Northwestern Medicine®

Background

Problem Statement: Incomplete ordering, collection, handling, and processing of specimens obtained from procedures is leading to a lack of information for physicians to appropriately care for patients.

Overall, there have been **189 cases, or 16 per** month, in the last 12 months reported in Northwestern's Event Tracking System (NETS) related to specimen management.

In addition, over the last **14 months**, **9 cases** related to specimen management were so impactful as to be reviewed by Clinical Classification and Evaluation Committee (CCEC), which translates to 0.62 cases/month.

Repeating specimen collection and/or processing can lead to patient safety and patient satisfaction concerns, as well as the possible destruction of an irreplaceable specimen.

Figure #1: High Level Process Map and **Questions to Answer**

Ordering	Collection	Transport	Processing	Results Reporting
 What specimens are ordered? What is the process for ordering (electronic/ paper)? Are the correct orders built in EPIC? What challenges are there with ordering (ie. orders in EPIC not clear) 	 How are specimens collected? How does staff know how much of the specimen to collect for testing? How does staff know what vessel /tube to place specimen in? How does staff know what fluid (ie. formalin/ saline) to keep specimens in? How does staff know stability timeframe? 	 Are specimens picked up by courier/ tubed/ walked down to lab? What is the timeframe where specimens are in transit/waiting for transit? Where are specimens stored while waiting for transit? Where are specimens stored while waiting for transit? Where are specimens dropped after transport? 	 Where are specimens dropped in the lab? How are shared specimens dealt with? How does the lab communicate back with the dept on any issues? 	 Who are the results delivered to? How does the dept know that results have arrived? How do results get back to the ordering MD? Are the results clear and understandable? What is the timeframe for receiving results?

Methods

workteams began implementation

Figure #4: Solutions Implemented

Improve Put link Link ph Add info and on Educatio 30-60 m Simplifi Add test Cell Cor **Processi** Calls goi

Call Schedules (West EPIC Enterprise Train HealthLab Kronos (NMH, LFH, MJ, McKesson PACS (CDH Milliman Care Guides (Wes NETS Patient/Visitor Repo NM EPIC PACS (KH, VWH) Patient Relations Report

Planning for OpTime Upgrades to begin later this year which will allow the OR, GI Lab, and Interventional Labs to eliminate the paper requisition

Making Procedural Specimen Management More Reliable

Executive Sponsors Maura O'Toole and Sal Dazzo

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ı					
Health Lab Test Directory and Build Awareness					
to lab test directory on NMI in more obvious place					
to of collection container/tube to individual tests in directory					
rmation on lab test directory & client services phone # (for questions) to daily safety huddles '5 things for leaders to know" on NMI					
on and Training for Procedural Staff					
inute Lab training session for all procedural staff/ physicians (slotted for June 2018)					
ed Paper Req for OR, GI Lab, and Interventional Labs					
directory/client svcs # in OR onboarding binders & on phone reference cards					
nt Tip Sheet for Ortho Offices					
ng/Receiving Improvements					
ng to Processing/Receiving forwarded to Client Services					
tion Provided by Client Services					
ervices to receive EPIC ordering training to be able to answer questions					

Test Directory Link Moved to More Visible Location

Pathology Handbook (NMH, LFH

Issue resolved on its own based on P1 upgrades and improved communication between the Lab and Intv Labs

Solution	
Specimen	Prep in Procedural Areas
Create a sh	ort list of specimens that are small and always go in f
Consistent	process for OR specimens that need fixative to quick
Lab to do v	visual check on specimens (is there a specimen there,
Specimen	Dropoff at Lab
Created a s Only exception	single drop-off point for specimens on- tissues during pathology hours of operation
Short term dropped of	: New dropoff log at processing/receiving to record # ff
Long term: against	EPIC monitor in processing/receiving that shows per
Courier/Of	ffsite Pickup Process Improvements
Education	on when stat pickups are required/escalation of couri
Cosigning	on pickup at selected RMG offices

NURSES:	DO NOT I WRITE AL	EAVE SPECIMEN WITHOUT L INFORMATION LEGIBLY.	LAB STAFF CHECKI	NG REQUISITION AND SPECIMEN BA	G.
Date	Time	Patient Name (or sticker)	SPECIMEN TYPE	TEST(S)	

Process Owners Multiple

Improvement Leader Jeanette Karon





Overall, we are tracking at 0.44 cases/month in the 11 months since the project started, versus baseline of 0.62.

For 5 months there was a streak of 0/month!

An FMEA was conducted after all solutions were implemented to identify any remaining high risk issues. Action Plans were developed and continue to be monitored.



Multiple metrics continue to be tracked as part of the control plan. Specific actions are recommended if metrics are deemed to be out of control.

• Make all specimen logs electronic and incorporate badge scanner and/or tablet signoff at

• Utilize barcode scanning and photographs wherever possible to track specimens • Implement a regular review meeting or assign a dedicated lab liaison to discuss process issues between the lab and procedural areas to ensure communication and collaboration