| ISSUE | DETAILS | What SPS should communicate to RN/DR | APPROPRIATE ACTION FOR RNs |
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| **Incorrect Requisition Submitted** | 1. Parent order/req submitted with sample. | 1. **"Please send us the requisition for the child order"** | 1. Submit correct child order/req with sample. |
| | 2. Cancelled req submitted with recollected sample. | 2a. When we are cancelling a test and notifying the RN about the cancellation please say **"we will need for you to re-order and re-collect the specimen"**<br>2b. If we receive an requisition for a cancelled order with the new sample **"We need for you to place a one-time order for us to process the specimen"** | 2. Recollections due to cancellations (clots, hemolysis, wrong tube, etc.) require a new order and corresponding new requisition. |
| **Add On Testing Requested Incorrectly** | 1. Actual test to be added on (CBC, CMP, etc.) being ordered in ORCA. | 1. **"Please place a lab add order and cancel the pending tests"** | 1. Order a Lab Add On to add testing to samples that are already in the Lab. |
| | 2. One test being ordered per Lab Add On request. | 2. Complete Addons, but notify provider **"you can use a single Lab Add On order for multiple tests being requested on the same sample"** | 2. Multiple tests can be requested on a single Lab Add On request. |
| | 3. Paper add on request submitted. | 3. **"Please place a lab add order in CPOE"** | 3. Submit Lab Add Ons electronically. |
| **Identifying CODES** | 1. Paper reqs are received, but no indication that the samples are for CODE. | 1a. If received from the ER, just log and keep copy for follow-up<br>1b. Any other location, call location and ask why CPOE order wasn't placed, if a "CODE" is indicated in the phone call place order manually | 1. Identify CODES by…….??? |
| **If/Then Orders** | 1. Physician requests an IF/THEN (common for blood gases) order and the nurse submits a sample without the actual lab order. | 1. **"We do not have a corresponding order in our system, can you please place a one time order so that we can process the specimen?"** You will need to exit out of the patient before the new order will cross the interface into Misys | 1. Actual lab test should be ordered in ORCA and the new requisition should be sent to the lab |

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| **EHPs** | 1. Orange EHP cards not placed with samples in pneumatic tube carrier from ICUs and ED. | 1. Keep copy of req for Jenn to follow-up with proper location | 1. ED and ICUs should place orange, laminated EHP cards in the pneumatic tube carrier to ensure timely processing. |
| **Labs Pending for Discharged Patients** | 1. Lab/Phlebotomy is attempting to locate patients for draw after discharge because they still appear to be pending. | | |
| **VLAC versus WBLAC orders** | 1. VLAC is being ordered in error by practitioners/nurses. | | 1. WVLAC should be ordered. |
| **Lab 'fixing' RN collect orders** | 1. Duplicate testing requested | 1. Duplicate testing will cause 2 separate groupings of tests in the lab system | 1. Check the status of the order before taking any action. To improve the efficiency of resulting the tests, lab will sometimes need to recombine these orders. Any lab generated orders will appear as a 'lab collect' in ORCA, but if the order status is pending, in progress, or completed then phlebotomy will not be coming to draw the patient since we already have the sample and are running the requested tests. The process of recombining orders will not effect future RN collects. |
| | 2. Multiple orders placed at different time points | 2. Multiple lab orders that are placed at different time points (i.e. 1 hour time difference between the 1st and 2nd request) will cause 2 separate groupings of tests in the lab system | |