

PROCEDURE FOR: Specimen Care and Handling

- POLICY:
1. All specimens will be handled according to requirements listed in *UCHC Laboratory Specimen Collection Manual* and in this standard.
 2. Assessment of specimen handling and collection needs will begin when the procedure is scheduled and continue throughout the procedure.
 3. Correct patient and specimen identification will be implemented during all steps of the process, including confirmation of consistent and accurate information on labels and forms, beginning when the specimen is removed from the patient.
 4. Documentation should establish chain of custody from the point of removal until pathological examination for all tissue specimens as well as material removed for forensic evidence.
 5. Collection and handling of all specimens will be completed in a manner that protects and secures the specimen and prevents contamination of personnel handling the specimen.
 6. Specimen containers will be labeled to communicate patient, specimen, preservative, and biohazard information.
 7. Communication between physicians, such as pathologist and surgeon, should be direct (ie, not through an intermediary) when it relates to diagnosis or specific diagnostic information about the specimen and a record of communication should be documented in the patient's record.
 8. Tissue specimens will be designated for routine pathological exam, gross identification only, or disposal according to state and federal guidelines.
 - a. All specimens obtained perioperatively will be sent to Anatomic Pathology with the exceptions noted in *Appendix A*.
 - b. All specimens sent to Anatomic Pathology will be examined for both gross and microscopic evaluation with the exceptions noted in *Appendix B*, which require gross examination only and shall be so marked on the Pathology Requisition.
 - c. The disposition of all tissue or other items removed from the patient should be documented in the nursing record, whether or not it goes to Anatomic Pathology, including any listing in *Appendix A*.
 9. Hand-offs will be used to prevent mishandling of specimens by verifying patient and specimen information before each transfer, and by transport personnel at each point of exchange.
 10. Caution will be used by all employees when handling or disposing of formalin. Ongoing monitoring of formalin levels in the Pathology Exam Room is the responsibility of the Dept. of Research and Safety.
 11. Anatomic Pathology will note scheduled sentinel node procedures and process the specimen appropriately. For any other specimen known or suspected to contain radioactive material, Research Safety will be consulted to ensure proper handling of the material.

PROCEDURE FOR: Specimen Care and Handling

12. Any unintentionally retained item that is removed during a subsequent procedure must be sent to Anatomic Pathology for processing as a permanent specimen.
13. All material removed from a patient which is or may be forensic evidence (e.g., knives, bullets, personal effects) will be preserved in a manner which maintains the integrity of the evidence and the chain of custody.
14. Requests for implants removed from patients will be addressed as follows:
 - a. patients may receive decontaminated implants removed from their own body upon request, except in cases where documentation of mechanism of hardware failure is deemed vital or necessary to diagnosis or treatment or serves as some medical or legal foundation for a particular case;
 - b. all persons other than the patient may receive decontaminated implants only if the patient has provided specific written consent for this on the informed consent document, except in cases where documentation of mechanism of hardware failure is deemed vital or necessary to diagnosis or treatment or serves as some medical or legal foundation for a particular case;
 - c. any implant that was placed as part of an investigational study must be returned only to the Principle Investigator of the study.
15. All placentas must be sent to Anatomic Pathology, which will determine if they are to be exempt from gross or microscopic exam.

EQUIPMENT: Specimen containers
Formalin
Dept. Anatomic Pathology Surgical/Cytology Requisition - HCH-765
Cytogenetics Test Request Form
Electron Microscopy Laboratory Requisition
Patient Labels

PROCEDURE:

Action

Points of Emphasis

1. From the time the booking is posted through the procedure itself, assessment and planning for specimen handling needs will include:
 - a. persons / departments to be notified (eg, pathology for frozen section;
 - b. supplies needed for transfer or transport;
 - c. availability of personnel;
 - d. specific requirements necessary for collection or handling of specimens (eg, timing of transfer, solution, container).

PROCEDURE FOR: Specimen Care and Handling

<u>Action</u>	<u>Points of Emphasis</u>
2. Determine and / or obtain containers and collection devices of appropriate size and type, with correct preservatives.	2. a. Containers should be large enough to safely secure the specimen and fluids, if used, to prevent leakage and unnecessary exposure of personnel or others handling the container or its contents. b. The container and collection device also should be of a size appropriate to allow the preservatives or solutions, if used, to contact all surfaces of the specimen. c. Collection containers may be sterile or clean, depending on collection requirements.
3. Assess the patient's cultural considerations to determine if there are any concerns related to appropriate handling and disposal of specimens.	
4. Identify the specimen at the time it is removed from the patient with both written and verbal communication to confirm the information. This should include a "read back" verification of the information, using a "write down, read back" process to confirm the communication and minimize the risk of miscommunication. "Write down, read back" verification should include, but not be limited to, <ul style="list-style-type: none">• physician to physician• physician to scrub person• scrub person to RN circulator• physician to RN circulator	4. Use two unique identifiers when the specimen is removed from the patient and when it is placed in the container for transfer and transport to minimize the risk of misidentification of a specimen, margins, or other information that can result in adverse outcomes, delay, error in diagnosis or treatment, or the need for an additional procedure.
5. Identification will be confirmed verbally between the surgeon / physician and registered nurse circulator and documented completely in the nursing record and on the <i>Surgical/ Cytology Requisition</i> , including but not limited to: <ul style="list-style-type: none">a. originating source of specimen (eg, site / side)b. type of tissuec. clinical diagnosisd. pertinent clinical information	6. Each specimen removed for examination should be clearly documented on the specimen container, operative record, and pathology documents. If Creutzfeld-Jakob Disease is suspected, the specimen label must clearly indicate this. The circulating nurse will confirm if there are any special considerations (pt history, course of treatment, last menstrual period, specimen-specific information, etc.) and documents same on the <i>Surgical/ Cytology Requisition</i> .

PROCEDURE FOR: Specimen Care and Handling

<u>Action</u>	<u>Points of Emphasis</u>
7. The scrub person will protect and secure specimens on the sterile field until it is confirmed with the surgeon / physician that the specimen may be removed from the surgical field. Specimens that must be kept on the sterile field before transfer should be maintained and labeled appropriately to prevent loss, damage, or mishandling.	7. Specimens should be passed off the sterile field as soon as possible. It is preferable for the scrub person to visibly label the specimen following "write down, read back" in order to prevent errors and misidentification and to minimize the chance for errors during the transfer / transport process.
8. Specimens for routine examination may be kept moist with isotonic irrigation solution in the OR/Procedure Room until the procedure is complete.	
9. Specimens and containers removed from the surgical field should be handled using standard precautions; the circulating nurse will provide a sterile container into which the scrub nurse or physician may aseptically place the specimen.	9. Large specimen containers are located in the Pathology Lab; limbs must be bagged. If the container becomes contaminated, the circulating nurse shall clean it with high level disinfectant.
10. The circulating nurse documents with dark, indelible ink on the specimen label: <ul style="list-style-type: none">• the name of the specimen;• its alphanumeric order (A, B, C);• the time it was received from the field;• the OR/Procedure Room #; and• the attending surgeon or physician; The circulating nurse then affixes the label to the specimen container, not the lid.	10. The circulating nurse again assures that two unique identifiers are used to identify the patient reference. Containers will be labeled to indicate if a biohazardous material is being transported to prevent contamination of personnel transporting or receiving the specimen, and will note on the label if chemical preservatives have been used.
11. For <i>frozen sections</i> , the circulating nurse ensures that the Anatomic Pathology department is alerted, then delivers the labeled specimen and completed requisition to the Pathology Exam Laboratory microscope counter.	11. No fixative is added to the specimen. For FSC frozen sections, the circulating nurse will notify transport personnel to take specimen to the JDH Pathology Exam Laboratory.

PROCEDURE FOR: Specimen Care and Handling

<u>Action</u>	<u>Points of Emphasis</u>
12. For reporting of test results obtained during the procedure (eg, frozen sections or needle localization breast biopsies), documentation should be entered in the nursing record whenever the pathologist has communication results directly to the surgeon. If communication directly between physicians is not possible, it should be written, marked with the date and time, and included in the patient's record.	
13. For routine (<i>permanent</i>) exam, the circulating nurse delivers the specimens to the Pathology Exam Lab/area, adds enough formalin fixative to submerge the tissue, and completes paperwork per step.	13. If a specimen cannot be placed in formalin (eg, limb) during off hours, specimen should be transported to Laboratory Central Processing for refrigerated storage until Anatomic Pathology can retrieve it.
14. At the completion of the procedure, the circulating nurse places a label from all remaining specimens in the Pathology Log Book and places the specimen requisition adjacent to the specimen(s) in the Pathology Exam Room/area.	14. Disposition of all tissue, devices and implants removed (explants) should be documented in the nursing record.
14. In the event of a formalin spill: a. small amounts - flush down drain or use disposable chux or huck towels to absorb fluid, then dispose in red bag biohazardous trash receptacle b. large amounts - close off the lab window to the inner core and post notice on the entryway to prevent staff from entering the room, and notify Research Safety for clean-up.	

PROCEDURE FOR: Specimen Care and Handling

Action

Points of Emphasis

Forensic Evidence Preservation

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| <p>1. When it is anticipated that forensic evidence will be obtained from a patient, the charge nurse or the nurse caring for the patient will notify UConn Health System Police (x2121) of the</p> <ul style="list-style-type: none">• patient's name,• TOO number,• type of injury, and• the estimated time of evidence availability. <p>2. Evidence will be collected in a manner that minimizes any alterations to it, such as avoiding contact with metal basins or unnecessarily grasping with surgical instrumentation.</p> <p>3. Evidence will be contained as follows:</p> <ul style="list-style-type: none">• <i>bullets</i> in a plastic specimen cup;• <i>knives</i> or other large sharp objects in cardboard, then enclosed in a plastic bag;• <i>clothing</i> or other large items in a paper bag, then wrapped in a plastic bag. <p>4. Sticky labels marked with the patient's name and TOO number will be used to seal shut any specimen cup or plastic bag containing forensic evidence.</p> <p>5. The physician and nurse caring for the patient will document in the patient record a description of the evidence obtained.</p> | <p>1. If the patient is a crime victim and it is known where the crime occurred, UConn Health System Police must be alerted to contact the appropriate authorities.</p> <p>2. Forensic testing may be affected adversely by incorrect collection practices.</p> <p>3. Universal Precautions must be maintained. Injury to hospital personnel must be avoided. Life-sustaining measures supersede the need to handle, secure, and document forensic evidence.</p> <p>4. Unbroken patient labels will indicate that no tampering has occurred.</p> |
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PROCEDURE FOR: Specimen Care and Handling

Action

Points of Emphasis

6. Evidence will be surrendered to the receiving police officer as identified by UConn Health System Police officer or directly to UConn Health System Police officer. The nurse will document in the progress notes the name, badge number, and district name/number of the receiving officer, and the date and time evidence was transferred.
7. The receiving officer will document and sign for receipt of evidence in the progress notes.

APPROVAL: Nursing Standards Committee
Anatomic Pathology

EFFECTIVE DATE: 1/87

REVISION DATE(S): 1/92, 5/93, 3/94, 12/94, 2/95, 1/96, 9/97, 5/00, 2/08,
10/08, 1/09

PROCEDURE FOR: Specimen Care and Handling

Appendix A - Specimens which do not have to be sent to Anatomic Pathology for either gross or microscopic examination (The disposition of all tissue or other items removed from the patient should be documented in the nursing record, whether or not it goes to Anatomic Pathology, including any listing in Appendix A):

1. Foreskin: Uncomplicated circumcision on newborns up to the first year of life.
2. Bone fragments removed as part of corrective or reconstructive orthopedic procedures (e.g. rotator cuff repair, synostosis repair) excluding large specimens such as femoral heads, and knee, ankle, or elbow reconstructions.
3. Normal, carious or periodontally diseased teeth and normal bone or soft tissue incidentally removed from non diseased areas.
4. Medical devices such as catheters, gastrostomy tubes, myringotomy tubes, stents, ruptured or intact saline breast prostheses, and sutures that have not contributed to patient illness, injury or death.
5. All prostheses considered medical devices need not be sent to pathology if intact except in cases where documentation of mechanism of hardware failure is deemed vital or necessary to the diagnosis, treatment or serves as some medical/legal foundation for a particular case. The operative note must specifically state that the hardware was removed and intact.
6. Skin or other normal tissue removed during a cosmetic or reconstructive procedure (eg, blepharoplasty, cleft palate repair, abdominoplasty, rhytidectomy, syndactyly repair), provided it is not contiguous with a lesion and the patient does not have a history of malignancy
7. Cataracts removed by phacoemulsification
8. Bone donated to the bone bank
9. Dental appliances
10. Fat removed by liposuction
11. Foreign bodies such as bullets or other medicolegal evidence given directly to law enforcement personnel
12. Intrauterine contraceptive devices without attached soft tissue
13. Middle ear ossicles
14. Rib segments or other tissues removed for the purposes of gaining surgical access, provided the patient does not have a history of malignancy
15. Saphenous vein segments harvested for coronary artery bypass
16. Therapeutic radioactive sources
17. Normal toenails and fingernails that are incidentally removed

Appendix B - Specimens which have to be sent to Anatomic Pathology for gross examination only and which should be so marked on the requisition.

1. Infant hernia sacs
2. Torn meniscus
3. Tissue and cartilage obtained during laminectomy for spondylosis or spinal stenosis
4. Traumatically injured or accessory digits
5. Scar tissue removed incidentally during another procedure
6. Kidney and urethral stones
7. Prosthetic silicone breast implants

All other specimens should be submitted to Anatomic Pathology for both gross and microscopic examination.