DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE

Policy Title: **Specimen Acceptance**
Policy # 710

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Purpose:

All specimens and laboratory request forms must be submitted with proper identification. Specimens of blood or other potentially infectious materials shall be placed in a sealable, biohazard bag, or a container with a secure lid, which prevents leakage during transport. As potential always exists for outside contamination of the primary container, the primary container should be placed within a second container, which prevents leakage during transport to the laboratory.

Policy:

Specimens from unauthorized sources (such as tests initiated by employees) will not be accepted. Specimens submitted in a syringe with a needle attached will not be accepted. The needle must be removed before the laboratory will accept any syringe.

Requests should be time stamped upon arrival in the laboratory by the individual delivering the sample. Specimens sent by dumbwaiter or the pneumatic tube system will be time stamped by laboratory Specimen Processing staff.

Requirements:

Specimens

- All specimens from should be labeled with the patient's name, date of birth, date and time of collection, and the initials of the collector. If known, include the medical record number, ECD number, and the patient's location. Specimens for Cytology, Histology, Microbiology, and Molecular Diagnostics must include the specimen source or type of specimen. Specimens for Histology must include the physician's name.

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Requisition

- Written orders from a provider must accompany all requests for testing. For specimens collected from patient's located in one of the hospitals or emergency rooms the requisition from Powerchart is sent and includes the following information: FIN number, Order HIS Id, Patient Name, patient's date of birth, location, ordering provider's name, their NPI number, reason for visit, Procedure Ordered, Name of the ordering provider, name of the person entering the order into Powerchart and the date and time the procedure was ordered.
- Requisitions for Outpatient testing must include:
    - Patient's name
    - Date of birth
    - The name, address, phone number, and fax number of the practice ordering the test.
    - The name of the test requested
    - The diagnosis code for the test requested along with the date and time of the request.
- Written orders are valid for 12 months from the date written on the order. The signature of the ordering provider can be electronic. Other information that may be included on the requisition – CPT codes for the tests, requesting test status (routine, Urgent), and the names of other providers requesting copies of the test results.
- Written orders for Blood Bank testing must also include the signature of the specimen collector.

Specimen Acceptance

- All specimens and laboratory requests must be submitted with proper identification. Specimens of blood or other potentially infectious materials shall be placed in a sealable biohazard bag, or container with a secure lid that prevents leakage during transport. The potential for outside contamination of the primary container always exists, therefore the primary container should be placed within a second container, which prevents leakage during transport.
- Specimens from unauthorized sources (such as tests initiated by a caregiver for themselves) will not be accepted. Specimens submitted in a syringe with a needle attached will not be accepted. The needle must be removed before the laboratory will accept any syringe.
- Requests should be time stamped upon arrival in the laboratory by the individual delivering the sample. Specimens sent by the dumb waiter, or the pneumatic tube system will be time stamped by the laboratories Specimen Processing caregivers.

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- Inpatient blood and urine specimens that are not properly labeled and accompanied by a correctly completed requisition form, will be rejected. The specimen will need to be recollected. Any rejections of a specimen will be reported by telephone or Vocera as soon as possible to the area from which it was sent, with the reason for rejection. The call will be added as a footnote in the LIS. An R2L report is generated to document the event. Specimens and request forms not properly labeled may be processed only with the knowledge and approval of the Manager, Supervisor, Section Director or Pathologist. During non-routine hours it is the responsibility of the Laboratory Scientist to use good judgement in determining the need to process an improperly labeled specimen. Follow-up with appropriate supervisory staff in a timely fashion is essential. Every effort should be made to identify and process "irreplaceable specimens" such as spinal fluid, special catheterization samples and specimens and samples from the Newborn Intensive Care Nursery.
- Unlabeled "CODE" specimens will be processed. The requesting party must then come to the laboratory to label the specimen. A note is added to the patient report that the testing was done on an unlabeled specimen a but labeled post testing. No exceptions are made for Blood Bank "CODE" specimens. They must be labeled to be processed.
- If analysis is performed on "unacceptable" specimens, the test report will note the nature of the problem and if applicable, and a caution in interpreting the results.

Patient Identification

- The Joint Commission requires two sources of patient identification for all specimens on the specimen and on the written order. See ChristianaCare's policy for specific instructions on identification of inpatients, outpatients, and those in the Emergency Department.
- The Joint Commission also requires labeling of collection tubes and containers next to the patient, either at bedside or in the phlebotomy chair.

Recollection Policy

- Unfortunately, there are instances when specimens received in the laboratory are unable to be tested. These specimens may have been collected by the inability of laboratory staff to order future testing in Powerchart, and the necessity to identify specimens uniquely by collection times. All recollects must be reordered by the nursing unit at the patient's current location.
- The following is the list of some of the reasons for recollection:
    - Clotted specimen for CBC, or coagulation testing
    - Specimen collected in the wrong tube.

- Quantity insufficient volume for testing
- Gross hemolysis
- Specimen received unlabeled or incorrectly labeled.
- Specimen damaged, broken or mislaid.

- For Inpatients - The Nursing unit will be contacted by the laboratory staff member identifying the problem.
- Laboratory personnel will explain the reason for recollection and document the person contacted for record documentation. Laboratory staff will also ensure the patient is not charged for the uncompleted test(s) and not charged inappropriately for multiple phlebotomy collections.
- The nursing personnel will determine the priority level of recollection and order appropriately in PowerChart.

Add-on Laboratory Requests

- Federal regulations require that all laboratories have a written or electronic request for the performance of all laboratory tests. The following procedure has been formulated to follow once a laboratory specimen is collected and delivered to the laboratory. Additional testing may be necessary for several reasons such as the results of the test previously collected yielded test results requiring testing of additional analytes or a test was forgotten, and a provider knows specimens were recently collected.
  - For a patients in one of the hospitals as an inpatient, the nursing unit should call the laboratory to verify that the existing specimen is acceptable for the new test request and that there's enough of the specimen to perform the test. If the answer is yes, an add-on study can be ordered in PowerChart in the section labeled "ADD-ON ORDERS". The requisition prints in the laboratory on an assigned printer. Someone in the laboratory is assigned to monitor this printer for orders. Once received, the laboratory enters the order in the LIS. This allows the new study to be assigned the same accession number as the original specimen already received in the laboratory.
  - For Outpatients, the provider must call the laboratory to verify if the existing specimen is acceptable for the new test request and there is enough specimen to perform the test. If the answer is yes, an add-on study can be ordered in Cerner Ambulatory in the section labeled "ADD-ON ORDERS". This order is faxed to the laboratory. The requisition prints in the laboratory on an assigned printer. Someone in the laboratory is assigned to monitor this printer for orders. Once received, the laboratory enters the order in the LIS. This allows the new study to be assigned the same accession number as the original specimen already in the laboratory.

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