HCA Healthcare®

CARE EXCELLENCE	Blood Culture Testing	TICKET TO TEST

BEFORE SENDING BLOOD CULTURE

1.	BEDSIDE RN PATIENT MEETS SEPSIS CRITERIA ❑ YES, PROCEED WITH SEPSIS BUNDLE ❑ NO, PROCEED WITH TICKET
2.	BEDSIDE RN ❑ ENSURE CRITERIA MET
3.	BEDSIDE RN ❑ PRESENT TO UNIT NURSING SUPERVISOR ✓ CHARGE ✓ MANAGER ✓ DIRECTOR
4.	NURSING LEADER ❑ VALIDATE AND SIGN BEFORE SENDING TO LAB
5.	LAB ❑ VALIDATE AND SIGN BEFORE PROCESSING

Patient Label

NURSING/PHLEBOTOMIST

DATE & TIME OF COLLECTION	DATE:	TIME:
CRITERIA MET	**FOR BLOOD CULTURE COLLECTION:** PLEASE CHECK EACH ITEM PRIOR TO SENDING SPECIMEN ❑ DRAW EACH SET OF BLOOD CULTURES FROM **SEPARATE PERIPHERAL VENIPUNCTURES.** DO NOT COLLECT BLOOD CULTURE THROUGH FRESH IV START. ❑ COMPLETE A METICULOUS SKIN PREPARATION PRIOR TO VENIPUNCTURE. ❑ CLEAN THE TOP OF EACH CULTURE BOTTLE WITH ALCOHOL OR CHG; AVOID TOUCHING THE TOP OF THE CULTURE BOTTLE AFTER CLEANING. ❑ COLLECT 1ML WASTE TUBE PRIOR TO FILLING EACH BLOOD CULTURE SET. ❑ FILL EACH BLOOD CULTURE BOTTLE WITH AT LEAST 8 MLS OF BLOOD TO PREVENT FALSE NEGATIVE BLOOD CULTURES. ❑ LABEL SPECIMENS AT THE BEDSIDE WITH DATE, TIME, AND SEQUENCE #1 OR # 2, SITE, COLLECTOR 3-4ID (PLEASE WRITE LEGIBLY,). PLACE BOTTLES IN BIOHAZARD SPECIMEN BAG FOR TRANSPORT TO LAB.	
SIGNATURES	SPECIMEN SUBMITTED BY (NAME & 3-4ID): ______________________ RN LEADER NAME: ______________ RN PHONE #______________________ THIS FORM MUST BE SIGNED BY THE PRIMARY RN AND SUPERVISOR TO CONFIRM ALL CRITERIA ARE MET.	

LAB

DATE & TIME OF COLLECTION	DATE:	TIME:
SIGNATURES	IF THE SPECIMEN ARRIVES TO THE LAB WITHOUT NAME/DATE/TIME DOCUMENTED, THE LAB PERSONNEL WILL CONTACT THE ORDERING NURSING UNIT TO OBTAIN MISSING INFORMATION. SPECIMEN RECEIVED BY: ___________________________	
THIS FORM MUST BE SIGNED BY: ✓ PRIMARY NURSE ✓ SUPERVISOR ✓ LABORATORY TECHNOLOGIST TO CONFIRM CRITERIA HAS BEEN MEET	**SIGNATURE REQUIRED**	

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Healthcare® | Division

HCA FL Fawcett Hospital 6/2024

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CARE EXCELLENCE | # C. DIFF TESTING | *TICKET TO TEST*

BEFORE SENDING STOOL SPECIMEN

Step	
1.	BEDSIDE RN ❑ ENSURE CRITERIA MET
2.	BEDSIDE RN ❑ PRESENT TO UNIT NURSING SUPERVISOR ✓ CHARGE ✓ MANAGER ✓ DIRECTOR
3.	NURSING LEADER ❑ VALIDATE AND SIGN BEFORE SENDING TO LAB
4.	LAB ❑ VALIDATE AND SIGN BEFORE PROCESSING

Patient Label

NURSING

DATE & TIME OF COLLECTION	DATE:	TIME:
CRITERIA MET (MUST MEET ALL)	**FOR C.DIFF TESTING:** PLEASE CHECK EACH ITEM PRIOR TO SENDING SPECIMEN ❑ **CONFIRM** PATIENT HAS BEEN PLACED ON **CONTACT PLUS PRECAUTIONS.** ❑ **CONFIRM** ANY SYMPTOMS PRESENT TEMP (>100.4°), INCREASING WBC, ABDOMINAL PAIN, CRAMPING, NAUSEA, VOMITING ❑ **CONFIRM** STOOL SPECIMEN IS LIQUID AND ASSUMES SHAPE OF THE CONTAINER. SEE BRISTOL SCORE 6-7. ❑ **CONFIRM** PATIENT HAS HAD >3 LOOSE STOOLS IN THE LAST 24 HOURS. ❑ **CONFIRM** PATIENT HAS NOT RECEIVED ANYTHING IN THE LAST 72 HOURS TO PROMOTE DIARRHEA (LAXATIVES, SUPPOSITORIES, BOWEL PREP, OR TUBE FEEDINGS). ORDER MUST BE ESCALATED AND APPROVED PRIOR TO TESTING. DO NOT HOLD TUBE FEEDS. ❑ **CONFIRM** C.DIFF TEST IS NOT A REPEAT WITHIN THE LAST 7 DAYS (TEST OF CURE). ❑ **PLACE** CUP IN BIOHAZARD SPECIMEN BAG FOR TRANSPORT TO LAB.	
SIGNATURES	SPECIMEN SUBMITTED BY (NAME & 3-4ID): ____________________ RN LEADER NAME: ________________ RN PHONE #________________________ THIS FORM MUST BE SIGNED BY THE PRIMARY RN AND SUPERVISOR TO CONFIRM ALL CRITERIA ARE MET.	

EXAMPLES OF MEDICATIONS THAT INDUCE DIARRHEA

❑ Bowel Preps	❑ Kayexalate
❑ Enemas	❑ Enemas
❑ Tube Feeds	❑ Golytely
❑ Oral Contrast	❑ MiraLAX
❑ Reglan/Metoclopramide	❑ Milk of Magnesia Mag
❑ Mag Oxide	❑ Citrate
❑ Senna	❑ Linzess
❑ Colace	❑ Amitiza
❑ Lactulose	❑ Movantik
❑ Dulcolax	❑ Symproic

LAB (LAB WILL REJECT SPECIMENS THAT DO NOT MEET CRITERIA)

DATE & TIME OF COLLECTION	DATE:	TIME:
CRITERIA MET	❑ **CONFIRM** STOOL SPECIMEN IS LIQUID AND ASSUMES THE SHAPE OF THE CONTAINER. SEE BRISTOL SCORE 6-7.	
SIGNATURES	SPECIMEN RECEIVED BY: ______________________________	
THIS FORM MUST BE SIGNED BY: ✓ PRIMARY NURSE ✓ SUPERVISOR ✓ LABORATORY TECHNOLOGIST TO CONFIRM CRITERIA HAS BEEN MEET	**SIGNATURE REQUIRED** IF THE STOOL CULTURE COLLECTION CRITERIA IS NOT MET AND THE ORDERING PROVIDER STILL REQUESTS THE TEST TO BE RUN, PLEASE REFER THEM TO CMO OR CNO FOR CLINICAL APPROVAL PRIOR TO PERFORMING LABORATORY TEST.	

HCA Healthcare®

Care Excellence

Urine Culture and U/A with Reflex

Ticket to Test

Before Sending urine Culture

1.	Bedside RN ❑ Ensure Criteria Met
2.	Bedside RN ❑ Present to unit Nursing supervisor ✓ Charge ✓ Manager ✓ Director
3.	Nursing Leader ❑ Validate and sign before sending to lab
4.	Lab ❑ Validate and sign Before processing

Patient Label

NURSING

Date & time of collection	Date:	Time:
Criteria met	**For urine culture collection:** Please check each item prior to sending specimen ❑ **Confirm** if a Foley catheter has been in place for >3 days, (if >3 days, the indwelling catheter system must be changed prior to collecting the urine specimen, unless contraindicated). ❑ **Ensure** order for UA with reflex to Urine culture. ❑ **Use** urine collection vacutainer tube with preservative for urine culture collection. ❑ **Label** specimen tubes at the patient bedside. Include collector 3-4ID, date, and time. Please write legibly. ❑ **Place** tube in biohazard specimen bag for transport to lab.	
Signatures	Specimen submitted by (name & 3-4ID): ______________________ RN Leader Name: ____________________ RN Phone # ____________________________ This form must be signed by the primary RN and supervisor to confirm all criteria are met.	

LAB (lab will reject specimens that do not meet criteria)

Date & time of collection	Date:	Time:
Signatures	❑ **If** the specimen arrives to the lab without name/date/time documented, the lab personnel will contact the ordering nursing unit to obtain missing information. ❑ **Confirm** Urine culture collected in the urine collection vacutainer preservative tube. Specimen received by: _________________________	
This form must be signed by: ✓ Primary nurse ✓ Supervisor ✓ Laboratory technologist to confirm criteria has been meet	**Signature Required** If the urine culture collection criteria is not met and the ordering provider still requests the urine culture test to be run, please refer them to CMO or CNO for clinical approval prior to performing laboratory test.	

HCA Healthcare®

CARE EXCELLENCE | **HD CATHETER NEWLY INSERTED & POA (INPATIENT)** | HAND OFF ASSESSMENT AND CHECKLIST

Patient Label

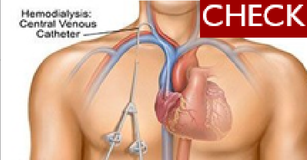
HD CATHETER ASSESSMENT

SENDING RN	
DATE AND TIME	/ / :
SUBJECTIVE DATA	❑ RECENT TREATMENT FOR INFECTION ❑ FEVER/CHILLS WHILE ON HD IN LAST 7 DAYS
OBJECTIVE DATA	❑ ↑TEMP ❑ ↑WBC ❑ ↑NEUTROPHILS
VISIBLE SIGNS & SYMPTOMS OF INFECTION	❑ SITE REDNESS ❑ PURULENT DRAINAGE ❑ MOISTURE UNDER DRESSING ❑ ABSCESS ❑ WARM TO TOUCH

YES **TO ANY OF THE QUESTIONS**

CHECKLIST TO BE USED BY NURSING AT FIRST POINT OF CONTACT

- HD NURSE
- ED NURSE
- BEDSIDE NURSE
- DAY SURGERY NURSE



RESPONSE CHECKLIST

SENDING RN

SIGNATURE ____________ DATE: TIME:	CATHETER CONDITION ❑ DRESSING DRY AND INTACT ❑ DATE OF LAST DRESSING CHANGE: ____________ ❑ BLEEDING/OOZING ❑ S/S OF INFECTION ❑ CLEARGUARD HD CAPS IN PLACE

RECEIVING RN

SIGNATURE ____________ DATE: TIME:	VITAL SIGNS ❑ BP:________ ❑ HR:________ ❑ TEMP:________ ❑ RESP:________ PENDING ORDERS RELATED TO HD CATHETER ❑ BLOOD CULTURE COLLECTION ❑ CATHETER REMOVAL ❑ CATHETER EXCHANGE

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CARE EXCELLENCE | HD CATHETER PRESENT ON ADMISSION

HAND OFF ASSESSMENT AND CHECKLIST

Patient Label

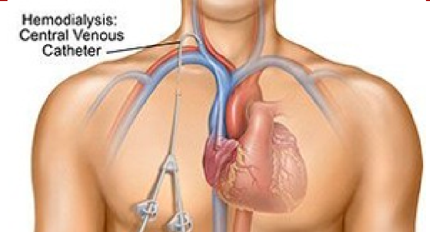
HD CATHETER ASSESSMENT

DATE AND TIME	/ / :
SUBJECTIVE DATA	❑ RECENT TREATMENT FOR INFECTION ❑ FEVER/CHILLS WHILE ON HD IN LAST 7 DAYS
OBJECTIVE DATA	❑ ↑TEMP ❑ ↑WBC ❑ ↑NEUTROPHILS
VISIBLE SIGNS & SYMPTOMS OF INFECTION	❑ SITE REDNESS ❑ PURULENT DRAINAGE ❑ MOISTURE UNDER DRESSING ❑ ABSCESS ❑ WARM TO TOUCH

YES — TO ANY OF THE QUESTIONS

CHECKLIST TO BE USED BY NURSING AT FIRST POINT OF CONTACT

- ED NURSE
- BEDSIDE NURSE
- DAY SURGERY NURSE



RESPONSE CHECKLIST

CHECKLIST	❑ NOTIFY PHYSICIAN OF ABOVE FINDINGS ❑ OBTAIN BLOOD CULTURE COLLECTED WITHIN 24 HOURS: DATE: ___________ TIME: __________ ❑ PERFORM DRESSING CHANGES REMOVE OLD DRESSING AND APPLY NEW DRESSING AND CLEARGUARD HD CAPS AT FIRST POINT OF CARE (FOLLOW STEPS TO CHANGE CVC DRESSING FOR HD CATHETERS). MUST BE COMPLETED PRIOR TO HANDING OFF THE PATIENT TO THE RECEIVING UNIT.
SIGNATURES	❑ PERFORM HAND OFF SENDING RN: ______________________ DATE: __________ TIME: __________ RECEIVING RN: ______________________ DATE: __________ TIME: __________

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