

Scan me!



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DESCRIPTION

The Gynecological Clinic at Humber River Health offers specialized outpatient care for cervical, vaginal, and vulvar abnormalities, and hysteroscopies using advanced technologies like the UltraPulse® CO₂ laser to provide minimally invasive treatment with reduced recovery time. The fast-paced clinic involves rapid collection of multiple specimens which led to increased incidents of pathology specimen errors (i.e., wrong patient) as a result of current process workflows. From January to July 2025 there were five reported specimen-related incidents, of which three (60%) were related to patient identification labelling errors. A systematic workflow review revealed many manual processes such as patient lookup and entry. The process was redesigned using available technology to reduce manual input and ensure correct patient identification at time of specimen order entry.

OBJECTIVE

Reduce client identification errors during specimen entry in the Electronic Medical Record.

ACTIONS TAKEN

1. Systematic review of current state workflows with leadership and clinical team
2. Identified gaps and improvement opportunities
3. Changed existing patient wristbands to scannable versions (as used across the organization)
4. Leveraged existing technological aids (i.e., Interventional Radiology scanners) to eliminate manual patient look up
5. Testing new process to validate
6. Implementation to the Gynecological Clinic

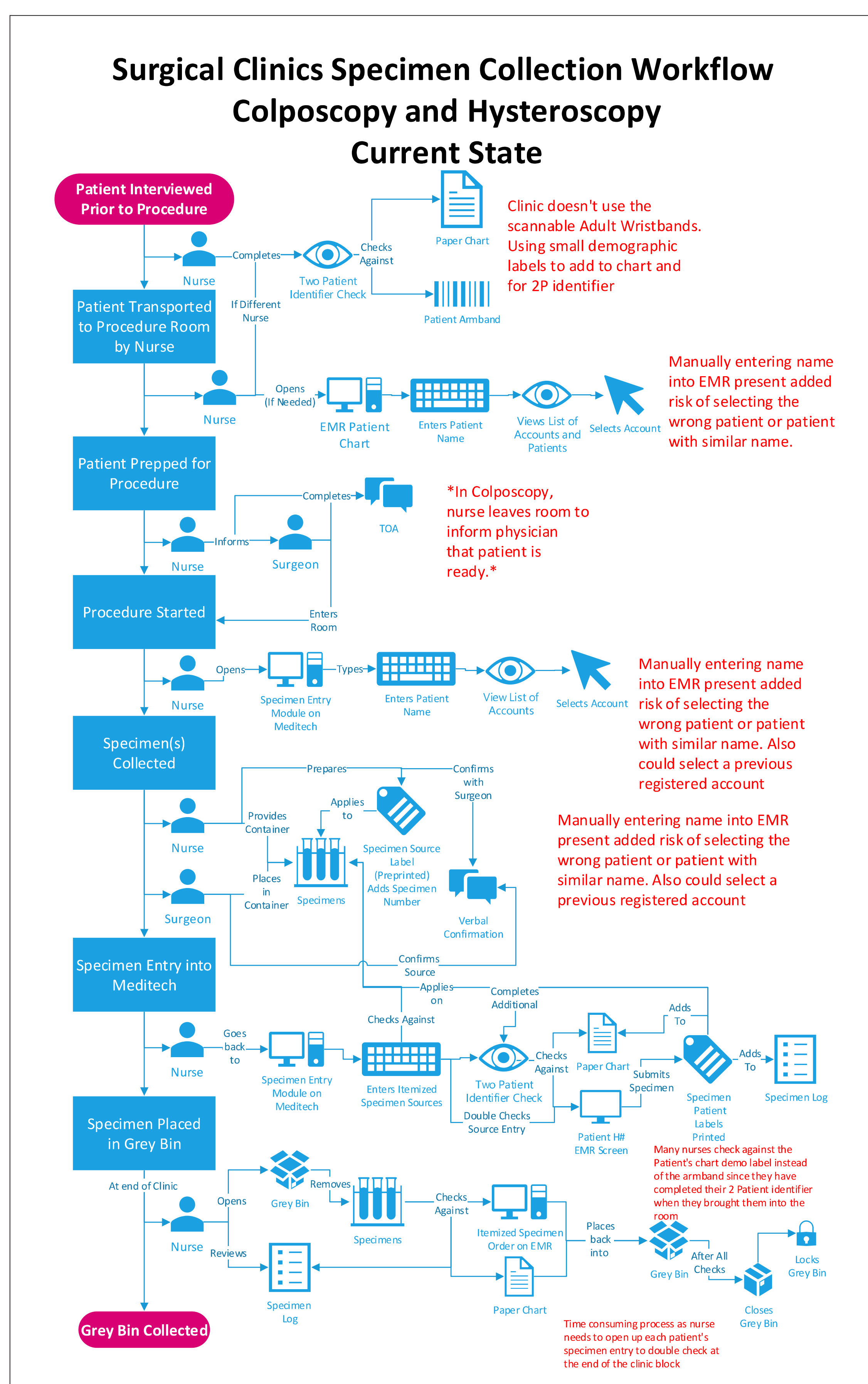


Figure 1. Process Workflow Current State with Gaps identified.

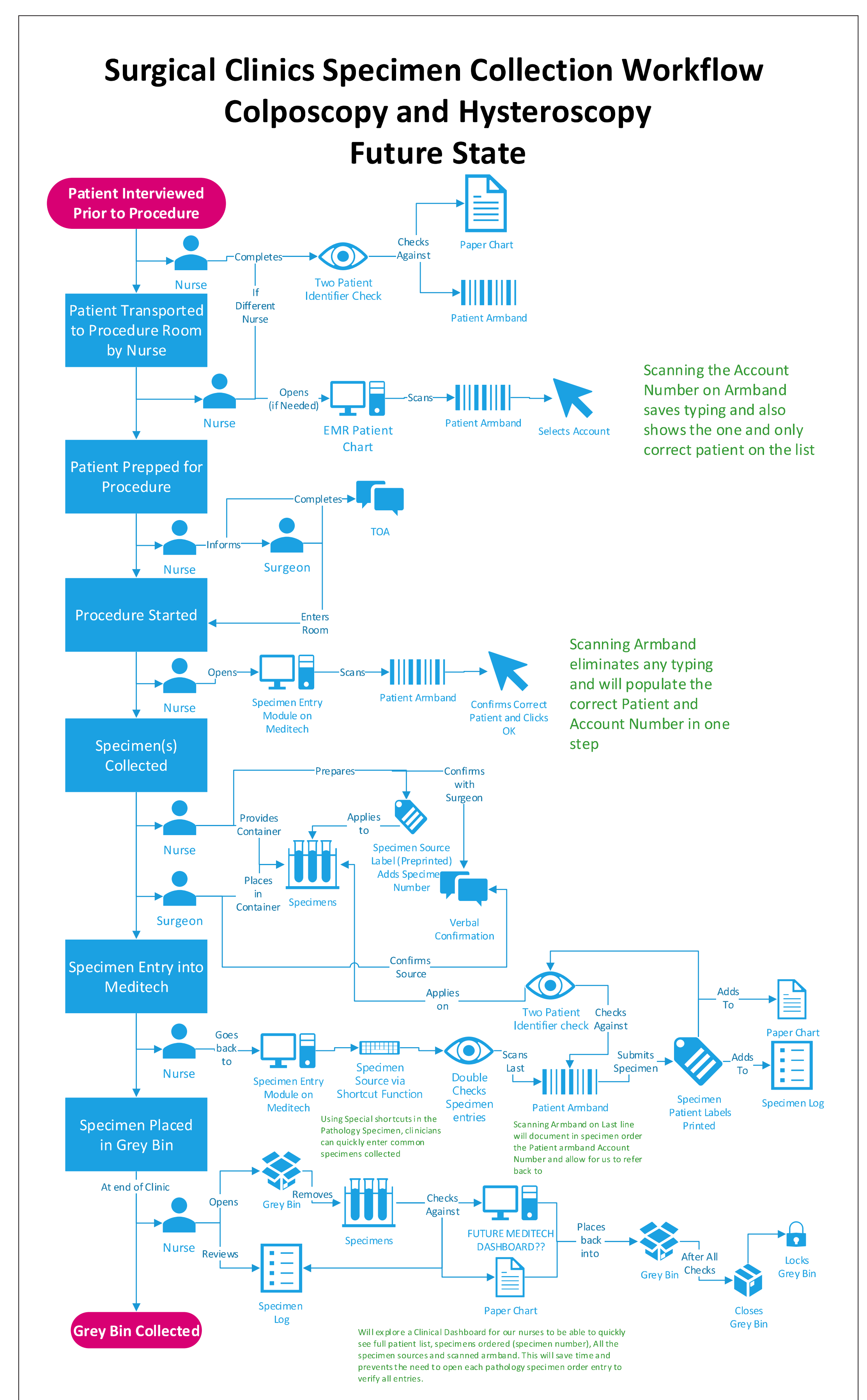


Figure 2. Process Workflow Future State Integrating Patient ID Scanning.

SUMMARY OF RESULTS

The new process was received well by the clinical team and proved easy to implement. The clinic acquired two Interventional Radiology scanners to facilitate wristband scanning. The new wristbands were standardized to match those used in other areas, and featured a scannable barcode. At registration, these were placed on the patient's left arm, closest to the computer during their procedure. Scanning the wristband during pathology specimen entry enabled quick and accurate patient and visit selection, eliminating multiple manual steps. Since implementation in July 2025, no patient identification or labelling errors have been reported.

LESSONS LEARNED

Following multiple incidents, it is essential to conduct a comprehensive process review and involve all stakeholders in developing new processes to ensure adequate buy-in and successful implementation.

