Birmingham Women's and Children's NHS Foundation Trust

Policy for Labelling and Transporting Laboratory Specimens

applies to BWH, BCH and FTB sites

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Policy Summary
This policy defines the procedures for a safe system for the labelling, packaging and storage of pathological specimens at ward/clinic level and for transportation of specimens to laboratories at Birmingham Women's and Children's Hospitals and elsewhere.

1 Summary of key points

1. The policy defines your reponsibilities within your ward / location
2. The policy defines the minimum acceptance criteria on request forms and specimens required by the laboratory
3. The policy defines how to send specimens to the laboratory

2 Introduction

Incorrect labelling and/or handling of laboratory specimens can lead to serious harms to patients, hospital staff and the general public. This policy outlines procedures that must be followed by all staff to ensure that persons are not put at risk, and that the Trust operates within the law.

The NHS Litigation Authority (NHSLA) expects a safe system of work to be in place, which ensures correct patient identification of specimens and reports, and the procedure to be adopted in cases where specimen mislabelling occurs.

Health and safety legislation requires laboratory staff to process separately from other work, using special precautions, any specimens which are known to present, or are suspected of presenting, a risk or danger of infection to laboratory staff. In a hospital it is likely that at any given time there will be a number of patients who present an infectious risk that are not identified, either because the diagnosis of a clinical illness has not been made, or the patient is an asymptomatic carrier of infection. Therefore, all specimens must be safely stored, transported and handled using standard precautions. If a patient is known to present, or is suspected of presenting, an infection hazard it is essential that all staff involved in the collection, transportation and handling of specimens are given information sufficient to enable them to take the appropriate precautions.

Several pieces of legislation relate to the transport of laboratory specimens outside the hospital. The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations and the ADR Regulations set out the conditions under which specimens can be carried by road. It gives details relating to the packaging and labelling of any biological samples transported by such means. The Royal Mail also provides explicit requirements for the inland posting of diagnostic samples, which comply with ADR. The Health and Safety Executive document *Transportation of Infectious Substances* provides an overview of the transport requirements for materials containing, or contaminated with, blood-borne viruses.

3 Purpose

The objectives of this policy are to describe a safe system for the labelling, packaging and storage of pathological specimens at ward/clinic level and for transportation of specimens to laboratories at Birmingham Women's and Children's Hospitals and elsewhere.

4 Scope

4.1 Includes

This document applies to all employees.

5 Duties

5.1 Duties within the Organisation

5.1.1 Laboratory Managers

It is the responsibility of Laboratory Managers to ensure that:

- All laboratory staff who are involved in the transport, handling or dispatch of clinical specimens are

familiar with this policy, and have appropriate training
- All laboratory staff know how to carry out the procedure for dealing with spillages of pathological materials in accordance with the Spillage Procedure. (Appendix B)
- Spillage kits and appropriate protective equipment are available to staff
- All materials associated with this policy comply with standards recommended in this policy and equipment is maintained to an appropriate standard.
- There is liaison with the appropriate departments concerning cleaning and disinfection of equipment used in this policy.
- Suitable facilities for specimen receipt, handling, storage and dispatch are available in each laboratory.
- Specific guidance is provided for service users in their user's manual.
- Ensure that containers used are appropriate for the purpose. Container and packaging will comply with UN standards, i.e. packaging purchased for non-high risk samples must which meets instruction P621 and UN3373 & UN2814.
- Maintain and make available appropriate COSHH assessments

5.2 Identification of Stakeholders

5.2.1 Directorate Managers and Heads of Nursing and Midwifery

It is the responsibility of Directorate Management staff to ensure that:
- All staff in their directorate who request, collect and transport clinical specimens are familiar with this policy and its associated procedures.
- All staff in their directorate have access to appropriate parts of the policy and procedures
- All staff in their directorate who handle specimens receive adequate training and instruction of the requirements of this policy and its associated procedures.
- There are adequate resources to enable this policy and its procedyres to be performed correctly and in a safe manner.
- Materials associated with this policy comply with standards recommended in this policy
- They, or a delegated representative, assist with any investigation or untoward incidents, or non-compliance with this policy.
- They determine with appropriate managers the sites for specimen storage areas within their area.

5.2.2 Clinical Staff (includes Medical, Midwifery, Nursing and Phlebotomy Staff)

It is the responsibility of clinical staff ordering tests, taking samples, or sending samples to the ward to:
- Be familiar with and comply with this policy and associated procedures.
- Be aware of the hazards to themselves and others that would exist through non-compliance with the policy

When requesting specimens for analysis that may present a high risk of infection, ensure that staff who may take or handle the specimen are warned of the risk so that appropriate additional precautions can be taken.

5.2.3 Portering Manager

It is the responsibility of the Portering Manager to ensure that:
- All portering staff who transport specimens are familiar with this policy, and have appropriate training
- The portering staff know how to carry out the procedure for dealing with spillages of pathological materials in accordance with the Spillage Procedure. (Appendix B)
- Spillage kits and appropriate protective equipment are available to staff.
- All materials associated with this policy comply with standards recommended in this policy and any equipment is maintained to an appropriate standard
- There is liaison with the appropriate departments concerning cleaning and disinfection of equipment used in this policy

5.2.4 Portering Staff

It is the responsibility of portering staff to:
- Collect and transport pathological specimens in a safe manner

- Convey only those specimens which are appropriately packaged and not leaking to the point of collection
- Be familiar with the procedure for dealing with spillages of pathological materials in accordance with the Spillage Procedure. (Appendix B)
- Not transport pathological specimens with any other items, e.g. waste, post, notes, x-rays, unless they are properly segregated
- Not leave pathological specimens which are not in a locked box or similar carrier in public areas

5.2.5 Transport Drivers

It is the responsibility of drivers to:

- Collect and transport pathological specimens in a safe manner as instructed in the procedures accompanying this policy.
- Convey only those specimens which are appropriately packaged and not leaking to the laboratory.
- Be familiar with the procedure to be undertaken in the event of leakage or spillage of specimens or other untoward event in accordance with the Spillage Procedure. (Appendix B)
- Not to transport pathological specimens with any other items, e.g. waste, post, notes, x-rays, unless they are segregated from such items.
- Not leave pathological specimens which are not in a locked box or similar carrier in public areas.
- Observe hygiene rules given in the accompanying “Safety Rules for Porters and Driver”. (Appendix D)
- Never leave specimens in transit unattended in an unsecured vehicle or at an unsecured location

5.2.6 External Taxi / Local Transport Providers

The contractor must have a Health and Safety Policy which satisfies the requirements of the Birmingham Women's and Children’s Hospitals NHS Foundation Trust.

- It is the responsibility of the contractor to ensure that all their personnel are informed of and are fully trained in the performance of this policy at all levels.
- It is the responsibility of the contractor to ensure that their policies and procedures reflect those contained within this policy.

NOTE: Specimens must not be left by drivers at the receiving Hospital’s Porters’ Lodge. They must be taken to the appropriate department.

6 Method for development

6.1 Consultation and Communication with Stakeholders

Consultation has occurred through the Pathology Quality Committee (BCH) and the Clinical Improvement Group (BWH)

7 Content

7.1 Categorisation of Specimens

All specimens must be handled with care and treated by all personnel as a potential infection risk. However, additional precautions are required for samples that are deemed to be high risk.

7.1.1 Low Risk Diagnostic Specimens (UN3373):

The majority of specimens collected and transported to the pathology departments do not present a significant risk of infection to staff handling them. These may be considered “low risk” diagnostic specimens. Such specimens will normally be packaged in a primary container (e.g. blood tube, swab tube, specimen pot), and an outer secondary container (a sealed pathology transport bag or sealed plastic bag). All specimens must be accompanied by an accurately, fully completed pathology request form which must preferably be integral and external to the bag. The tertiary container used to transport specimens around and between hospitals may vary in design, but must comply with the P60 specification outlined in this Policy.

7.1.2 High Risk Infectious Specimens (UN2114):

Some patients may be suffering from, or be suspected of having a disease which may present higher

risk to staff. Legislation requires specimens from such patients to be identifiable. A list of diseases presenting such a risk and the specimens from those patients constituting “high risk” specimens are given in Appendix A.

- The specimen containers and pathology transport bags used for these specimens will be identical to those used for routine specimens. The identification of risk associated with these specimens will be by the use of “DANGER OF INFECTION” labels. The specification for these labels is given in Appendix C.
- It is the legal responsibility of the person who requests the laboratory examination of the specimen to ensure that both the request form and the container are correctly labelled to indicate a danger of infection. “DANGER OF INFECTION” labels must only be used for specimens which are suspected of or are known to contain pathogens listed in Appendix A.

7.2 Requesting laboratory investigations

The laboratories have well established acceptance criteria which need to be present for samples to be accepted and processed. All essential items need to be present on the form to ensure that patients are uniquely identified so that results are not allocated to the wrong patient, and that the correct test can be performed and reported to the correct clinician and sent to the correct location.

It is the responsibility of the requesting clinician to complete the correct request form fully. Errors or incomplete information WILL result in the delay in specimen processing and reporting.

To comply with laboratory procedures, we will only accept samples where all mandatory information and minimum patient identifiers are provided. The following essential information is required;

Essential Criteria	Desirable
NHS Number / Hospital Registration Number	Patient address
Surname	Recent transfusion history (where relevant)
Forename	Any anticoagulant agents admistered
Date of Birth	Contact phone number / bleep
Identification and location of requestor	Indication of the urgency of the request
Investigation required	Gender
Date and time of collection	Medical Speciality
Specimen Type, & the anatomical site of origin	NHS/PP category
Relevant clinical information	
Fasting or dietary status	
The date of the onset of symptoms or date of contact	
Details of antibiotic therapy and drug therapy	
Biohazard warning label	

Transfusion requests for blood grouping and cross-matching MUST use the dedicated transfusion request form. All the same criteria apply including the name of the person taking the sample.

Electronic Requesting
Please use ICE requesting whenever possible. The BCH Hospital transfusion Committee strongly advises the use of electronic requesting for all blood grouping and product requests

Specimen Labeling
Specimens must be clearly labeled and accompanied by a completed request form.
All samples relating to blood transfusion shall be labeled by hand and MUST include:

- Hospital registration number
- Surname (correctly spelled)
- Forename (correctly spelled)
- Date of Birth
- Date and time of collection.
- Location (ward)
- Signature and name of person taking the sample (mandatory for all transfusion requests)

Please note that:

- **Unlabeled specimens will not be processed.**
- **Printed labels on samples will not be accepted under any circumstances**

Emergency Requests
Urgent requests must be confined to specific tests that will immediately affect the management of a case. Urgent requests must be clearly marked on the request form. Unlabeled and mislabeled specimens will not be accepted.
For histopathology specimens, it is advised that you contact the department prior to sending the sample.

Acceptance and Rejection
Occasionally the laboratory will reject the sample for testing for the following reasons:

- Printed labels used on blood transfusion bank requests
- Unsigned request form and or sample for blood bank requests
- The request is inappropriate
- The names on the specimen and request form do not match or the specimen or form are received unlabeled
- Incomplete patient demographics
- Insufficient information is provided on the request form to determine the request required
- The sample is unsuitable for investigation (haemolysed, insufficient)

- The specimen fails to comply with safety protocols

See departmental handbooks for further information

For high risk samples “DANGER OF INFECTION” labels must be applied to both the request for and the specimen container. Take care when applying these labels to ensure that important information on the request form or specimen container is not obscured.

7.3 Specimen collection

- Wear appropriate personal protective equipment as per local risk assessment
- Avoid removing used needles from syringes where possible. Note that needles must never be re-sheathed
- Ensure that all hazardous collection materials are disposed appropriately.
- Ensure the specimen container used is the appropriate one for the purpose, that it is properly closed and that it is not externally contaminated by the contents.
- Ensure that the specimen container is appropriately labelled
- Ensure that a high risk sticker is applied to the specimen container where appropriate
- Ensure the specimen is packaged and stored in a suitable and safe manner and in a suitable place, whilst awaiting transportation to the laboratory
- Ensure that any urgent specimens are adequately packaged in accordance with this policy.
- Ensure that if taken by ward staff to the central specimen reception point within the
- hospital, that specimens are carried in a safe manner.

7.4 Specimen transport at Birmingham Women’s hospital

7.4.1 General points

- Transport providers must comply with the appropriate ADR requirements
- For most specimens, the container is placed into the leak-proof pathology bag with integral request form.
    - The bag is sealed as directed on the form. On no account are these bags to be stapled, pinned or clipped
    - These bags are not to be re-used
- Specimen containers which do not fit into the pathology bag are placed in a polythene bag which is sealed by knotting or the use of tape, but never by the use of staples, pins or clips. These bags should not be re-used.
- The Delivery suite has developed a separate procedure for the packing, labelling and transport of placenta samples.
- If the integral request form\envelopes are not used, the request form is attached to the outside of the bag and not placed inside the bag with the specimen container
- This box must be cleaned with detergent/water weekly or, if soiled, it must be cleaned immediately with 1% hypochlorite solution (see Spillage Procedure, Appendix B).
- Specimens must be kept safe and secure at all times during transport

7.4.2 Transport of specimens within Birmingham Women’s hospital

- Samples may be sent to the laboratories via the air-tube system, by ward or department staff delivering them directly to the laboratories or by leaving them in the designated area on the ward or department for the next routine specimen collection round.
- Specimens awaiting collection are placed in the designated ward/clinic specimen collection area
- Ward staff must transport the specimens to the laboratory in an appropriate specimen storage box
- Do not send “High risk” specimens via the air-tube system.
- Do not send histology samples via the air-tube system.

NOTE

- *Specimens must be kept in a locked area when unattended to prevent patient/general public access to the specimens.*
- *The boxes used to store the specimens must be washed weekly using detergent/hot water.*
    - *If soiled, they must be cleaned using the spillage kit as directed.*

7.4.3 Transport of specimens outside Birmingham Women's hospital

Departments wishing to send samples / biological material outside the Trust should discuss the management of these samples with the relevant pathology department. In certain cases, pathology may not be responsible for the dispatch of these specimens and the requesting department must organise the transportation.

7.4.4 Transport of specimens by taxi / local transport providers and community midwives from Birmingham Women's Hospital

- Occasional "in hours" and all "out of hours" specimens may be transported by private taxi to other laboratories.
- Copies of this Policy and Procedures will be available to the contracted taxi companies.
- Taxi drivers must have a copy of "Safety Rules for Porters and Drivers" (Appendix D) and must also be familiar with the health and safety implications of transportation of pathological specimens and how to deal with spillage\leakage of any specimens. (Appendix B)
- Transport boxes used by all drivers (taxi drivers and Trust staff) must conform to the standards described in this Policy (Appendix C). Transport boxes must not be placed on the vehicle seats. The boxes must be stored in the car boot, or secured at the rear of the vehicle if an estate car or van is used
- The specimens must be transported in such a way that if leakage occurred, it would be contained within the outer container
- The outside of any transportation box must be labelled as per the Policy
- Spillage kits and other equipment to deal with spillage must be available at the headquarters of the vehicle's base or within the vehicle.
- Specimens in transit must never be left unattended in an unsecured vehicle or at an unsecured location.

7.4.5 Transport of specimens by laboratories to laboratories not served by local transport providers of taxi services

Most transport is provided by specialist couriers. Each department within pathology will have its own arrangements with appropriate courier services.

7.5 Specimen Transport from Birmingham Children's hospital

7.5.1 General points

- Transport providers must comply with the appropriate ADR requirements
- For most specimens, the container is placed into the leak-proof pathology bag with integral request form.
    - The bag is sealed as directed on the form. On no account are these bags to be stapled, pinned or clipped
    - These bags are not to be re-used
- Specimen containers which do not fit into the pathology bag are placed in a polythene bag which is sealed by knotting or the use of tape, but never by the use of staples, pins or clips. These bags should not be re-used.
- Specimens must be kept safe and secure at all times during transport

7.5.2 Transport of specimens within Birmingham Children's hospital

- Samples may be sent to the laboratories via the air-tube system, by ward or department staff delivering them directly to the laboratories or by leaving them in the designated area on the ward or department for the next routine specimen collection round.
- Specimens awaiting collection are placed in the designated theatre/ward/clinic specimen collection area and are collected daily by pathology staff
- Do not send "High risk" specimens via the air-tube system.
- Do not send histology samples via the air-tube system.

NOTE

- *Specimens must be kept in a locked area when unattended to prevent patient/general public access to the specimens.*

- *The boxes used to store the specimens must be washed weekly using detergent/hot water. If soiled, they must be cleaned using the spillage kit as directed*

7.5.3 Transport of specimens outside the hospital

There are routine transport runs taking samples to other local hospitals 3 times a day organised with City Sprint. Please contact the laboratory for further details.

Departments wishing to send samples / biological material outside the Trust should discuss the management of these samples with the relevant pathology department. In certain cases, pathology may not be responsible for the dispatch of these specimens and the requesting department must organise the transportation.

7.6 Laboratory handling of specimens

Laboratory staff will not allow samples to be re-labelled with the exception of precious samples, e.g. surgical samples, foetal blood samples, admission swabs taken at birth. Such samples may be allowed with the agreement of senior laboratory staff.

For urgent and in-patient samples, staff will attempt to notify the requesting source of the sample rejection. The specimen is recorded in the laboratory information management system (LIMS) and a report generated.

All request forms for un-tested samples must be kept for 4 years (RCPath guidelines). Write the reason for the sample rejection on the request form and document within the LIMS. Auditing of instances of sample rejection may be carried out to highlight any training issues.

7.6.1 Samples Unsuitable for Analysis

Requests relating to samples that fail any of the first checks (i.e. sample/ request form PID checks, sample integrity/suitability) are booked onto LIMS with appropriate codes detailing reasons for rejection. The requesting clinician is notified directly and the incident is logged.

For any incomplete antenatal screening request forms, screening midwives are contacted to notify them of the errors made or incomplete information provided on request from.

7.6.2 Fresh Un-fixed Histology Specimens at Birmingham Women's Hospital

Specimens sent for histological examination that also require genetics analysis must be kept fresh. Once genetics sample has been taken the rest of the tissue is fixed in 10% Neutral Buffered Formalin ready for histological examination.

Any foetal material for genetic analysis will be returned to ward/dept/hospital for disposal according the HTA guidelines.

All placenta specimens from delivery suite must be sent fresh for histological examination (Please refer to 'Delivery Suite Procedure for the Preparation of Placenta Specimens for Histological Examination' - which can be found on the Trust Intranet).

It is important that fresh specimens are stored between 2 and 8 degrees centigrade as soon as possible, to prevent decomposition prior to histological examination.

7.6.3 Fresh Un-fixed Histology Specimens at Birmingham Children's Hospital

Intraoperative procedures

Intraoperative procedures including frozen section diagnosis, smear or squash preparations for intraoperative diagnosis or assessments of adequacy of biopsy material.

We ask to be notified in advance by our colleagues, so that we can respond to your request in a timely fashion. Please do not forget to include your contact details on the request form.

Theatre/clinical staff are advised to send the samples in a suitably sized container without any fixative. **Do not submit them in saline.**

Tumour Specimens

All tumour specimens, whether benign or malignant, biopsies or resections, should be submitted fresh, to allow appropriate workup.
Biopsies are best placed in a moist chamber (see above for instructions), to avoid drying. Do not submit them in saline. Please notify the laboratory in advance.

If fresh tumour biopsies (trucut biopsies etc) are to be sent to the department from theatres the theatre/clinical staff are advised to send the samples in a moist chamber (a universal rinsed out with saline and then the biopsies attached to the wall of the universal or a piece of moistened gauze placed into a universal container and again the biopsy placed on the all of the container) to avoid drying. **Do not submit them in saline.**

Muscle Biopsies

Muscle biopsies should be submitted fresh to the department. Ideally 2 specimens should be submitted: a 1.5cmx0.5cm longitudinal piece and a further 0.5x0.5xm piece should be placed either dry into a dry universal container or wrapped in cling film and then placed in a universal container.

These should then be delivered by hand as soon as possible (within 10 minutes of taking the specimen) to the Histopathology department and not placed into the POD system.

The department should be notified of the impending muscle biopsy as soon as possible so that handling arrangements may be made.

Skin biopsies accompanying the muscle biopsy should be sent directly to the Biochemistry department.

Please inform the laboratory if you are sending a muscle biopsy out of hours. For information in how to send a muscle biopsy out of hours, click on the attachment on the Intranet.

Rectal Biopsies

Fresh rectal biopsies for the diagnosis of Hirschsprung's disease, are to be sent to the department from theatres. Theatre/clinical staff are advised to send the samples in a moist chamber (a universal rinsed out with saline and then the biopsies attached to the wall of the universal or a piece of moistened gauze placed into a universal container and again the biopsy placed on the all of the container) to avoid drying. **Do not submit them in saline.**

NOTE

All of the above specimens should be delivered to the department with as little delay as possible (ideally in these circumstances the specimen should be delivered by hand and not placed into the POD system) to avoid delays in reporting.

7.6.4 Specimens that Contain Other Hazardous Materials

These include, pathological specimens that contain radioactive material or cytotoxic drugs, and specimen containers which may contain hazardous reagents. These represent a minority of specimens at the Birmingham Women's and Children's Hospitals NHS Foundation Trust.
The requirements for the transportation of radioactive materials by road, are described in the ADR 2015 regulations.
Local procedures for wards and departments concerning the packaging and transportation of radioactive materials and specimens containing radioactive residues are available and have been written with guidance from the Radiation Protection Adviser.

8 Education & Training Requirements

There is no formal training in relation to this policy or its procedures. However, If staff external to pathology would like to learn more or organise some ad-hoc training, please contact pathology and this can be arranged to meet your needs.

Please refer to section 5 to see the roles and responsibilities for training in departments and wards external to pathology.

Mandatory Training

- *Not applicable*

Non-related Mandatory Training

- *Not applicable*

9 Monitoring Compliance With and the Effectiveness of the policy

9.1 Process for Monitoring Compliance and Effectiveness

All specimens that do not meet the criteria set out in section 7.2 will be error logged in each department. More serious incidents will be logged as a Datix incident.

Departmental error logs are reviewed regularly to detect trends. Significant numbers of errors will be raised as a Datix and investigated accordingly.

All Datix incidents are monitored at the Diagnostics & Therapies Governance meeting.

9.2 Standards/Key Performance Indicators

There is not a key performance indicator that measures compliance of the content of this policy

10 References

- Working with ADR. An introduction to the carriage of dangerous goods by road, Department of Transport; 2004; ISBN 1-904763-4732
- European Agreement Concerning the International Carriage of Dangerous Goods by Road (ADR) 2015; United Nations, 2015. Available online at:
- Carriage of Dangerous and Use of Transportable Pressure Equipment Regulations 2009. Available online at:
    - http://www.legislation.gov.uk/uksi/2009/1348/contents/made
- Carriage of Dangerous Goods Manual, HSE Guidance, available online at:
    - http://www.hse.gov.uk/cdg/manual/index.htm
- Please refer to pathology intranet page and departmental handbooks
- BW Waste Management Policy B 6668
- BC Waste Management Policy Version 2.0.0

Appendix A – List of Samples Considered "High Risk" Suspected or Proven Infections in Category 3

All Specimens

- HIV
- Hepatitis B or C or D
- Q fever
- Rabies.
- Transmissible spongiform encephalopathies (e.g. Creutzfeldt-Jakob disease)
- Patients who have a fever and who have recently returned from Africa (risk of infection with category 4 pathogens)
- Selected Specimens
- Sputum and other material that may contain tubercle bacilli from patients with suspected or proven tuberculosis.
- CSF, brain tissues and spinal cord material from patients classified as being ***at risk*** of having a transmissible spongiform encephalopathy.
- Urine, faeces and blood from patients with suspected or proven typhoid or paratyphoid fevers. Faeces from patients suspected or proven to have:
    a. Dysentery due to *Shigella dysenteriae* type 1.
    b. Infection with verotoxin-producing *E. coli* (VTEC) (e.g. *E. coli* O157).
- Upper respiratory tract specimens, blood cultures, CSF and samples from skin lesions from patients with suspected or proven meningococcal infection, until 24 hours after commencing appropriate antibiotic therapy.
- Other samples as directed by Infection Control Team.

Further information can be found in the Trust's Infection Control Manual which can be found on the Trust intranet.

Appendix B – Spillage Kit Procedure

DISINFECTION TABLETS FOR PREPARING "HYPOCHLORITE" SOLUTIONS
Hypochlorite solutions are not very stable and this may cause problems when diluted, thus throughout this policy fresh solutions are made using effervescent tablets. The solutions recommended can be prepared as shown on the package.

- **AVOID USE ON METALLIC EQUIPMENT WHEREVER POSSIBLE.**
- **WASH HYPOCHLORITE OFF METALLIC EQUIPMENT WITH DETERGENT AND HOT WATER AND DRY.**

For blood/body fluid spillage – see spillage section of this policy.
Where possible, ensure good ventilation when using the higher strength chlorine solutions.

Use of Spillage Kits
These kits are only for use in cases of blood and body fluid/product spillage.
NOTE: FOR URINE – SEE NOTE 3.
This spillage kit contains:

- 1 tube of 10 x 1.8g tablets
- 1 x 500g disinfectant granules
- 1 x 1 litre bottle

The following items will also be necessary to use this kit:

- Orange waste bag
- Disposable cloths or paper towels
- Hot water and detergent
- Disposable gloves
- Disposable apron
-

Methods of Use

1. Put on apron and gloves
2. Sprinkle granules liberally over spillage, ensuring complete coverage. Leave for at least 2 minutes. Do not leave unattended.
3. Scoop debris into orange plastic bag.
4. Wipe up with damp paper towel any remaining powder – put paper towels into orange bag,
5. Wipe area with detergent and hot water.
6. Put all disposable equipment, gloves, apron etc into orange bag and seal.
7. Wash hands.

As an alternative to granules, 1 tablet may be dissolved in 100ml of water to give a hypochlorite solution of the same strength. This would only be for large volume or vertical spillages.

A fresh solution must be made up for each incident and disposed of carefully down the sluice.After use, the plastic bottle must be washed well and left upside down to drain before being stored dry.

NOTE 1:
Chlorine gas may be generated when hypochlorites are used – only use in well-ventilated area.

NOTE 2
Chlorine containing products may bleach colour from carpets and upholstery.

NOTE 3:
Caution – urine spills – contact of products with urine will liberate toxic gas.
In the event of urine spillage, first soak up excess using paper towels and dispose of in clinical waste bag, then treat as for blood spillage.

If the spillage kit is required for any other purpose, please contact the Control of Infection Team.

Replacement spillage kits are available from pharmacy.

The following are requirements which must be met in order to ensure the safe collection and transport of specimens to the laboratory. Specimen containers must meet instruction P621.

Specimen Containers

- Specimen containers must be sufficiently robust to withstand the stresses likely to be put upon them and must not leak in normal use.
- Specimen= containers and closures which are to be used more than once must be able to withstand autoclaving or disinfection and must remain leak-proof after each re-cycling process.
- Damaged closures or containers must be discarded and not taken back into use.
- Every specimen container label must describe the nature of the specimen, the identity and location of the person or details which would enable hospital staff to identify the source quickly, should the need arise.

Specimen Transport Bags

- These will be used whether or not a specimen is considered high risk.
- The transport bag must be sealed by means of an integral sealing strip or by other suitable means that can be opened without the use of sharp pointed instrument.
- Bags which require sealing by the use of pins, staples, or metal clips, are not acceptable.
- The bag should preferably have an integral request form or suitable means of containing the form other than in with the specimen, e.g. a separate document pocket.
- For larger pathological specimens, a suitable bag must be considered.
- Specimen transport bags must not be used more than once.

Specimen Transport Envelopes

These will be paper envelopes to be used for specimens carried by taxis.
These envelopes bear “Pathological Specimen”, “FRAGILE – WITH CARE – URGENT” and the UN3373 diamond.

Specimen Boxes

- Special specimen transport boxes are required for the safe transport of specimens which are classed as “Infectious Substances”.
- Several different styles of box are available but any box selected must comply with UN2814 requirements and meets instruction P621.

“Danger of Infection” Labels

Labels used for the identification of hazardous specimens as defined in this policy must confirm as follows:

- If applied by the user, be self-adhesive.
- Conform to internationally recognised health and safety standards. This will be a yellow label bearing black lettering stating “DANGER OF INFECTION” and have the biohazard trefoil.

Specific and up to date guidance can be found at the following UN Economic Commission for Europe (UNECE) website:
http://www.unece.org/trans/danger/publi/adr/adr2015/15contentse.html

Appendix C – Safety Rules for Community Midwives, Porters and Drivers

1. If you wear an overall, keep it properly fastened. Keep it apart from your outdoor clothing, not in your locker. Never wear your overall in the staff room or canteen.
2. Cover any cuts or grazes on your hands with waterproof dressings.
3. If you do touch a container accidentally, or you become contaminated by leakage from the specimen, then wash your hands as soon as possible.
4. Wash your hands before meal breaks and at the end of a session on duty.
5. Never eat, drink or smoke when you are carrying specimens.
6. Carry all specimens in the boxes/bags provided, not in your hands or in your pockets.
7. Containers are breakable, handle with care at all times.
8. If a specimen is leaking on the ward or at a central collection point, or the pathology form shows any signs of biological spoilage, do not remove it but inform your line manager. If it leaks in your box, or into your vehicle, inform a senior member of the laboratory staff immediately on arrival or contact your base for advice.
9. If you have an accident associated with a specimen whereby you become contaminated, inform a senior member of the laboratory staff or your manager immediately.
10. If you drop or break a specimen, use your radio/phone to request a Spillage Kit and clean up spillage as per Spillage Procedure, Appendix B.
11. Never leave samples unattended in an unsecured vehicle or location.
12. Community Midwifery Team Leaders receive 'train the trainer' driver awareness training to cascade through their teams.
13. Comply at all times with the ADR and Carriage of Dangerous Goods and Use of Transportable Pressure Equipment regulations.

NOTE

Your attention is drawn to the fact that whilst the specimens are in your possession, you have a duty of care and it is your legal responsibility under the Health & Safety Act to ensure that specimens are transported in a secure and safe manner.

Appendix D – Policy Review Group Checklist for the Review and Approval of Procedural Document.
To be completed by the Policy author prior to submission for approval/ratification

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**State Title:**		
	Is the title clear and unambiguous?	Yes	
2.	Has all of the information on the front page been completed?	No	Reviewed in pathology,
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
3.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
4.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of appropriate consultation with stakeholders and users?	No	
5.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
	Is the language used in the document clear, jargon free and spelt correctly?		
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	N/A	
7.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	No	
8.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	No	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
9.	**Document Control**		
	Does the document identify where it will be held?	No	
	Have archiving arrangements for superseded documents been addressed?	No	
10.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to	No	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	support the monitoring of compliance with and effectiveness of the document?		
	Is there a plan to review or audit compliance with the document?	No	
11.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	No	
	Equality Impact Assessment		
	Has an EIA been carried out?	N/A	Relevant to all staff
12.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Policy Review Group Ratification			
If you are happy to ratify this document, please sign and date.			
Committee /Other Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Kerry Gawthorpe	Date	18.07.18
Signature			

Appendix E

SECTION A: The 'BEE FAIR' Screening Tool Lens

1. **Name of document being analysed**	**Policy for Labelling and Transporting Laboratory Specimens**
2. **Person completing analysis**	Kerry Gawthorpe
3. Contact information	Kerry.gawthorpe@nhs.net
4. **Date of analysis**	18.07.18
5. Is it a policy, strategy, service or function that is being assessed?	Please specify: Policy
6. Name of the policy/ strategy/ service / function	Insert name: **Policy for Labelling and Transporting Laboratory Specimens**
7. Provide a brief description of the aims of the policy/ strategy/ service/ function (include details of key objectives and who your intended customers are) **Purpose and aims**: (briefly describe the overall purpose and aims of the policy/service – for a new service – describe the rationale and need for the proposal, referring to evidence sources. For a change in service or pathway – specify exactly what will change and the rationale/evidence, including which priorities this will contribute to).	Aims: To provide guidance to all staff the procedures for labelling and transporting laboratory specimens Objectives: To give guidance to all staff with regard to labelling and transportation of specimens Customers: All staff
8. Is responsibility for this policy/ strategy/service/function shared with another agency? No □	If yes: describe their involvement in this process. If a partner has conducted an Equality Relevance Assessment and/ or an Equality Analysis Template, please attach this information.
9. Is this policy/service/function/strategy carried out (partially or completely) by contractors? No □	If yes: please tell us how you will ensure that due regard is given to the aims of the Public Sector Equality Duty by the contractor and how this is monitored via the procurement process.
10. Does the policy/ strategy / service/ function affect stakeholders? Stakeholders include customers, service users, staff, the wider community or other organisations. This includes commissioned services and services that rely on the input or resources of the Trust. Yes □	If the answer is no to both questions 9 and 10 then the policy is not relevant to the Equality Duty. You must detail and evidence why it is not relevant. You must also reference any research, intelligence or data that you have used to come to this conclusion. If the answer is yes to both questions 9 and 10 a full equality analysis must be completed. See section B If you answer no to question 9 and yes to question 10 full equality analysis must be completed. See section B
11. If you have reached a conclusion that the policy, service or function is not relevant to equalities and you have clearly evidenced why then exit here and submit this form to: bwc.beefair@nhs.net	

Relevant □ (Complete the details below and go on to complete Section B Full Equality Analysis)
Not relevant □ (Complete the details below and submit the form electronically to the above: retaining a copy for your records).

Signature (*person completing this screening tool lens*) _____**18.07.18**_____
Date _____

Head of Service/Dept.
_____

Signature _____ ___ **Date**
_____ _____

N.B. Emails received from the responsible officer's email address will be accepted as formal submissions. There is no need to provide a hard copy in addition to this.

Appendix E(i)

SECTION B: Full Equality Analysis

Equality Action Plan – What are the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitative) used. If the work is targeted towards a particular group(s) – provide justification e.g. women

Even if you have found no evidence of potential negative impact, you should consider how to improve any positive impacts or how your policy could be adapted to promote equality.

A=Age / S=Sex / D=Disability/ R=Race / SO=Sexual Orientation / MCP= Marriage/civil partnership / PM= Pregnancy and Maternity / GR= Gender Reassignment / RB=Religion and Belief

Potential positive or negative impact	Potential impact on (please tick)									Action identified to resolve	Who will action	When by
	A	S	D	R	SO	MCP	PM	GR	RB			
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Consultation – How does this proposal affect the rights of patients, staff and other stakeholders?

What have patients/staff or other stakeholders already told you about the policy and any negative impacts? State who has been consulted and the methods used for the engagement, consultation etc	No stakeholders have been consulted.
Do you need to carry out further consultation if so who will you be consulting with and by what methods?	No

Monitoring Arrangements – What are the existing and new monitoring arrangements?

Is the service/policy accessible to all groups?	**Yes**
If there is a lack of information, what research will be carried out and for which group?	**N/A**

Including people who need to know - Consider the way in which the proposal will be explained to a wider audience.

Will translation or interpretation materials be required (audio, pictorial, Braille as well as alternative languages); are there any particular approaches required for different cultures using outreach or advocacy support**;** is some targeted marketing required.

Decision Making – Identify what your next step will be for the proposal.

Take the equality analysis and the engagement into consideration, and the responsibilities around the Public Sector Equality Duty.

Decision steps available	**Rationale for your decision**
1. Continue unchanged	No
2. Adjust the proposal	No
3. Fundamental review of/stop the proposal	No

Sign Off and publication

Senior Responsible Officer*	
Date signed	
Presented to .....(insert)..... **Committee**	
Publication date	

as the Senior Responsible Officer you need to be assured that you have sufficient information about the likely effects of the policy in order to ensure proper consideration is given to the statutory equality duties.

Once approved by the EA sub-group, the EA will be published on the Trust's equality and diversity internet pages. In accordance with the duty *"Trusts must publish evidence of the analysis that they undertook to establish whether their policies or practices would further or would have furthered the aims of the duty, details of the information that they considered and details of engagement undertaken when doing the analysis."*[1]

[1] NHS Employers: Equality analysis and equality impact assessments

Publication of the analysis template helps to ensure that we are being open and transparent in our decision making process.

1. Send the completed Equality Analysis with your document to: bwc.beefair@nhs.net

2. Make arrangements to have the EA put on an agenda for the appropriate Committee
3. Use the Action Plan to record the changes you are intending to make to the document and the review date.

Appendix E(ii)
Equality Analysis Sign Off:
This section is designed to be copied and pasted into a blank word document or into the required paperwork e.g. PID or policy etc. please note: The Equality Analysis Approval Committee have the key leads from the following key areas:

- **Workforce (Human Resources & Education & Learning)**
- **Service (Operational, Estates and Facilities)**
- **Commissioners (internal and external partners)**

<table>
<tr><td>Directorate/Project details</td><td></td><td colspan="2">Service/Workstream:</td></tr>
<tr><td><Type name here></td><td></td><td colspan="2"><Type name here></td></tr>
<tr><td>Executive Sponsor:</td><td>Project Lead:</td><td colspan="2">Project Manager:</td></tr>
<tr><td><Type name here></td><td><Type name here></td><td colspan="2"><Type name here></td></tr>
<tr><td colspan="4">Title: <Insert <i>Name of the Strategy/Policy/Project/Service here</i>></td></tr>
<tr><td colspan="4">EA details</td></tr>
<tr><td colspan="2">Version:</td><td>Date:</td><td>Equality team Lead Assessors detail:</td></tr>
<tr><td colspan="2"><Type version here></td><td><Type date here></td><td><Type Name & Ext. details ></td></tr>
<tr><td colspan="4">Is this a: <Tick as appropriate> Relevance Screening □ Full Analysis □</td></tr>
<tr><td colspan="4">Are the Equality Analysis sub-group assured by the EA?</td></tr>
<tr><td colspan="4">If ‘No’ please send this document (electronic format only) back to the originator for more details</td></tr>
<tr><td>If ‘YES’ please sign</td><td colspan="3"><please sign here></td></tr>
<tr><td colspan="4">Please send this signed document to: bwc.beefair@nhs.net</td></tr>
</table>

Appendix E – Plan for Dissemination of Procedural Documents
To be completed and attached to any document which guides practice when submitted to the Policy Review Group for consideration and approval.

Title of document:	**Policy for Labelling and Transporting Laboratory Specimens**		
Date finalised:	18.07.18	**Dissemination lead: Print name and contact details**	Kerry.gawthorpe@nhs.net
Previous document already being used?	**Yes**		
If yes, in what format and where?	• PDF held on BW intranet • PDF on pathology QMS (Ipassport)		
Proposed action to retrieve out-of-date copies of the document:	Pathology documents managed by QMS (in line with ISO15189:2012		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
All staff	Intranet	Electronic	

Dissemination Record – to be used once document is approved.

Date put on register / library of procedural documents		**Date due to be reviewed**	

Disseminated to: (either directly or via meetings, etc)	**Format (i.e. paper or electronic)**	**Date Disseminated**	**No. of Copies Sent**	**Contact Details / Comments**

Appendix F – Summary of Significant Changes to previous version of Policy

Policy Title			
Version	**Date**	**Author**	**Comment (Identify any significant changes to the procedural document)**
3.0	Oct 2011	Nigel Coles, Quality Manager	Updated by Jim Gray, Consultant Microbiologist to supersede previous separate infection control policy entitled Specimen collection, handling & transport Policy
4.0	Nov 2014	Nigel Coles, Quality Manager	• To include common and consistent approach across Pathology and Genetics labs in line with SHOT 2012 • Add unequivocal patient ID as 4 data items • Update to ADR15 from ADR09 • Correct typing and formatting errors • Change references to Telepath to LIMS • Add criteria for rejection of specimens • Storage criteria for Fresh un-fixed Histology specimens
5.0	July 2018	Kerry Gawthorpe Quality manager	• Changes to include procedures form BCH • Have updated the section to include acceptance criteria for specimen acceptance into the laboratory
5.1	Sept 2018	Kerry Gawthorpe Quality manager	• Addition of reference to the Trust Waste Management Policy