Specimen Collection Policies

Purpose

Great River Medical Center Laboratory is a hospital-based and outreach laboratory with specific standards of excellence. To best serve our patients, all specimens will be collected according to the guidelines in this policy to ensure accurate patient results.

Policy

I. Venipuncture:

1. The patient’s identity must be verified prior to specimen collection, by using at least two identifiers. Laboratory staff will verify the patient’s name and medical record number prior to specimen collection.

2. Assemble the supplies (gauze, alcohol pad, needle, and tube holder, correct blood collection tubes).

3. Ask the patient to close his/her hand.
   a. The veins become more prominent and easier to enter when the patient forms a fist.
   b. Vigorous pumping should be avoided.

4. Selection of the vein site is important.
   a. The larger of the median cubital and cephalic veins are the most often used.
   b. Hand and wrist draws are acceptable.

5. Procedure for vein selection.
   a. Palpate and trace the path of veins several times with the index finger.
   b. Unlike veins, arteries pulsate, are more elastic, and have a thick wall.
   c. If superficial veins are not readily apparent, blood can be forced into the vein by massaging the arm from wrist to elbow.
   d. Tapping sharply at the vein site with the index finger will cause the vein to dilate.
   e. You may also consider the veins in the opposite arm.

6. Apply the tourniquet.
   a. Use a tourniquet to increase the venous filling, which makes the veins more prominent and easier to enter.
   b. PRECAUTIONS when using a tourniquet. Never leave a tourniquet on a patient’s arm longer than one minute. To do so may result in hemoconcentration or a variation in blood values.
   c. Apply the tourniquet around the arm 2-3 inches above the venipuncture site.
   d. Cleanse venipuncture site with alcohol and allow to air dry. This will reduce pain and possible
hemolysis. Once the area has been cleansed, DO NOT contaminate by retouching.

7. Inspection of the needle and equipment.
   a. Inspect the tip of the needle you will be using carefully.
   b. Make sure the needle does not have any burrs or hooks at the tip.
   c. Check for any debris that could obstruct the flow of blood.

8. Venipuncture procedure using evacuated tubes.
   a. Prepare needle and holder for use.
   b. Before use, tap all tubes containing additive to ensure that there is no additive lodged around the stopper.
   c. Insert the blood collection tube into the holder but not beyond the guidelines. DO NOT PUSH THE TUBE ONTO THE NEEDLE END. THIS WILL EXHAUST THE VACUUM.
   d. Make sure the patient’s arm or the puncture site is in a downward position while maintaining a needle in the arm. This will prevent a back flow from the tube into the patient’s arm.
   e. Grasp the flange of the needle holder and push the tube forward until the butt end of the needle punctures the stopper, exposing the full lumen of the needle.

9. The tourniquet should be removed as soon as the blood flow is established.

10. The tube should be filled until the vacuum is exhausted.

11. Remove the tube from the holder.

12. Another tube may be pushed onto the holder to obtain more blood from the patient.

13. Any tube containing additives (purple top, blue top, green top, etc.) should be mixed immediately. Clot formation will interfere with test results. Refer to Evacuated Blood Collection Tubes: Contents and Use procedure for a listing of evacuated blood collection tube additives and their amounts.

14. Ask the patient to open his/her hand after enough blood has been collected.

15. Remove the needle from the arm.

16. Activate the safety shield on needle.

17. Place gauze on the puncture site. Apply pressure for 2-3 minutes. If necessary, place a bandage on the puncture site if pressure has not stopped the bleeding.

18. If bleeding persists, apply pressure for 5 minutes and stay with the patient until the bleeding does cease.

19. Label all tubes with appropriate patient information (first name, last name, date and time of collection). ALL samples must be labeled at the patient’s bedside or chair immediately after collection and within sight of the patient.

20. Dispose of the used needle and tube holder combination in a biohazard sharps container. DO NOT DISCONNECT THE NEEDLE FROM THE HOLDER PRIOR TO DISPOSAL.
II. Fingerstick:

1. The patient’s identity must be verified prior to specimen collection, by using at least two
   identifiers. An identifying wristband must be on the patient. Laboratory staff will verify the patient’s name and medical record
   number prior to specimen collection.

2. Assemble the supplies (gauze, alcohol pads, approved skin puncture device, and micro collection tube).

3. Put on gloves.

4. Select the site.
   a. In infants less than one year old, heel puncture is generally performed. Fingers of newborns must not
      be used.
   b. With older children and adults, use the palmar surface of the distal and not the side or tip of the finger.
   c. The middle and ring finger are the preferred sites. The fifth finger must not be punctured.

5. Warm the finger, if needed. This increases blood flow.

6. Cleanse the area with 70% isopropyl alcohol. Allow to air dry.

7. Puncture the skin. Using an approved automated fingerstick device, puncture the finger across the
   fingerprints, not parallel to them.

8. **Wipe away first drop of blood** with a dry gauze pad.

9. Collect the specimen in the chosen container. Mix properly and label with the patient’s first and last
   name and date/time of collection. **ALL samples must be labeled at the patient’s bedside or chair immediately after collection
   and within sight of the patient**

10. Apply direct pressure to the site with a clean gauze pad.

11. Dispose of used supplies in the proper biohazard container and wash hands.

III. **Clean Catch Urine Specimen (Female):**

1. Wash hands with soap and water. Rinse and dry.

2. With one hand “spread yourself” and continue to hold yourself spread during cleansing and collection
   of the urine sample.

3. **WASH.** Using one towelette at a time, begin to wash gently, wiping from front to back between the
   folds of your skin, then discard the towelette. Repeat this front-to-back process with the remaining
   towelette.

4. **VOID.** Void a small amount of urine into the toilet. Collect a portion of the remaining urine in the
   provided specimen container. Keep fingers away from the rim and inner surface of the container.
   When voiding is complete, replace the lid securely on container.

5. **LABEL.** Label the specimen with patient’s first name and last name, and collect date and time. **ALL
   samples must be labeled at the patient’s bedside or chair immediately after collection and within
   sight of the patient**

6. **REFRIGERATE.** Refrigerate the specimen until it is brought to the Outpatient Testing or
   Registration area at Great River Medical Center. The specimen must be received within 12 hours of
collection for urinalysis or 24 hours of collection for culture.

IV. **Clean Catch Urine Specimen (Male):**

1. Wash hands with soap and water. Rinse and dry.
2. **WASH.** Wash penis with towelette provided.
3. **VOID.** Void the first portion of urine into the toilet. Collect the remaining urine into the provided specimen container. When voiding is complete, replace the lid securely on specimen container.
4. **LABEL.** Label the specimen with patient’s first and last name, and collect date and time. *ALL samples must be labeled at the patient’s bedside or chair immediately after collection and within sight of the patient*
5. **REFRIGERATE.** Refrigerate the specimen until it is brought to the Outpatient Testing or Registration area at Great River Medical Center. The specimen must be received within 12 hours of collection for urinalysis or 24 hours for culture.

V. **Timed Urine Collections:**

Use the following procedure for correct specimen collection and preparation.

1. Warn patient of presence of potentially hazardous preservatives in collection container.
2. Instruct patient to discard *first-morning* specimen and to record time of voiding.
3. Patient should collect all subsequent voided urine for remainder of the day and night.
4. Collect *first-morning* specimen on day 2 at same time as noted on day 1.
5. Please mix well before aliquoting and provide total volume of 24-hour urine collection.
6. Refer to specific timed urine collection tests in the test catalog.

VI. **Urine for Culture Collection Kit:**

1. This kit consists of a collection tube containing a preservative and a urine transfer device.
2. Collect the urine specimen using the appropriate clean catch or catheterized urine collection technique.
3. Submerge the tip of the transfer device to the bottom of the urine container.
4. Place the collection tube in the holder portion of the transfer device. Push the tube all the way into the holder.
5. Hold in position until the urine stops flowing into the tube. *A minimum of 4 mL of urine is required.*
6. Shake the tube vigorously. **Label the tube with the patient’s full name and birthdate, collection date and time,** and send to the laboratory. *ALL samples must be labeled at the patient’s bedside or chair immediately after collection and within sight of the patient*

**NOTE:** A urinalysis can not be performed on urine collected in a Urine Culture collection kit. **Please submit a separate urine specimen if requesting a routine urinalysis**
VII. **Stool Specimen Collection Kit:**

1. This kit consists of 1 or 2 vials. The vials may or may not have liquid in them. The liquids are *poisonous*. Do not drink them. Keep them out of the reach of children.

2. The stool should be passed into a clean **DRY** container. Use a clean plastic container.

3. Open the vial containing the liquid. Using the collection spoon built into the lid of the tube, **place** stool into the vial until the contents rise to the red line. **DO NOT OVERFILL.**

4. Mix the contents of the vial with the spoon. Twist the cap tightly closed and shake the tube vigorously until the contents are well mixed. Repeat this for all vials containing liquid (red, blue and yellow caps). **CHECK ALL CAPS TO BE CERTAIN THEY ARE TIGHTLY CLOSED.** Store these vials at room temperature.

5. If your kit contains a clear tube with no liquid, fill it to the red line with stool. **Refrigerate this vial only.**

6. **Label all the vial(s) with the patient’s first and last name, and collect date and time.** Also check the box on the label which describes the consistency of the specimen (formed, loose, soft, watery).

7. Return the collection kit to the Outpatient Testing or Registration areas within 3 days of collection.

VIII. **Specimens for Culture:**

Refer to the culture description in the test catalog.

IX. **Specimens for Cytology and Histology:**

Refer to the test description in the test catalog.

**References**


Specimen Labeling and Rejection Criteria, Document # ADM0181