

BUNG IT IN A BOTTLE

Getting Theatre Specimens Correctly Sent to the Laboratory

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THE LOCATION

- Tertiary University Teaching Hospital in Dublin
- Beds 479



THE PROBLEM

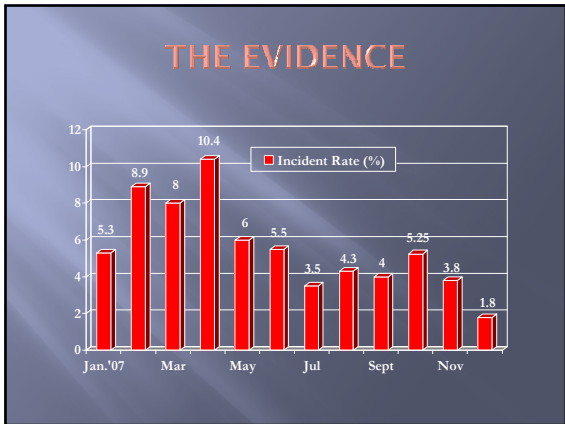
- Noticed a number of recurring incidents with theatre specimens for histopathological investigation.
- Adopted as a joint Quality Initiative between Theatre & Histology Dept.

"To reduce to zero the number of specimen integrity incidents"

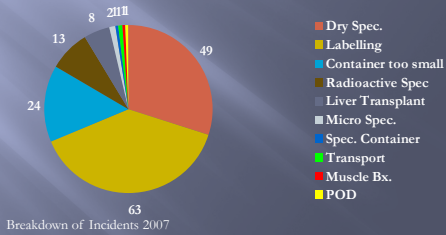
THE EVIDENCE

Incidents 2007

No. of Patients for Histological Investigation	No. of incidents	Incident rate
2989	163	5.5%



THE EVIDENCE



THE INTERVENTIONS

- After every incident an Incident Proforma letter sent to consultants (Jun.'07)
- Histology representation on Theatre Health & Safety Group (Sept.'07)
- Poster "Before sending Specimens to Histopathology" posted in each theatre suite (Jan.'08), highlighting labelling, size of container and fixative volume requirements
- Copy of above poster to every SVUH consultant (Jan.'08)
- Copy of Incident Proforma letter sent to Theatre Clinical Facilitator (Apr.'08)
- Education session with new NCHDs as part of induction (Jul.'08)
- Staff awareness through teaching sessions (May'08 & Jul.'09)
- Move to new theatre facility - Prefilled containers (Feb.'09)

Department of Histopathology
Tel: 01 221 4613/ Fax: 01 209 4840

Dear

Patient Name
MRN
Sample of

A tissue specimen was received for histological investigation on
This specimen was sub-optimal because:

- Specimen was received dry
- Specimen placed in too small a container
- Specimen container was not labelled adequately
- Specimen container was unlabelled
- Specimen had no radioactive hazard labels
- Request form was not labelled adequately
- Request form was unlabelled
- Labelling on request form & specimen did not correlate
- Other.....

In the interests of continued patient safety, you might address this issue with your clinical team. If you require any further details or information on this occurrence, please do not hesitate to call me at extension 4613.

Yours sincerely,
John Harford
Senior Medical Scientist, Histopathology Dept.

BEFORE sending SPECIMENS to HISTOPATHOLOGY

Label **BODY** (not the lid) of **CONTAINER**
with

1. patient name,
2. hospital number
3. specimen type

Label **HISTOLOGY FORM** with

1. patient name,
2. hospital number
3. specimen type

For **ROUTINE** histopath. investigation
Use a **PROPER** sized container
filled with formalin
in the ratio of
10:1 fixative to specimen volume

THE IMPACT

Incidents 2007

No. of Patients for Histological Investigation	No. of incidents	Incident rate
2989	163	5.5%

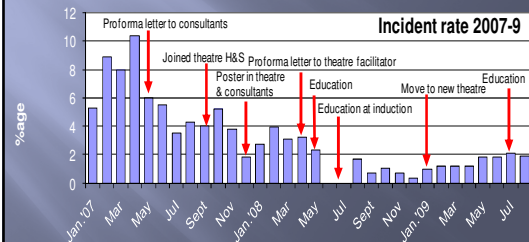
Incidents 2008

No. of Patients for Histological Investigation	No. of incidents	Incident rate
3651	62	1.7%

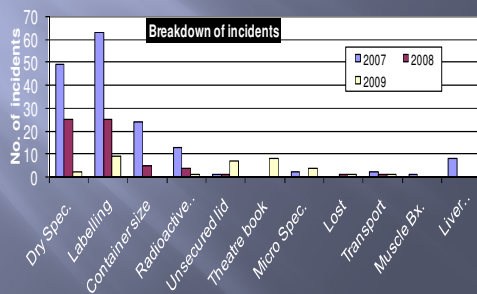
Incidents Jan.'09 – Aug.'09

No. of Patients for Histological Investigation	No. of incidents	Incident rate
1960	26	1.5%

THE IMPACT



THE IMPACT



LEVEL OF IMPACT

Intervention	Effectiveness
Proforma letter to Consultants	Low
Proforma letter to Theatre Clinical Facilitator	High
Attendance at Theatre H&S Meetings	High
Poster to Consultants	Low
Poster to Theatre Suites	Medium
Education Sessions	Medium
Move to New Theatres	High

CONCLUSIONS

- ❑ Direct feedback loop with theatre had most effective impact on reducing incident rate
- ❑ Interventions have brought a reduction in incidents (even though workload has increased)
- ❑ This rate seems to have levelled off at approx. 1.5%
- ❑ Need to push the progress on by focusing on certain areas (e.g. labelling)
 - through dissemination of results to appropriate hospital committees
 - reviewing tissue handling policies
 - giving incident reports / individual theatres
 - continuous education sessions

ACKNOWLEDGEMENTS

- ❑ To all Theatre and Histopathology Staff who continually strive to ensure that the aims of this QI can be achieved and maintained and who fully understand the importance of this QI to patient safety.
- ❑ Dr. Ian Callanan for his help & support