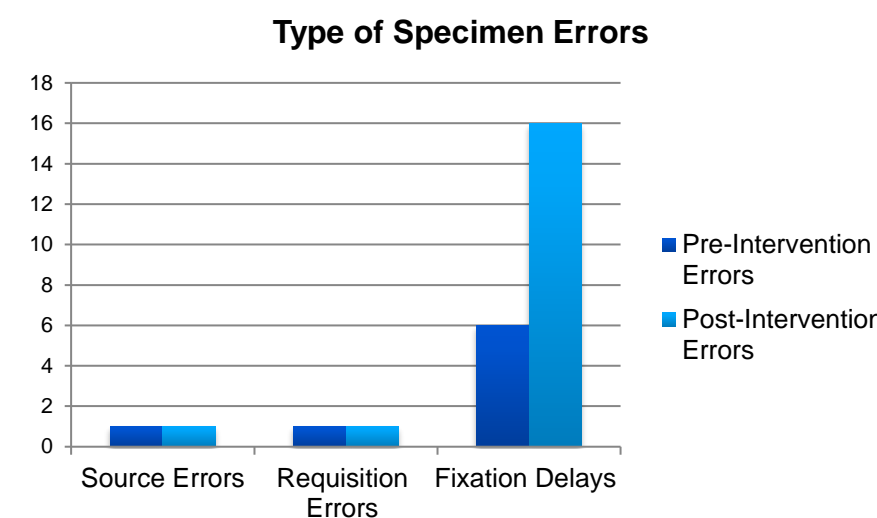
Creation of a GYN specific specimen source aid and preparation, transportation, and documentation guide were used as the primary interventions. Implementation included:

- Educating staff on utilization of the guide
- Defining a fixation delay
- Placing a source aid in every operating room (OR)
- Utilizing the source aid to improve communication between the OR team when labeling specimens
- Process change for permanent only specimens

RESULTS

IMPLEMENTATION PHASE 1

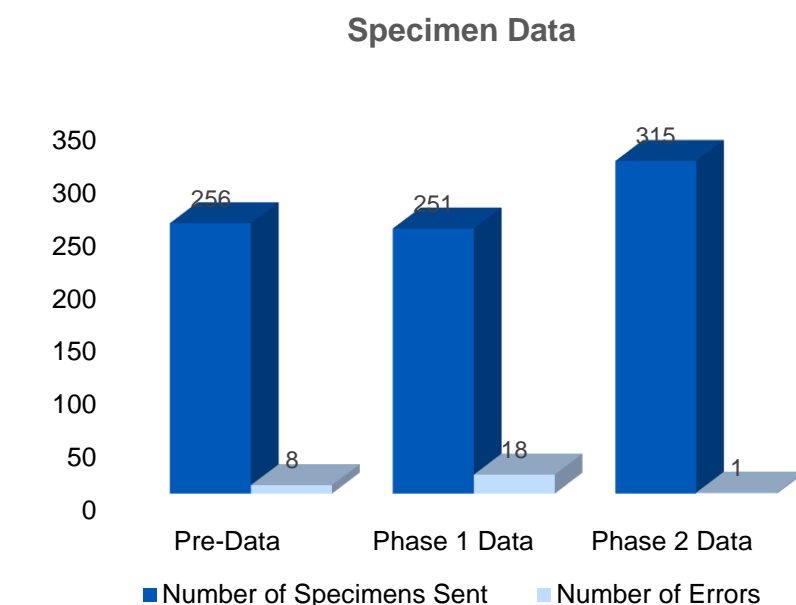
The post-intervention data included 251 specimens in comparison to the pre-intervention analysis of 256 specimens in an eight-week analysis period. There was a 7.17% error rate (18 errors).



Graph 2: Post-intervention there were 18 errors with 16 of those errors being fixation delays, one source related error and one requisition related error.

IMPLEMENTATION PHASE 2

- Phase 1 ignored fixation delay related errors
- Implement a process change for smaller specimens



Graph 3: The post-intervention phase 2 data included 315 specimens with one requisition error. This graph highlights the number of specimens and errors during the three data collection periods.

FUTURE DIRECTIONS

LESSON LEARNED

- Broad assessment of a situation is important to understanding the root cause of an issue
- Creation of an Interdisciplinary Specimen Workgroup
- Need for divisional source aids for all specialties
- Resident/provider education on specimen errors, specifically fixation delays
- Limitation: one specialty within an outpatient setting

REFERENCES

- D'Angelo, R. (2016). Getting it right for patient safety: Specimen collection process improvement from operating room to pathology. *American Journal of Clinical Pathology*, 146(1), 8-17.
- Kinlaw, T., & Whiteside, D. (2019). Surgical specimen management in the preanalytic phase: Perioperative nursing implications. *AORN Journal*, 110(3), 237-250.
- Zervakis, B. (2016). OR specimen labeling. *AORN Journal*, 103(2), 164-176.