Purpose: To insure proper identification, labeling, containment, preservation, transportation, and disposition of surgical specimens. This includes a chain of custody (document/paper trail) showing the collection, transfer and disposition of all specimens.

Procedure: Specimens removed during a surgical procedure will be sent to pathology for evaluation. This includes tissue, blood and body fluids as well as foreign bodies removed from a patient during a surgical procedure, for pathological, microbiological and/or gross examination.

The Department of Surgery has deemed the following specimens may be exempted from sending to Pathology:

- A. Cataracts
- B. Previous incision scar tissue
- C. Bone removed during total joint replacement
- D. Orthopedic appliances (rods, plates, screws)
- E. Placentas that are grossly normal and have been removed in the course of a Cesarean Section.
- F. Teeth, (the name (number) of tooth removed is documented on the operative record
- G. Disc and/or meniscal material is at the discretion of the surgeon
- H. Foreign bodies (for example bullets) that for legal reasons are given directly to law enforcement representatives
- I. Therapeutic radioactive sources, the removal of which is guided by radiation safety requirements (see policy OR 519)
- J. Portion of rib removed only to enhance operative exposure
- K. Skin or soft tissue removed for cosmetic reasons without known or expected pathology as determined by the surgeon (note: All breast parenchyma or other tissue with a reasonable incidence of pathology should be submitted to the Pathology department for examination).
- L. Anterior/posterior vaginal tissue without known or expected pathology as determined by the surgeon.
- M. Foreskin from patients less than 12 years of age without known or expected pathology as determined by the surgeon.

I. Preparation for the specimen before the procedure:

- A. Scrub nurse should have an identified area on back table identified for specimen placement in the circumstance that the circulating nurse cannot immediately take the specimen. If specimen cannot be handed off to the circulator immediately after retrieval, the specimen must be labeled on the sterile field using the green labels (from the med marker).
- B. Assemble supplies needed for transport:
  - i. Container that is large enough to safely secure the specimen to prevent leakage and that allows preservatives to contact all sides of the specimen
  - ii. Appropriate preservative
    - 1. 10% buffered formalin for routine histological examination
II. Specimen Identification and Handling

1. Specimen identification begins at the time the specimen is removed from the patient and identified by the surgeon.
2. The scrub person verifies the specimen, what tests are to be performed by pathology (e.g. frozen section, permanent, margins to be checked), and if they may pass the specimen to the circulating nurse.
3. Specimens should be passed off the sterile field as soon as possible. Should the specimen need to be held on the sterile field the first scrubber will have a designated area and label specimen description. This again includes a write down/read back verification between the first scrubber and the surgeon. Specimens held on the sterile field must be maintained in a manner to preserve the specimen.
   a. Tissue may require being kept moist with saline
   b. Soft curetting should be placed on telfa
   c. Use of a petri dish for maintaining sterility of tissue/bone cultures when swabs are not used.
4. First scrub needs to request time to complete specimen handling prior to going to the next part of a procedure if it is a “multiple part” procedure.
5. If the first scrub or circulating nurse is relieved for a break or at the end of their shift, a “hand-off” is done which would include the type of specimen(s), number, and location of the specimen(s) on and off the sterile field.
6. First scrub is responsible for cleaning off the mayo stand and back table. Verifying that all specimens have been handed off. No one is to touch the back table unless first scrub verifies it is OK to do so.
7. The circulating nurse is handed the specimen by the scrub person, Verifies that all specimens name and the tests the surgeon wants performed. This includes a write down/read back process between the RN circulator and the surgeon.
   a. Identify the specimen, including:
      i. Originating source of the specimen (e.g. site or side)
      ii. Type of tissue
      iii. Clinical diagnosis
      iv. Any other pertinent information such as tissue markers and suture tags for orientation.
   b. Place a patient label (which contains the patient’s name, date of birth and FIN number)
c. Each specimen/culture retrieved for examination must be clearly documented on the specimen container, operative record and any pathology documents. The specimen must also be entered into the electronic medical record in the form of an order.

d. Personnel must use personal protective equipment, which includes gloves, face/eye shields when handling specimens and fixative.

e. All specimens must be bagged for transportation.

III. Specimen Report During Summation

A. Circulator will verify with surgeon and first scrub, the number, type of specimens, and test performed on specimens on all cases at wound closure or before drapes are removed.

IV. Transportation of Specimens

Transporting of specimens with documentation of chain of custody for all specimens include:

A. All specimens will be documented on the operative record. This includes specimen description as it is written on the specimen label, and type (fresh, frozen section, permanent, cytology or culture).

B. Each specimen will be entered into the electronic medical record as an order.

C. Fresh specimens and frozen sections need to be accompanied by the green pathology sheet with appropriate specimen information, pre-op diagnosis, doctor requesting the frozen section, OR room number and what type of anesthesia the patient is receiving.

D. Place a patient sticker with the date and number of specimens and your initials in the logbook located at the main OR desk. This applies to all procedures even if there are no specimens. This logbook is reconciled by the OR secretary using the completed patient’s OR record with the OR schedule to verify that all surgeries/procedures performed have/do not have specimens.

E. The specimen may be placed in holding at the OR desk accompanied by the computer print out unless it is fresh or a frozen section which then needs to be transported to pathology immediately and handed to the pathologist or pathology technician.

F. When specimen is taken to lab, OR staff will verify number of specimens taken to the lab by putting their initials next to the patient’s label in the OR logbook.

G. Pathology specimens are logged into the Pathology logbook (located in lab) upon arrival with the date, time, and description of specimen and initials of person transporting the specimen.

H. Any questions regarding labeling or handling of specimens should be directed to the Histology/Pathology department of the lab or directly to a pathologist.

V. Amputated Extremities

A. “Disposition of Body Parts” form #00757 must be signed and placed on the chart prior to surgery starting, identifying the extremity to be amputated and whether the extremity should be given to a mortuary to be buried or disposed of by the hospital.

B. Upon completion of the amputation, the extremity will be taken to the pathology department by OR personnel, properly labeled, bagged, and accompanied by specimen transfer computer printout sheet and “disposition of Body Part” form.

C. If the amputation is performed on evenings or weekends, or when the pathology technicians are not available, OR personnel should place the extremity in the pathology refrigerator, notify the laboratory staff on duty and record in the pathology logbook that the
extremity was placed in the refrigerator. If the diagnosis is unknown (e.g. tumor) the pathologists should be notified as determined by the surgeon.

IV. Explants

A. Defective Medical Devices: (removal of Orthopedic Appliances—OR634 eliminated)
   a. Risk Management must retain medical devices removed due to apparent failure of the device. All portions of the device should be retained together, as well as the packaging when applicable or if available.
   b. Defective explanted medical devices may be sent for pathology examination for identification purposes
   c. The removed medical device should not be decontaminated or sterilized before it is transported from the surgical suite.
   d. A PEERS report should be completed including the reason for removal and Risk Management notified.

NOM explant may be released to patient if it is considered a defective medical device or if it cannot be properly decontaminated (unable to remove all visible biodurden or unable to sterilize without destroying the explant.)

e. If a patient has requested that they would like to keep their explanted device (prosthesis, rods, plates, screws, etc), the surgeon needs to approve of it and the "Authorization for Release of Pathologic Materials form" (copy2240) for the explant is signed and dated by the patient or patient representative, surgeon, and witness and placed on the patient’s chart.
   f. The explant shall be sent to Central Sterilization with a patient label to be manually cleaned and processed through the washer-sterilizer.
   g. The orthopedic appliance should be put into a plastic bag/container, secured, and labeled with the patient’s name and surgeon and sent to the surgeon’s office where it will be given to the patient.
   h. The circulating nurse documents on the OR record the disposition of the appliance.

V. Forensic Specimens

A. Forensic specimens should be handled in a manner that preserves the condition of the evidence and verifies that the evidence has been in secure possession at all times. (Preservation of Evidence from Criminal Action Policy OR513—eliminated)
   i. Any foreign body, such as bullets, ect should be preserved and placed in an appropriate sealed receptacle and labeled with the patient’s identification, collection date, time and given to the law enforcement official by the RN who witnessed removal of the object.
   ii. Obtain official’s identification and signature of the Law Enforcement official receiving the item(s) (Form=copy 483 Authorization for Examination/Treatment and Collection of Evidence/Receipt of Information—found on the Mercy intranet or in ER). Xerox a copy, put the original on the chart and give the copy to the Law Enforcement Official
   iii. Documentation on the Operative Record should include description of the removed item(s), area of the anatomy from which it was removed and disposition of the specimen.
iv. Bullets should not be handled with metal instruments, if possible, because they may scratch the bullet surface or be placed in a metal container.

v. Clothing or other personal articles are to be placed in paper bags—plastic bags trap moisture and may facilitate growth of mold, which could destroy evidence (one article per bag), sealed and labeled with the patient’s identification. (bags are kept in ER) When removing or cutting off clothing, preserve evidence by not cutting through bullet holes or stab wound holes but around them or along seam lines. After collecting objects in appropriate paper containers, place heavily saturated objects in plastic to avoid leakage of fluids and contamination to evidence collectors.

vi. Informational evidence (i.e. patient statements, appearance, behavior, bodily marks) should be documented in detail on the Operative record or in the EMR in Nurse’s notes.

vii. Documentation should be completed to establish the chain of custody from the point of removal until examination. Chain of custody is required for tissue specimens as well as clothing and other personal items removed for forensic examination.

V. Care of Fetal Remains/Products of Conception BCPP076

VI. Touch Preps to be done for sentinel lymph nodes injected with radionuclides (Policy ORPP501)

Developed by: OR Practice and Standards Committee


Reviewed by: OR Policy & Procedure Committee

Revised: 01/12

The original signed copy of this policy is kept in the Operating Room Department.