Short Stay (SSU) Pre-Post Care Pre-Learning Addendum

Contents

Ambulatory/Outpatient Admission Data

For additional information refer to full Policy: *Ambulatory/Outpatient Admission Data* in PolicyStat

Admission Assessment

1. Vital signs including, temperature (T), pulse (P), respiratory rate (R), blood pressure (BP), age, height, and weight for all patients, O2 saturations and NPO status.

Patient Profile

2. Mutuality (patient and family individual preferences) – care plan
3. Health history and review of systems
4. Advance Directives – pre-op checklist
5. Contact information for discharge

Patient Education

6. Learning assessment including preferred language
7. Education needs as appropriate
8. Initial cognitive, cardiac, respiratory (including STOP BANG for sleep apnea), procedure and patient specific assessment, and pain assessment

i. Risk assessments for falls, violence in the home, safety, latex sensitivity and pregnancy

ii. Review and validation of prior-to-admission medications, allergies, substance use (including tobacco & alcohol use), history and physical by LIP and verification of consent.

A. *Adult Patient*: Person 18 years of age and older.
B. *Pediatric Patient:* Person 1-17 years of age.
C. *Neonatal Patient*: Person less than one year of age.
D. *Ambulatory/Outpatient Procedure*: Health services provided to individuals who are not confined to institutional beds as inpatients during the time services are rendered.

POLICY:

For outpatient procedures, the RN is responsible for completion of the Admission Assessment, Patient Profile and Patient Education. If data were collected in a pre-surgical services setting, the RN is responsible to review and update as necessary.

If the required data on the Patient Profile cannot be collected or reviewed, the goal/outcome evaluation documented by the RN will serve to reflect the patient condition or unavailability that did not support data gathering. If the patient declines to provide information, the RN will document this as a significant event note.

If the patient transfers and the level of care remains the same, the documentation requirements do not change. The level of care, not the physical setting, dictates the documentation requirements. For example, an adult ambulatory patient transferred to a medical-surgical unit for several hours of post-anesthesia recovery remains at the same level of care as an ambulatory patient whose recovery is completed in a surgical short stay unit. If the patient's level of care changes, the admission data defined for the new level of care must be completed within 24 hours.

Certified Nursing Assistants and other interdisciplinary professionals may collect and document admission data within their scope of practice.

The RN is responsible to integrate admission data into an individualized plan of care.

Ambulatory/Outpatient Admission Data (cont)

Patient Profile		Adult	Peds	OB	Out patient
Group	Question				
General Information	Language Assistance	X	X	X	X
Advance Directives	Advance Directives (Medical Healthcare)	X	X	X	X
Current Health	Anticipated Changes Related to Illness	X			
	Services Anticipated at Discharge	X	X		X
	Anticipated Discharge Disposition	X	X		X
Mutuality/Individual Preferences	What anxieties, fears or concerns do you have about your health or care?	X		X	X
	What questions/concerns do you/child have about you/your child's health or care?		X		
Nutrition Risk Screen	Nutrition Risk Screen	X			
Functional Level Prior	Change in Functional Status Since Onset of Current Illness/Injury	X			
Functional Level Current	Swallowing	X			
Abuse Screen	Do you feel that you are treated well by your partner/spouse/family member?	X		X	X
	Do you feel you are treated well by your family/friends/significant others?		X		
	Do you feel unsafe going back to the place you are living?	X	X	X	
Mood Disorder Screening to Assess Suicide Risk	PHQ-4 Total	X		X	
Pediatric Suicide Risk Screen	PHQ-4 Total		X		

Immunization Screen	Have you ever had a vaccine for pneumonia?	X		X	
	Have you ever had a vaccine for influenza?				
Latex Screen	Latex Screen Positive?	X		X	X
Pain	Preferred Pain Scale	X	X	X	X
	Acceptable Comfort Level	X	X	X	X
Chronic Pain	Chronic Pain	X	X	X	
Values/Beliefs/Spiritual Care	Cultural, Spiritual, Religious Practices Important for Staff to Know	X	X	X	X
	Patient Care Summary	Adult	Pediatrics	OB	Out Patient
PHS Fall Risk Factors	At Risk for Falls?	X	X	X	X
Nutrition Risk Screen	Nutrition Risk Screen	X		X	
Pain/Comfort (Pediatrics)	Observed/Reported Pain		X		
Skin	Braden	X		X	X
	Braden Q		X	X	
Functional Level Current	Swallowing			X	

Perioperative Electronic Minimum Documentation

For additional information and elaboration refer to full Policy: *Perioperative Electronic Minimum Documentation* in PolicyStat

The intra-operative nurse reviews the patient's chart to complete the pre-op assessment. Important elements that need to be addressed include:

1. NPO Status, Advanced Directive, Patient Chart Verification, Procedure and site verification, Regional Blocks, Medications, Beta Blockers

The intra-op nurse will document Event Times:

1. Set-up start (optional per ministry).
2. Ready for patient.
3. Enter under staff, the surgeon, anesthesia, and other licensed personnel that are participating in the care of the patient for the case.
4. Enter surgeon in and out times, especially when there is more than one surgeon, one following the other.
5. Enter anyone observing (students, reps, visitors) In and Out times – must be utilized to provide a clear picture of responsible staff in the room that are caring for the patient. Relief staff must have in and out times documented.

The intra-op nurse will document all sponge, instrument, needle and miscellaneous counts according to policy.

Additional documentation required

E. Pre-op Skin
F. Patient Belongings
G. Safe Surgery Checklist
H. Equipment
I. Patient positioning
J. Site Prep
K. Lines/Drains (LDA) can be defined as any device inserted into or added to the patient.
L. Procedures
M. Supplies
N. Intra-op Meds
O. Implants
P. Orders
Q. Order Sets
R. Acknowledge/Collect
S. Specimen Collection Status
T. Point of care testing
U. Specimens
V. Site Completion
W. Post-op Skin Condition must be recorded
X. Handoff Staff: Care Handoff – Complete the following fields if used in your ministry:
Y. PNDS – Documentation is only required if something other than the expected outcomes occur.
Z. Verify - The intra-op nurse is required to authenticate that all documentation has been completed.
AA. Professional Exchange – does not require documentation, but can be utilized to give report.

Universal Protocol

For additional information refer to full Policy: *Universal Protocol for Invasive Procedures* in PolicyStat

SAFE SURGERY CHECKLIST: PROVIDENCE OREGON		
BRIEFING	**TIMEOUT**	**DEBRIEF**
Verify prior to induction of Anesthesia	**Immediately before procedure start. All team members *suspend activity* & verbally participate.**	**At the end of the case and before the SURGEON leaves the OR.**
Before patient enters OR, CIRCULATOR confirms: ❑ Room thermostat temperature confirmed ❑ Implants / Specials are available	**SURGEON / PROCEDURALIST leads the timeout & begins by stating:** ❑ Patient Name ❑ Procedure planned	**CIRCULATOR confirms with SURGEON:** ❑ Counts are correct ❑ Actual procedure performed
Upon patient entry to OR, CIRCULATOR & SCRUB pause and verify: ❑ Patient identified using 2 unique identifiers matched to consent ❑ Procedure & laterality confirmed with patient & matched to consent ❑ Site marking confirmed per policy ❑ Allergies verified ❑ Active warming / SCD devices available	❑ Laterality * ❑ Confirms visible site marking * ❑ Confirms review of recent labs and display of relevant images *	❑ Wound class ❑ Specimens verified and labeled
	ANESTHESIA PROVIDER states: ❑ Antibiotic given * ❑ Patient glucose *	**ANESTHESIA PROVIDER confirms with SURGEON:** ❑ Estimated blood loss (EBL) ❑ Patient glucose *
	SCRUB continues by stating: ❑ Instruments ready & medications labeled ❑ Confirms plan for management of heat generating devices, including cautery holster location	**SCRUB verifies with CIRCULATOR:** ❑ Local medication administered ❑ Implanted items
CIRCULATOR & ANESTHESIA PROVIDER verify: ❑ Special anesthesia equipment present ❑ Blood product availability addressed *	**CIRCULATOR continues by stating:** ❑ Patient name & procedure match consent form ❑ Are there any other concerns? ❑ **"THE TIMEOUT IS COMPLETE"** Note: A colored towel covers the instrument tray until the CIRCULATOR states that the "TIMEOUT IS COMPLETE"	* *as applicable by policy, protocol or procedure* 

Process for site marking, all invasive procedures:

- The Proceduralist marks the site prior to surgery/invasive procedure.
- The site is marked with patient involved, awake and aware, if possible.
- The marking pen ink will be sufficiently permanent to remain visible after skin prep and draping.
- The mark is made at or near the procedure site or the incision site.
- For sites below the neck, the site is marked with the Proceduralist's first and last name initials. If the Proceduralist's initials are "N.O." their middle initial needs to be included at the time the site is marked.
- For sites above the neck an arrow may be used to point to the intended incision or insertion point.
- For spinal procedures, the mark is made on the skin at the approximate spinal level intended for surgery. Laterality is indicated if intended for the procedure. Additional intraoperative internal marking techniques may be used to confirm the exact spinal level.
- For procedures with laterality of paired internal organs performed via a midline incision or laparoscopically, skin marking is required indicating the intended side.

Consent and Refusal of Consent for Procedures

For additional information (including age of consent, competence, and allowed disclosures refer to full Policy: *Consent and Refusal of Consent for Procedures* in PolicyStat

Medical Center Staff Responsibility

1. Informed Consent (PARQ) is the responsibility of the provider.
2. Informed Consent (PARQ) must occur before the hospital consent form is signed.
3. The initial Informed Consent, at times, may not be done by the actual performing proceduralist (i.e., OB Informed Consents may be done in the physician's office, but an on-call physician does the procedure).
4. The actual performing proceduralist, if different from the initial physician that provided the PARQ, must re-PARQ prior to the commencement of the procedure.
5. The Informed Consent must be documented prior to the commencement of the procedure but not necessarily prior to signing the consent form.
   G. Documentation on the hospital consent form will include:
    1. The name of the procedure(s) is/are entered on the consent form by the RN or provider.
    2. The only acceptable source for transcribing the procedure is the provider order.
    3. The procedure(s) shall be entered without using abbreviations.
    4. Careful attention must be given to laterality; "right" and "left".
    5. All physicians/proceduralists and LIPs performing significant procedures, as defined in the Professional Staff Bylaws, will have their name listed.
    6. There must be a separate consent form signed EACH time a procedure is done.

Fire Safety in Surgical Services

For additional information refer to full Policy: *Fire Safety in Surgical Services* in PolicyStat

II. Response to Fires in the OR

A. In all cases of unexpected fire or smoke in the OR

a. The charge nurse will be contacted as quickly as is safely possible to activate the code red response team (dial 88, pull manual station if the fire alarm is not already activated) and alert other OR staff if deemed necessary.

b. The code red response team will meet the charge nurse or designee at a predetermined location outside the restricted area for briefing and determine the appropriate response.

III. Surgical Intubations-Extinguishing Airway Fires

A. At the first sign of an Airway or Breathing Circuit fire, be prepared to assist with any of the potential interventions, listed below, as deemed appropriate and directed by the attending physician.

a. Disconnect the breathing circuit from the tracheal tube.

b. Remove the tracheal tube:

1. Have another team member extinguish it using water/saline
2. Remove cuff-protective devices and any segments of burned tube that may remain smoldering in the airway
3. Stop the flow of gases to the airway
4. Pour saline or water into the airway
5. Care for the patient:
    1. Re-establish the airway and resume ventilating with air until certain that nothing is left burning in the airway; switch to 100% oxygen
    2. Examine the airway for the extent of damage and treat the patient accordingly
6. Save involved materials and devices for later investigation.

IV. Fires on the Surgical Patient

A. In the event of a small fire on the patient, immediately:

a. Cover and sweep small fires with water/saline soaked sponge/towel.

b. Remove the burning material from the patient.

c. Check for and remove any smoldering material from the OR,

d. Complete a Datix report.

B. In the event of a large fire or unexpected smoke:

a. Stop the flow of breathing gases to the patient.

b. Remove the burning material from the patient.

c. Have another team member extinguish the burning material with water/saline.

d. Care for the patient:

i. Resume ventilation

ii. Control bleeding.

iii. Evacuate patient to another smoke compartment, if indicated due to smoke or fire.

iv. Examine the patient for injuries and treat accordingly.

e. ONLY THE NURSE SUPERVISOR AND/OR THE DEPARTMENT MANAGER, OR THEIR AUTHORIZED DESIGNEE, WILL SHUT OFF MED GAS SERVING THE AREA THAT THEY MANAGE.

f. Complete a Datix report.

C. Save all items that are involved in the fire to facilitate the investigation.

a. Provide all items that are involved in the fire to quality/risk management personnel.

b. All fire events must be investigated and findings are reported to Safety/Environment of Care Committee.

V. Fire or smoke in the OR ***not involving a patient***:

A. Extinguish the fire using the appropriate fire extinguisher.

B. For fire involving equipment - if possible/practical disconnect equipment and remove from the OR for hand-off to the code response team.Do not leave extinguished equipment unattended.

C. Evaluate the status of the OR and proceed or prepare to evacuate the patient.

D. Complete a UOR

Malignant Hyperthermia

For additional informaino refer to full Policy: *Malignant Hyperthermia* in PolicyStat

C. Implementation of Protocols for an acute event:

1. Nurse or designee institutes emergency code as directed by anesthesia provider and/or physician.
2. Call RRT, Code Blue and/or main OR as appropriate per facility. Designated person brings malignant hyperthermia cart into room.
3. Nursing leadership and pharmacy are notified.
4. Assign additional support staff as necessary to assist anesthesia and circulator.
5. Contact the Malignant Hyperthermia Association of the United States (MHAUS) Hotline at (800) 644-9737 per anesthesia provider.

D. Treatment of Symptoms: Anticipate need for prescribed medications.

1. Dantrolene: Reconstitute (Dantrium/Revonto/Ryanodex)
    a. Locate on the malignant hyperthermia cart.
    b. Reconstitute only with preservative free sterile water, 2.5 mg/kg rapidly
    c. Shake Dantrium/Revonto vial well, until clear; Ryanodex is a suspension that does not clear.
    d. Repeat until signs of MH are reversed
2. Additional Medications: Prepare medications as required such as: sodium bicarbonate; IV glucose and insulin; calcium chloride; anti-arrhythmic agents. When Ryanodex is used, mannitol should be available.
3. Thermoregulation Measures:
    a. Obtain refrigerated saline or ice, if "patient cooling" is indicated.
    b. Use cold saline for I.V.'s. Note: Do not use IV Lactated Ringer's solution.
    c. Surface cooling may be indicated using ice, cold wet cloths, a hypothermia blanket and/or misting the patient with cool water per spray bottles. In addition a fan may be used to assist in the cooling process.
    d. Implement protective measures to prevent skin/tissue injury due to thermal sources.
    e. Consider internal cavity lavage per MHAUS recommendations (peritoneal or thoracic cavity lavage supported. Gastric or rectal lavage not supported per 2019 edition).
    f. Extracorporeal circulation and heat exchanger (femoral to femoral).
    g. Stop cooling if temperature <38 degrees C and falling to prevent hypothermia
4. Blood Specimen tubes should be collected per following guidelines (in order of draw):

TEST ORDERED	TUBE TYPE	EXPECTED TAT for RESULTS
Blood Cultures	Set of 2 bottles, Aerobic and Anaerobic	
PT, APTT, D Dimer, Fibrinogen	Blue Top	30 minutes
TSH, Free T4	Yellow SST	24 hours
CMP, LDH, CK, CKMB	Mint Green top	45 minutes
Myoglobin	Mint Green top	2 hours
CBC with or without Diff, PLT	Purple top	30 minutes
Lactate	Grey top	30 minutes

*Blood cultures are very useful and should be included to rule out bacteremia.

5. Urine collection for myoglobin level may be indicated if blood is positive on the UA dipstick. Pigmenturia (e.g., brown or red urine) indicates that renal protection is mandated. When the urine is centrifuged or allowed to settled, and the sample shows clear supernatant, i.e., the coloration is due to red cells in the sample.
6. Admit patient to appropriate Intensive Care Unit.
7. Educational materials will be provided to the patient and patient's family.

E. Documentation

1. Assessments and care given will be documented by the procedural or circulator RN on the intra-operative or appropriate procedural record.
2. A Datix Event Report will be filled out and sent to the unit manager and Quality Management.

Specimen Handling

For additional information refer to full Policy: *Specimen Handling in Surgical Services* in PolicyStat

Specimen Handling is a complex process with many steps involved to ensure the test is completed correctly for the correct patient.
Policy: *Specimen Handling in Surgical Services* comprehensively outlines all steps needed to ensure safety. Refer to full policy when on site if handling specimens.

OR/Procedural RN Specimen Handling Responsibilities:

1. Correctly and appropriately handle, label, document and provide safe delivery of specimens.
    i. Specimens requiring special handling will be directly taken to pathology, where pathology personnel are notified and verbally told what exam is required and whether a call back is needed.
2. Specimens are:
    i. Obtained from the sterile field as soon as possible/within a timely fashion with surgeon's permission.
    ii. Placed in closed containers, with secure lids, and kept moist.
    iii. Verified with the surgeon in order to correctly document:
        a. Specimens in EPIC
        b. The information and details on the consultation form (if/when needed)
        c. See detailed process further below in policy
    iv. Correctly logged in the specimen log book when transporting/dropping off specimens for pathology.
        a. See detailed process in Procedure B, section 4 in policy,

1. Each specimen must be accurately and legibly labeled with the following:
    a. Patient identification – patient sticker (to include at a minimum two patient identifiers - patient name, DOB)
    b. Letter of Specimen
    c. Name and/or Description of specimen, including site and laterality
    d. Date specimen collect
    e. Time specimen collected from the field
    f. OR RN initials
    g. Surgeon

Labeling of Medications and Solutions

For additional information refer to full Policy: *Labeling of Medications and Solutions* in PolicyStat

A. Labeling occurs when any medication or solution is transferred from the original packaging to another container, unless it is administered immediately by the person who prepares the medication or solution. If the medication or solution that has been removed from its original container will be used over the course of the procedure, the receiving container (including syringes) must be labeled.

B. All solutions and medications used will be in containers that legibly and correctly identify the current contents.

1. Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.
2. Containers that have not been appropriately labeled will not be used. Any medication or solution found without proper identification will be discarded.
3. The contents must be identified by a label on the main body of the container (i.e. not the lid).
4. A handwritten label or tape may be used.

C. Labels will include:

1. Name of the solution/medication/substance;
2. Strength of solution/medication;
3. Quantity
4. Diluent and volume if not apparent from container;
5. Expiration date when not used within 24 hours
6. Expiration time when expiration occurs in less than 24 hours
   (Expiration date and time are not necessary for short procedures).

D. Medication containers do not need to be labeled if immediately prepared and administered by the same person.

1. If the provider preparing the medication or solution participates in another function before administration, the container must be labeled.
2. If more than one medication is prepared by the provider, each medication container must be labeled.

E. If two or more people participate in the preparation and administration of the medication or solution, a two-person verbal and visual verification of the label's accuracy is required. (Medications prepared and labeled by a pharmacist do not require a second person verification).

F. At the conclusion of an operative or non-operative procedure, all supplies including the contents of any medication(s) or solution(s) will be appropriately discarded. This applies to multi-dose vials unless the vial was accessed outside of the patient room or procedural area. Refer to CDC link under References for information on dating multi-dose vials utilized outside of the immediate patient treatment area.

Pregnancy Testing

For additional information refer to full Policy: *Pregnancy Testing in the Female Perioperative Patient* in PolicyStat

PROCEDURE

A. All female patients aged 12 to age 55 and/or menarche that are undergoing elective and urgent procedures requiring anesthesia, will be presented with the option to undergo routine urine HCG or serum BHCG testing prior to surgery within 24 hours of surgery, unless the surgeon or proceduralist denies the order or the patient falls into the exceptions list:

    1. Existing known pregnancy or admitted for incomplete abortion, missed abortion or ectopic pregnancy
    2. Previous hysterectomy
    3. Trauma case

B. Surgeon/Proceduralist and Anesthesia to be notified if patient or guardian refuses HCG testing.

C. Patients that undergo the urine HCG or serum BHCG test, will not be admitted to the operating room until the results are known.

D. Surgeon/Proceduralist will be notified of positive results.

E. Surgeon/Proceduralist will communicate the positive result to the patient alone first, and for patients below the age of 15 the surgeon will also talk to parents or guardian separately.

Latex

For additional information refer to full Policy: *Latex Policy* in PolicyStat

POLICY STATEMENT

1. Providence is a latex-**reduced** environment.
2. Providence approved latex gloves are the only type of latex-containing glove permitted in Providence Oregon facilities and are used in departments such as: Operating rooms, to include c-section rooms and cardiac catheterization labs or wherever a sterile surgical procedure is performed.
3. Non-sterile latex exam gloves should not be purchased or used.
4. Latex balloons are not permitted in Providence Oregon facilities.
5. Where alternatives are available, departments will evaluate alternate products that do not contain latex to possibly replace latex containing products.
6. During test procedures, departments will avoid, whenever possible, use of any product containing latex, e.g. not use latex tourniquets, syringes with rubber gasket, latex tubing, etc.

DEFINITIONS

High Risk Populations include:

1. Individuals with spina bifida/spinal cord injury.
2. Individuals with history of chronic or recurrent infections of the genitourinary tract.
3. Individuals with occupational exposure to latex.
4. Individuals with multiple allergies to medications and/or environmental allergens, e.g., food allergies to bananas, avocados, tropical fruits, kiwi, and nuts.
5. Individuals with a history of a local reaction (urticaria or contact dermatitis) to latex

Latex means natural rubber latex (NRL) manufactured from the milky sap of the rubber tree *Hevea brasiliensis*.

Latex paint does not contain the latex protein. It is not linked to latex sensitivity and is not covered by this policy.

Latex-reduced environment is an environment that minimizes contact and aerosolized latex allergen exposure.

RESPONSIBILITIES

Managers

a. Implement this policy within the department.

b. Ensure latex-free products are used whenever possible.

c. Do not order latex products outside the system to replace latex-free products available through the system.

Caregivers

a. Complete the latex questionnaire provided by Caregiver Health during the initial health screening.

b. Do not bring latex containing products, including latex balloons, into Providence facilities.

c. Report known or suspected latex sensitivity/allergy to Caregiver Health via the EHS Hotline (503- 216-3200)

d. Caregivers who experience signs and symptoms that may be associated with latex products, or symptoms that interfere with their ability to perform essential job functions will report to their supervisor, file an incident report and/or a Job Accommodation Request via the Sedgwick Portal.

e. Caregivers who are sensitized to latex will:

- Seek to minimize contact with latex containing products.
- Follow policies and procedures for latex sensitive individual.
- Collaborate with their core leader and HR Client Manager to discuss the need for accommodation.

Caregiver Health

a. Direct caregivers to the Sedgwick Portal for reporting of health issues related to Latex sensitivity or to submit a Job Accommodation Request.

Transfusion Specimen Collection and Labeling

For additional information refer to full Policy: *Transfusion Specimen Collection and Labeling Procedure* in PolicyStat

STEP	ACTION
1	**Inpatients**: Check that the patient is wearing a facility identification armband. The band must be attached to the patient's body. **Outpatients**: Prepare a patient armband that includes the following; patient first and last name, PH&S medical record number, patient date of birth. Attach the band to the patient's body, usually the wrist. **Provide instructions to the patient to leave the band attached until either: a) their outpatient transfusion procedure is completed or b) they are discharged from the hospital.**
2	For a conscious patient, ask them to state and spell their first and last names and state their date of birth. Verify that the information given matches the information on their identification armband **exactly**. If not, correct any discrepancies before proceeding. If the patient is not conscious or is incoherent, ask a family member or friend that is accompanying the patient to verify their identity. If a family member or friend is not present, ask the patient RN to confirm the patient identity.
3	Verify that the patient first and last names and date of birth on the physicians order **exactly** matches the identification armband. If not, correct discrepancy before proceeding.
4	Prepare the specimen label - **do not affix label to the tube until after the specimen is collected.** A hand written or pre-printed label may be used. Alternately, hand write the required information directly on the tube. Patient information on the specimen label must **exactly** match the patient information on the identification armband. **The label must include the following legible information**: • Patient full last name, full first name (middle name optional) • Medical record number • Date of collection (The date on a pre-printed label must match the current date, otherwise the date of collection must be handwritten.) • Time of collection • Collector's initials ◦ **Note**: For Cerner Bridge labels, the pre-printed phlebotomist identifier is acceptable. **Notes:** • If the patient has an unusually long name, the pre-printed labels may have truncated the name. The label must include the full first and full last name and match the patient armband exactly. Hand writing may be necessary. • The Admitting Department caregivers must contact the facility blood bank prior to making changes to any patient identifier and swapping out armbands. A new transfusion specimen must be collected if any of the required patient identifiers above are changed. Refer to *Updating Wellsky Patient Registry Procedure*.
5	Collect the sample by venipuncture or from an established line taking care not to contaminate the sample with intravenous fluids. It is acceptable to shut off the IV for 2 minutes and then collect the sample if necessary.
6	Immediately place the prepared label on the sample in the presence of the patient. Place the label lengthwise on the sample aligned so the left side of the label is closest to the tube cap. **NEVER leave the patient's side with the sample unlabeled.**
7	Follow local processes to deliver the sample to the appropriate facility laboratory Blood Bank as soon as possible.

Transportation of Patients

For additional information refer to full Policy: *Transportation of Patients* in PolicyStat