University Hospitals of Morecambe Bay
NHS Foundation Trust

Document Type: **Standard Operating Procedure**	**Unique Identifier:** THEAT/LOCSSIP/001
Document Title: **Local Safety Standards for Invasive Procedures (LocSsip) for:** **Specimen Verification, Labelling and Onward Transfer from the Trust's Operating Theatre Suite**	**Version Number:** 4
	Status: Ratified
Scope: All theatre X bay clinicians, registered practitioners, support workers and operating department orderlies.	**Classification:** Departmental
Author / Title: Rachel Moss, Clinical theatre Manager FGH	**Responsibility:** Theatres
Replaces: Version 3, LocSsip for Specimen Verification, Labelling and Onward Transfer from the Trust's Operating Theatre Suite, Theat/LocSsip/001	**Head of Department:** Faye Bennett, Matron FGH Theatre Sue Howard, Matron WGH theatre Claire Rawes, Matron RLI Theatre
Validated By: Surgery & Critical Care Procedural Document Group	**Date:** 25/06/2021
Ratified By: Surgery Governance Assurance Group (SGAG)	**Date:** 13/07/2021
Review dates may alter if any significant changes are made	**Review Date:** 01/02/2024
Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**	
Document for Public Display: No	
Reference Check Completed by Kerry Booth **Date: 12.05.21 (2021-2022/124)** **To be completed by Library and Knowledge Services Staff**	

BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

Specimen retrieval is common practice in surgical procedures; it is important that all staff ensure safe handling and know the correct processes relating to specimen management and transportation from the operating theatres.
Documentation errors, for instance involving incorrect labelling of specimens taken for diagnostic purposes have nationally been identified as risk factors for wrong site surgery. Surgical specimens are rarely incorrectly labelled, wrongly preserved or transported untimely, but in the event that an error related to this occurs, the effect to a patient could predispose to harm or be responsible for a further avoidable procedure.

2. PURPOSE

The correct labelling and onward timely transfer of a procedural specimen to the pathology department is a fundamental element of effective patient care.

The LocSsips (Local Safety Standards for Invasive Procedures) are localised safety steps that have been developed from the NatSsips (National Standards Framework for Safe Invasive Procedures) to reduce errors which could occur at labelling, preservation, storage, or onward transportation of the patient specimen.

Following the steps of this LocSsip will result in:

- A universal standard being followed by peri-operative teams for, identification, labelling and onward transfer transport processes of retrieved specimens.
- An improved patient experience as mistakes will be avoided.
- There will be no delays in diagnosis/treatment attributed to the untimely despatch of the specimens from the theatre suites.

Embedding safety steps into the everyday practice of behaviours by teams will promote a safety culture.

3. SCOPE

This document is required to be followed by all clinicians, registered practitioners, clinical support workers and operating department orderlies who participate in any part of the process relating to the ‘specimen’ journey from patient retrieval in the operating theatres to receipt in the pathology laboratories across all UHMB Operating Theatre Suites.

4. PROCEDURE

4.1 1st Checks performed at receipt of specimen.

- The type of specimen expected must not be labelled in advance on the pot or request form.
- Specimen verification must be undertaken on an individual patient basis and begins at the time the specimen is removed from the patient.
- Therefore patient addressograph identification labels must only be applied to the specimen pots at the time of receiving the specimen.

- Specimen labels must never be applied to the lid of specimen pots.
- If no patient labels (addressographs) are available only then must a hand written label for the pot be used.
- The specimen pathology request form is prepared and must be appropriately labelled with the patient addressograph and both the top and bottom copy.
- If no patient label/addressograph is available then in this situation written population of patient details can be scribed on the pathology request form. (In these situations, you must ensure any writing where a carbon copy forms the underneath sheet is legible and clear.)
- At the time when the circulating practitioner or Clinical Support Worker receives a specimen from the Scrub Practitioner the following must be confirmed by the operator, to the scrub and circulating practitioner:
    - The name of the specimen.
    - The location the specimen has been taken from (site) i.e. breast,
    - Laterality if relevant i.e. left.
    - The type of specimen analysis required must be confirmed i.e. microbiology, histology, cytology, so correct preservation of the specimen occurs.
    - Preservation medium must be confirmed.
- **Any Specimens that are taken and are suspected to be disease carrying i.e. tuberculosis (TB) or other high risk transmittable diseases, must have both the addressograph label on the pot and the specimen form stating 'Highly Infectious'.**

4.2 2nd Checks performed at Step 4 Sign Out of 5 Steps to Safer Surgery

- The specimen must be verified as being correct at 'Step 4' Sign Out during the checklist of the 5 steps to safer surgery.
- It must be confirmed that the patient data written on the specimen pot matches that on the specimen histology form and in the operating register.
- The operator must again confirm the specimen description plus laterality and site if relevant the circulator must confirm this matches the logged information on the specimen pot, and is correctly duplicated on the pathology request form.
- The specimen retrieval must be logged in the Lorenzo Theatre Management System (LTMS) on the patient care-plan.
- All the pathology forms must be signed by the Operator at the completion of the surgical case and the transfer of the patient and the clearing of the operating room.
- Once all of the above is completed, the specimens and the paperwork are collated and stored in the designated specimen collection/holding box in the theatre unit reception.
- The scrub nurse must ensure that the specimen is taken directly to the specimen collection box held in the theatre suite reception.
- It is the responsibility of the scrub practitioner to ensure the theatre specimen log book has been populated with details of the specimen from each surgical case.
- The Clinical Coordinator for the shift must ensure that specimens held in the theatre suite specimen storage box are transferred the pathology laboratories with the corresponding specimen book at the agreed specified times during working hours.
- Pathology will then check each specimen against the details in the book and sign to confirm receipt of each specimen to their department.
- If there is no one present at pathology to receive and sign the log book for the

specimens the orderly or C.S.W. (clinical support worker) must not leave the specimens unattended.
- The specimens must be returned to theatres in the storage box with the book and the situation escalated to the Clinical Coordinator for further action.

Additional steps to the above for retained products of conception:

- Two completed cremation forms should accompany the patient from the ward.
- Both must already be signed by the mother and the surgeon.
- Presence of both the form and the signature must be checked in the anaesthetic room before the patient is anaesthetised.
- At the end of the procedure, the specimen trap in the suction machine should be placed into a labelled histology pot and covered with formalin.
- Following the procedure, the surgeon must sign the cremation forms for the 2nd time to confirm that the specimen is complete. The histology form must also be signed.
- Both forms must then go with the specimen to pathology.

For cytogenetic testing of foetal remains:

Please see Section 6 related policies 'Cytogenetic Testing' S.O.P. (Standard Operating Procedure) for guidance.

When Pathology is closed.

- All specimens retrieved are still procured and verified to the standards of this document.
- If the specimen is considered non-urgent by the operating surgeon for pathology then in these instances onward transfer to pathology does not occur.
- Therefore the specimen/s must remain in the central specimen storage box in the main theatre reception.
- A communication relating to the storage of the specimens will be recorded for the Clinical Coordinator to action the transfer of the specimens at the first opportunity in normal working hours and complete the transfer and verification process.

For urgent specimens:

The on call system should be used to ensure all urgent specimens are processed.
In cases where there is requirement for an urgent call out of a pathologist and the pathology laboratory is closed:

Personal protective equipment:

Personal protective equipment such as eye protection, gloves and aprons must be worn when handling buffered formalin solution. See COSHH risk assessment for further details (see Section 6 for link).

5. ATTACHMENTS	
Number	**Title**
1	NatSsips Inclusion Table
2	Equality & Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS

The latest version of the documents listed below can all be found via the Trust Procedural Document Library intranet homepage.

Unique Identifier	Title and web links from the document library
Corp/SOP/002	Cytogenetic Testing
Corp/Pol/064	Control of Substances Hazardous to Health (COSHH)
Surg/LocSsip/005	LocSsip for: Surgical Site Marking and WHO '5 Steps to Safer Surgery'

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Number	References
1	NHS England (2015) 'National Safety Standards for Invasive Procedures,' [Online] Available from: https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf (accessed 12.05.21)
2	NHS England (2015) 'NHS/PSA/RE/20015/008 Supporting the introduction of National Patient Safety Standards for Invasive Procedures,' [Online] Available from: https://www.england.nhs.uk/2015/09/psa-natssips/ (accessed 12.05.21)
3	Association for Perioperative Practitioners (2016) *Standards and Recommendations for Safe Perioperative Practice*, 4th Edition
4	Human Tissue Authority (2016) 'Human Tissue Act 2004,' [Online] Available from: https://www.hta.gov.uk/policies/human-tissue-act-2004 (accessed 12.05.21)

8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
NatSsips	National Safety Standards for Invasive Procedures
LocSsips	Local Safety Standards for Invasive Procedures
C.S.W.	Clinical Support Worker
LTMS	Lorenzo Theatre Management System
S.O.P.	Standard Operating Procedure
UHMB	University Hospital Morecambe Bay

9. CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**

10. DISTRIBUTION PLAN	
Dissemination lead:	Faye Bennett, Matron FGH Theatre Sue Howard, Matron WGH Theatre Sue Rawes, Matron RLI Theatre
Previous document already being used?	Yes
If yes, in what format and where?	Trust document library.
Proposed action to retrieve out-of-date copies of the document:	Exchange document after all governance processes completed.
To be disseminated to:	.
Document Library	
Proposed actions to communicate the document contents to staff:	Share with the seven Clinical Theatre Managers across the three sites. Staff briefing during audit session Include in the UHMB Friday Corporate Communications Roundup – New documents uploaded to the Document Library

11. TRAINING Is training required to be given due to the introduction of this policy? Yes		
Action by	**Action required**	**Implementation Date**
Clinical theatre manager(s) and clinical leaders	To ensure specimen training incorporating LocSsip is undertaken during local workplace induction for new starters	On-going; all new employees within theatres
Clinical theatre manager(s) and clinical leaders	To train and brief staff on the LocSsip at monthly audit session	Within 1 month of ratification
Clinical theatre manager(s) and clinical leaders	To incorporate LocSsip into development of eLearning package	Within 3 month of ratification

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
2	12/04/2017	All Attachment 1 Path labs	Harmonisation to NatSsips. Table of applicable NatSsips added to document. No change to these processes.	01/04/2020
2.1	29/06/2017	Section 4.1	Added instructions on labelling any specimens suspected to be disease carrying	01/04/2020
3	27/11/2018	Section 4.2 page 3 Glossary Page 5	O.R.M.I.S (Operating Room Management Information System) changed to LTMS O.R.M.I.S Operating Room Management Information System changed to LTMS	01/02/2021
4	11/05/2021	Section 4.2 page 5	Two person check of the preservation medium before it is added to the specimen.	01/02/2024

Appendix 1 – NatSsips Table

Description of NatSsips which are mandatory inclusion in this LocSsip.	By Whom/How	Where identified	Inclusion achieved
Identified common theme from NatSsips on incorrect labelling of specimens	All theatre team	Page 1 Summary clearly defined. Safe mapping steps throughout the document.	Yes
Confirmation that any specimens have been labelled correctly, to include the patient's name and site or side when relevant.	Peri Operative surgical team	4.2 2nd stage checks pages 3 to 4. Sign Out Step 4 of 5 steps to safer surgery.	Yes

Appendix 2: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Theatres	
Lead Assessor	Rachel Moss	
What is being assessed?	LocSsip for Specimen Verification, Labelling and Onward Transfer from Trust's Operating Theatre Suite	
Date of assessment	11/05/2021	
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Network for Inclusive Healthcare?	NO
	Staff Side Colleague?	NO
	Service Users?	NO
	Staff Inclusion Network(s)?	NO
	Personal Fair Diverse Champions?	NO
	Other (including external organisations):	

1) **What is the impact on the following equality groups?**

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination / harassment / victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	

Other (e.g. carers, veterans, people from a low socioeconomic background, people with diverse gender identities, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.