

# Specimen Opportunity Journey

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## Background and Clinical Issue

As a system, specimen-related errors had been steadily increasing, highlighting the need for real-time monitoring, problem-solving, and identification of systemwide gaps.

To address this, the Specimen Committee was launched on August 21, 2024, with the goal of identifying barriers and implementing actionable, sustainable solutions. The committee brings together leaders from all six campuses, meeting regularly to:

- Review trends
- Troubleshoot issues in real time
- Identify root causes
- Develop and recommend corrective strategies

## Clinical Setting and Description of Team

Northeast Georgia Health System (NGHS) is a six-campus hospital system with more than 962 inpatient beds and 42 operating room suites across the region.

Surgical capacity across the system includes:

- Gainesville-Level I Trauma with 28 operating rooms (pictured below)
- Braselton-7 OR suites
- Barrow – 3 OR suites
- Lumpkin – 4 OR suites
- Habersham– 5 OR suites
- Ambulatory Surgery Center (ASC) – 4 OR suites and 2 endoscopy rooms

In addition to the above, endoscopy procedure rooms are located at:

- Gainesville
- Braselton
- Ambulatory Surgery Center

The operating room leadership team consists of directors, managers, assistant nurse managers, clinical specialty coordinators, and clinical educators.



## Assessment

Operational assessments revealed several key contributing factors:

- Variability in workflows among the six campuses, including differences in labeling, handoff practices, and documentation.
- Lack of real-time visibility into trends, limiting the ability to identify and mitigate risks before errors occurred.

Additionally, the size and diversity of the system, multiple endoscopy units, and a wide distribution of procedural areas created operational complexity that amplified the need for a unified, system-level approach.

- This assessment demonstrated that reducing specimen errors required:
  - Standardized workflows
  - Timely data review
  - Cross-campus collaboration
  - Consistent education and reinforcement

## SWOT Analysis

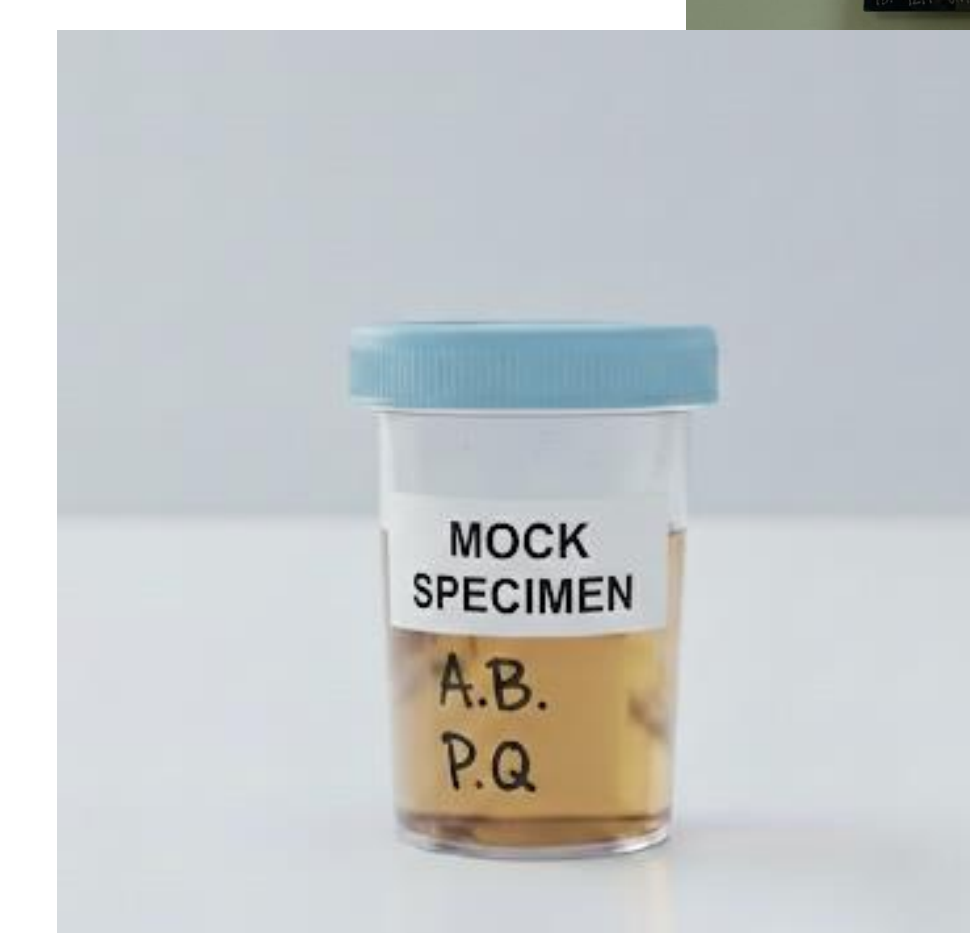
- **Strength:** Strong alignment across frontline teams and campus leadership, with a unified commitment to reducing surgical specimen errors systemwide.
- **Weakness:** Initial uncertainty around which data points would provide the most value across all campuses, requiring time to identify meaningful metrics and prioritize which specimen error types to target first for improvement.
- **Opportunity:** Variation in specimen handling and laboratory workflows across campuses presents a clear opportunity to standardize processes, reduce variability, and enhance systemwide reliability.
- **Threat:** Workflow inconsistencies and resistance to change may challenge implementation efforts, emphasizing the need to demonstrate value and ensure consistent adoption of new practices.

## Implementation

To reduce specimen-related errors and strengthen systemwide reliability, NGHS implemented a series of targeted, collaborative interventions across all perioperative campuses:

- **Integration of a Specimen Board into the OR Huddle Board:** Added to daily huddles to provide real-time visibility of specimen status, enhancing situational awareness and accountability.
- **Introduction of the Specimen Runner Role:** A dedicated role created to support timely and accurate handling of specimens
- **Strengthening the Specimen Facilitator Workflow for After-Hours Coverage:** Facilitator responsibilities were enhanced to ensure consistent oversight, communication, and specimen handling support during evenings, nights, and weekends.
- **Team Coaching and Education:** Ongoing coaching, competency reinforcement, and focused staff education were deployed to standardize practices and address process gaps identified through event reviews.
- **THH (This Happened Here) Flyers at Huddles:** Real examples of recent, de-identified errors were incorporated into daily huddles to increase awareness, promote transparency, and support learning from actual events.

These interventions collectively improved communication, accountability, situational awareness, and process reliability, contributing to a significant reduction in systemwide specimen errors.



## Outcome

Specimen Errors Heat Map – 2024

Error Type	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Communication													0
Handling	1	2	1	2		2	1	1			1		11
Labeling	1		1	1		1		1		1	1	1	9
Ordering									1				1
Monthly Total	2	2	2	4	0	3	1	3	0	1	2	1	21

Specimen Errors Heat Map – 2025

Error Type	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Communication													0
Handling		1	1		2	1	3		1				9
Labeling						2		1			1	1	5
Ordering								1					2
Monthly Total	0	1	1	0	2	4	3	2	1	1	1	1	17

- 19% reduction in total specimen errors in 2025:
  - Decreased from 21 → 17, even with 2025 scope expansion to include Endoscopy.
- 2 campuses achieved significant reductions:
  - Braselton: 80% reduction
  - Habersham: 50% reduction
- 3 campuses reported zero specimen errors:
  - ASC
  - Barrow
  - Lumpkin
- Handling errors (largest error type in 2024) decreased by 18.8% in 2025

## Implications

- Enhanced Patient Safety:
  - Fewer specimen errors reduce delays in diagnosis, prevent repeat procedures, and lower the risk of incorrect or incomplete treatment.
- Stronger System Reliability:
  - Sustained reductions across multiple campuses demonstrate that standardized workflows and cross-campus collaboration improve consistency and reduce variation in specimen handling
- Improved Staff Confidence & Engagement:
  - Clear processes, real-time visibility tools, and reinforced education empower perioperative teams to perform tasks accurately and confidently.