

Project Title

Reducing Specimen Errors in Urgent O&G Centre (UOGC): A Quality Improvement Initiative

Project Lead and Members

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Organisation(s) Involved

KK Women's and Children's Hospital

Healthcare Family Group Involved in this Project

Nursing, Ancillary Care

Specialty or Discipline

Urgent Obstetrics & Gynaecology Centre

Project Period

Start date: Jul-2020

Completed date: Apr-2021

Aims

To reduce the incidence of specimen errors, thereby aiming to target zero harm for our patients in UOGC

Background

See poster appended / below

Methods

See poster appended / below

Results

See poster appended / below

Lessons Learnt

See poster appended / below

Conclusion

See poster appended / below

Additional Information

Singapore Healthcare Management (SHM) Conference 2021 – Shortlisted Project (Risk Management Category)

Project Category

Care & Process Redesign, Quality Improvement, Workflow Redesign, Job Effectiveness, Value Based Care, Safe Care, Risk Management, Adverse Outcome Reduction, Training & Education

Keywords

Specimen Collection Workflow, Independent Co-Checking, Blood Tube Racks, Swab Compartments, Specimen Poster

Name and Email of Project Contact Person(s)

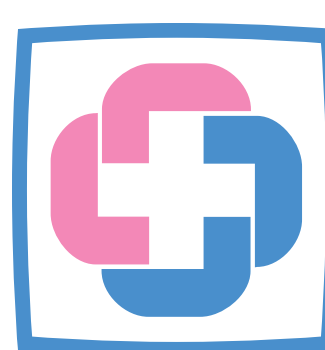
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Singapore Healthcare Management 2021

Reducing specimen errors in Urgent O&G Centre (UOGC): A quality improvement initiative



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INTRODUCTION

In UOGC, **19** specimen errors occurred in Jan 2019 – June 2020 from 0 in 2018.

Ensuring patient safety is a universal imperative. In an effort to improve patient safety, accurate patient identification and specimen labelling are critical steps which must be followed in order to prevent medical errors.

AIM

To reduce the incidence of specimen errors, thereby aiming to target zero harm for our patients in UOGC.

METHODOLOGY

To reduce these specimen errors, a series of strategies were implemented over a 10-month intervention period (Jul 2020 – Apr 2021):

Enhanced specimen collection workflow

- 1 designated area for blood collection. All blood specimen collection will only be performed in the Treatment Room.

Independent co-checking

- 2 of specimens before despatching. Ensure correct
 - Patient identifiers
 - Media
 - Barcode is available

Blood tube racks

- 3  Say goodbye to needlestick injuries, messy tables and missing blood tubes!

Swab compartments

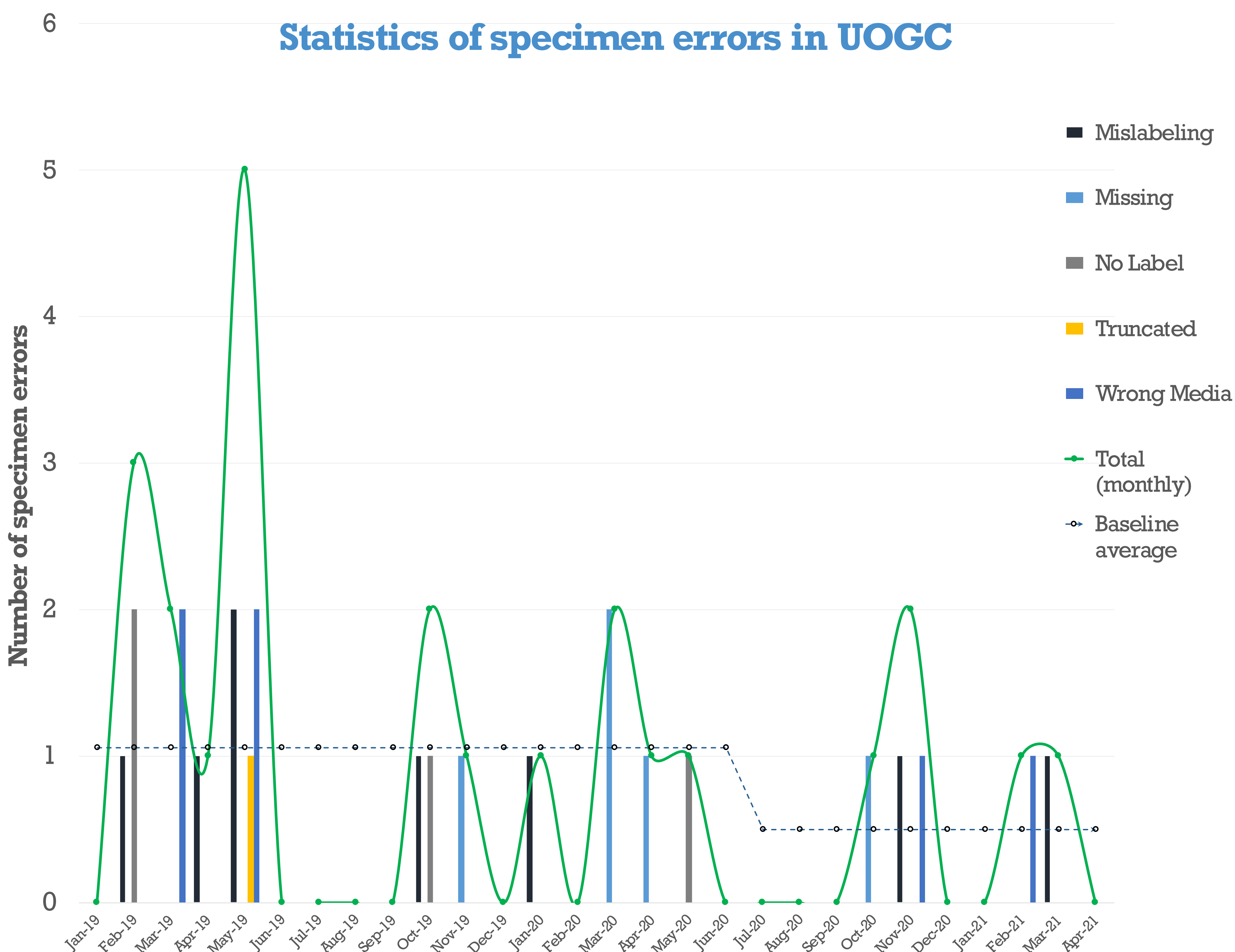
- 4  easy retrieval and identification of swab tests

Specimen poster

- 5  **SPECIMEN BOARD**
Your quick lab guide

RESULTS

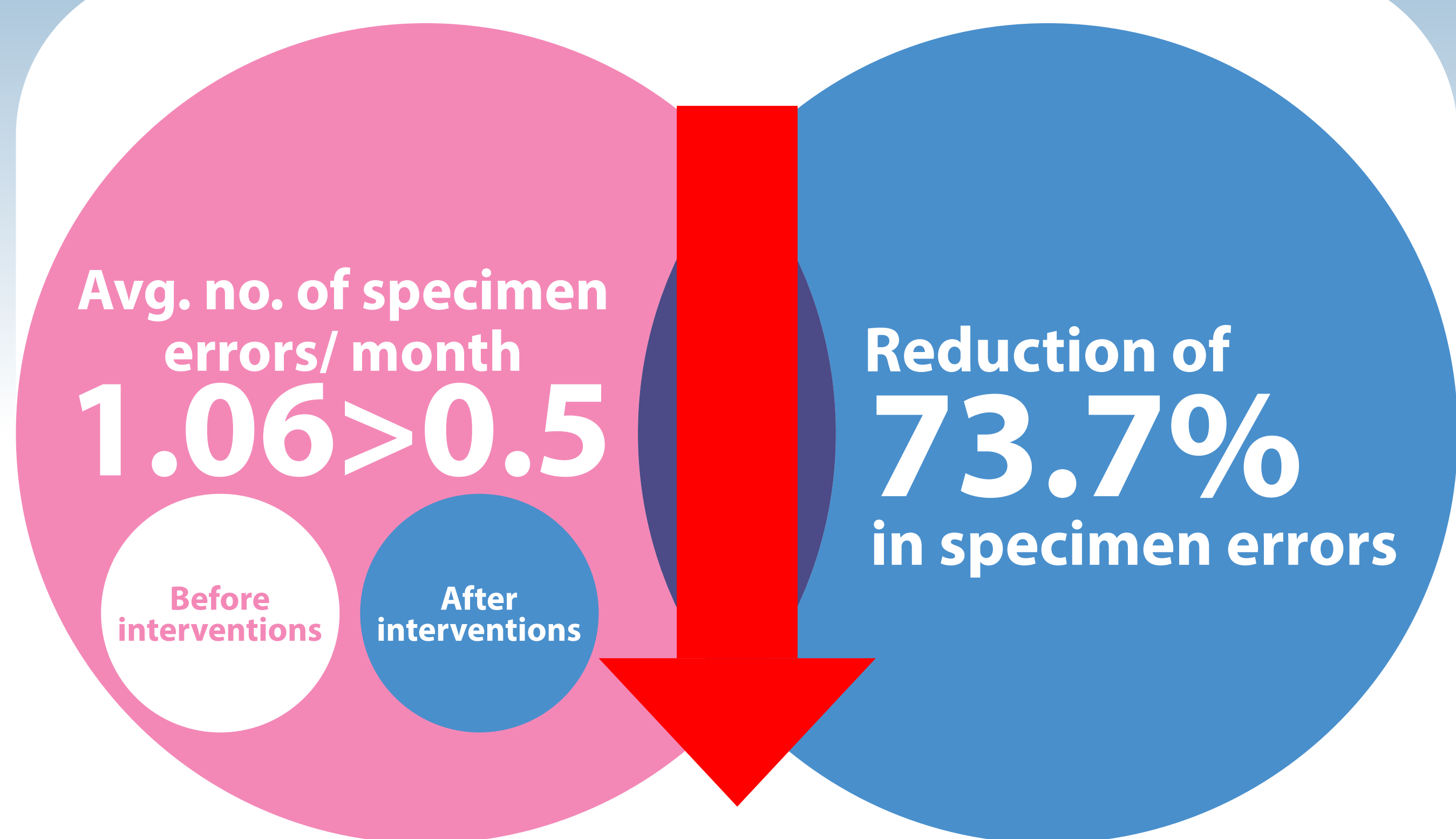
Statistics of specimen errors in UOGC



Total number of specimen errors

January 2019 – June 2020 **19**

July 2020 – April 2021 **5**



At present, this initiative is still ongoing and results are continuously monitored.

CONCLUSION

The collective strategies implemented are effective methods to prevent and reduce the incidence of specimen errors. Our quality improvement initiative helped to reduce the incidence of specimen errors and improved nurses' performance, thereby improving the safety for our patients in UOGC.