CHESTER AND WIRRAL MICROBIOLOGY SERVICE USER GUIDE

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REVISION HISTORY

REVISION	CHANGE DETAILS	SECTION(S)	PAGE(S)	MADE BY	APPROVED BY	ACTIVE DATE
5.0	Full Review Added guidance on the labelling of high-risk samples	6.1	10	BJE	BDB	14.07.25
5.0	Added Gonorrhoea testing to eye swab. Removed VTM swab as now use Roche Uni swabs	10	29	BJE	BDB	14.07.25
5.1	Added section on Consent	3.6	8	BJE	BDB	27.07.25
5.1	Updated multiple samples	6.1	11	BJE	BDB	27.07.25
5.2	Clinical staff names and contact details updated	2.0	5-6	CSAQ	CIK	28/08/25
5.2	Added reference to COCH transport policy	4.1	10	CSAQ	CIK	28/08/25
5.2	Section on Information Governance updated to include COCH and WUTH	3.5	8	CSAQ	CIK	28/08/25
5.2	Section on Consent updated to include COCH and WUTH	3.6	8	CSAQ	CIK	28/08/25
5.2	Investigations reviewed and updated	10	28-46	CSAQ	CIK	28/08/25
5.2	Reference range table removed. Referred to reference range on reports	13	48	CSAQ	CIK	28/08/25
5.3	Removal of Dr Azza Abdelrahman	2.0	5	BCG	BCG	18/08/2026
5.3	Added in Lee Carter as Pathology Training Manager	2.0	6	BCG	BCG	18/08/2026
5.3	Removed PCR performed at APH	3.0	7	BCG	BCG	18/08/2026
5.3	Updated accreditation badge	3.2	7	BCG	BCG	18/08/2026
5.3	Added glucan guidance	10.0	34	BCG	BCG	18/08/2026
5.3	Updated with new C diff report comments	14.0	51	BCG	BCG	18/08/2026

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5.3	Added section on Complaints	3.7	10	BJE	BCG	18/08/2026
5.4	CoCH onsite PCR location changed	1.0	6	BCG	BCG	26/08/2026
5.4	Added in information about using re-printed Cerner labels	5.0	13	BCG	BCG	26/08/2026
5.4	Updated turnaround times	10.0	Throughout section 10.0	BCG	BCG	26/08/2026
5.4	Updated the Antimicrobial therapy section with the information provided by EUCAST	3.2	8	BCG	BCG/BDH	26/08/2026
5.5	Updated blood culture collection volumes in line with manufacturer recommendations	10.0	31	BCG	BCG	14/10/2026

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1.0 GENERAL INFORMATION

The Medical Microbiology Service is part of collaboration between Wirral University Teaching Hospital NHS Foundation Trust and Countess of Chester NHS Foundation Trust. The main Microbiology Laboratory is located on the Croft Business Park, Bromborough.

The **Microbiology Laboratory** address is:

Chester and Wirral Microbiology Service
11 Bassendale Road,
Bromborough,
Wirral.
CH62 3QL

Tel 01244 362500

24-hour cover is provided for ALL aspects of infectious diseases.

On-call service for urgent clinical advice

The Consultant Medical Microbiology advisory on-call service covers the following periods:

Monday – Thursday: From 17.00 to 09.00 following morning
Weekends: From Friday 17.00 to 09.00 Monday morning.

Outside of this time frame (Monday – Friday 9.00 – 17.00) CMMs of the individual Trusts are responsible for the advisory service.

The on-call service will be through the provision of telephone advice to the relevant requesting hospital. All requests will be routed through the switchboard of the requesting hospital to the consultant on call.

It is expected that all requests for on-call medical microbiology advice are initiated for unwell / deteriorating patients or to discuss an important microbiology result. IV antibiotics to oral switch (IVOS) advice should be based on your antibiotic formulary or IVOS tool and this is not an indication for contacting the on-call Microbiology consultant.

Please note that the on-call Consultant Microbiologist should only be contacted in response to requests from the following categories of personnel:

Consultants or Registrars

Pharmacists

Laboratory staff

General Practitioners or on-call ANP/ACP (including UTC ACPs) – (they should have been well conversed with community antimicrobial formulary/PGDs with alternative choices of antibiotics)

OPAT nurses for antibiotic choices after d/w with own GP

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Countess of Chester Hospital

There is a limited onsite service providing Molecular testing for SARS-CoV-2 and Flu in Cellular Pathology at Countess of Chester Hospital

Cellular Pathology Department
Department of Pathology
CoCH
Tel: 01244 365595

2.0 KEY CONTACTS AND THEIR TELEPHONE NUMBERS/ EXTENSIONS

Laboratory Results/Enquiries

Monday – Sunday 09-00hrs, - 19-00hrs	01244 362500

Consultant Staff (Countess of Chester)

Dr Ildiko Kustos	01244 366785
Dr Jeremy Gardner	01244 366788
Dr Kenneth Mutton	01244 362726

Staff Grade Doctor (CoCH)

Dr Muna Yousif	01244 363518

Clinical Scientists (CoCH)

Mrs Sarah Wood	01244 364062
Dr Eleanor Senior	01244 362729

Trainee Clinical Scientist (CoCH)

Miss Hannah Concannon	01244 362731

Medical Secretaries for clinical enquiries (COCH)

Monday – Friday: 09-00hrs – 17-00hrs	01244 366773

Consultant Staff (Wirral)

Dr Kavya Mohandas	0151 482 7694
Dr David Harvey	0151 604 7466

Staff Grade Doctor (Wirral)

Dineeka Gunaratne	0151 678 5111 Ext 5735
Meher Khan	0151 678 5111 ext. 2526

Clinical Scientist (Wirral)

Mrs Sharon Bamber	0151 678 5111 Ext 2847
Dr Elizabeth Thursby	0151 552 1875

Medical Secretaries for clinical enquiries (WUTH)

Monday – Friday: 09-00hrs– 17-00hrs	01244 362500 Option 3

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Referrals for Microbiology clinical advice for inpatients should be sent via Cerner, using the ORDER ''Refer Microbiology Inpatient.''
This service will operate during routine working hours between 9:00 - 4.30pm for inpatients only.

For any inpatient referrals on weekdays between 4.30 pm - 5:00 pm, please call Ext 7875
For outpatients during working hours, please call Ext 7875.

Laboratory Manager
Nadia Duggan 01244 362499

Technical Manager / Deputy Laboratory Manager 01244 363352
Claire Greene

Chief Biomedical Scientist / Deputy Laboratory Manager
Dave Bond 01244 363352

Quality Management
Mrs Joanne Evans

Pathology Training Manager
Lee Carter 01244 363352

Senior BMS Team (Microbiology) wuth.microdutysenior@nhs.net
Senior BMS Team (Serology) wuth.serologyduty@nhs.net

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3.0 MEDICAL MICROBIOLOGY – PRINCIPAL SERVICES

3.1 Clinical Service

The principal diagnostic laboratory is based at The Croft Business Park, Bromborough.
Limited molecular testing is also performed CoCH (refer to **Section 1.0**)
Access to consultative and principal diagnostic service outlined below is available on a 24-hour basis.

3.2 Diagnostic Service

Chester and Wirral Microbiology Service provides a comprehensive microbiological service in medical bacteriology, mycology, virology, parasitology and serological investigations. Advice on the selection of appropriate diagnostic specimens, their collection and transport are available.

The laboratory is accredited by the United Kingdom Accreditation Service (UKAS) to ISO 15189 for the test repertoire stated on the Schedule of Accreditation, which can be accessed at:
9595 Medical Multiple (ukas.com)

UKAS
MEDICAL
9595

Accredited to
ISO 15189:2022

Any tests reported that are not on the UKAS Schedule of Accreditation will have the following report code added.
"Test internally verified awaiting UKAS Accreditation"

Results of clinical significance are phoned through to the surgery or relevant.
medical staff, irrespective of whether the original request is marked as urgent or routine.

Delay in results – if there is going to be a significant delay in the availability of results, the users will be informed.

Antimicrobial Therapy and Clinical Consultation
When a conclusive microbiological diagnosis has been reached, optimum therapeutic regimens. are reported when necessary. They will be reported as:

- **S - Susceptible**, standard dosing regimen: A microorganism is categorised as "Susceptible, standard dosing regimen", when there is a high likelihood of therapeutic success using a standard dosing regimen of the agent.

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- **I - Susceptible**, increased exposure*: A microorganism is categorised as "Susceptible, Increased exposure*" when there is a high likelihood of therapeutic success because exposure to the agent is increased by adjusting the dosing regimen or by its concentration at the site of infection.
- **R - Resistant**: A microorganism is categorised as "Resistant" when there is a high likelihood of therapeutic failure even when there is increased exposure.

* Exposure is a function of how the mode of administration, dose, dosing interval, infusion time, as well as distribution, metabolism and excretion of the antimicrobial agent will influence the infecting organism at the site of infection.

Ref: Redefining S, I and R 2019 – www.eucast.org

The serum concentration of relatively toxic antimicrobials and those used in critical infections. are monitored.

Empirical (blind / provisional) prescribing regimens can be found in the WUTH Prescribers' Guide and The COCH Antimicrobial Formulary

3.3 Teaching and Training

The Department of Medical Microbiology supports scientific and professional training for its staff, as well as the teaching of science students attending local universities and colleges. It is also actively involved in providing work experience placements for BTEC students from local colleges. Placements are also given to students undertaking the Biomedical Science degree course at Liverpool John Moore's University and University of Chester.

3.4 Document Control

All documents used in Microbiology are managed electronically via QPulse and backed up on Countess of Chester Servers to protect their integrity.

There are policies, procedures and templates specific to Microbiology as well as shared directorate documents.

The department is obliged to follow Trust policies and procedures. To avoid duplication some of these policy and procedure documents are used in place of departmental ones.

The Laboratory is hosted by Wirral University Teaching Hospital NHS Foundation Trust policies and procedures are located on the intranet.

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3.5 Patient Confidentiality/Personal information

WUTH and COCH adopt the NHS Information Governance framework to ensure patient, staff and other confidential information is handled securely and safely. The WUTH and COCH Information Governance policies relates to all information used by the Trusts and their employees and to other NHS policies and legislation. Through mandatory staff induction programmes, both Trusts ensure staff are made aware and follow procedures documented in the policies and subsequently annual mandatory assessments are required to allow the trusts to monitor compliance.

3.6 Consent

Informed consent for the venepuncture procedure and the testing of samples taken is required. For patients attending our Phlebotomy Clinics consent is assumed by them presenting themselves to Phlebotomy with a request form and then presenting their arm for venepuncture.

For patients that are in a hospital bed consent for the procedure is verbally checked by the phlebotomist before they are bled. They have an opportunity to refuse the procedure. For those who are unable to consent, i.e. are unconscious the decision to bleed and complete the relevant testing is taken by the clinical team in the best interests of the patient.

The consent for testing, is assumed to have been gained by the clinician or healthcare professional requesting the test and is inferred to the laboratory through the receipt of the request form with the relevant sample(s). Similarly, for samples that are received from GPs or other laboratories referring work to CWMS Laboratory the consent for testing is gained by the clinician or healthcare professional requesting the test and is inferred to the laboratory through the receipt of the request form with the relevant sample(s).

For work referred to us, consent to disclose clinical information and family history to relevant healthcare professionals within CWMS Laboratory is inferred by the receipt of the request form with the relevant sample(s). Similarly, work that we refer to other laboratories for specialist testing the consent to disclose is assumed and then inferred to those laboratories by the receipt of a request form with the relevant sample(s).

The consent for other collection procedures, e.g. Invasive, tissue biopsy is gained by the clinical team completing the procedure and the record kept as part of the patient's notes. This is covered by the Trusts Consent Policy at WUTH and COCH.

The decision whether to consent or not is entirely the patient's decision to take.

In an emergency, the doctor is excused from conferring with the patient in circumstances of necessity, as for example where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision. The laboratory will therefore accept and process samples in these circumstances.

Clinicians should also be aware that the laboratory may perform additional tests where clinically indicated or to aid in interpretation.

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3.7 Complaints

Each individual Trust has its own complaints team, and their primary role is to coordinate the concerns and complaints process and provide a centralised point of liaison for service users raising concerns or complaints. Each individual hospital website lists how to access these services.

Feedback, Compliments, Concerns and Complaints | Wirral University Hospital NHS Foundation Trust

PALS and Complaints | Countess of Chester Hospital

4.0 'URGENT' SPECIMENS FOR MICROBIOLOGICAL INVESTIGATION

Biomedical Scientists (BMSs) are available in the laboratory 24 hours a day, 7 days a week to process any samples that are considered urgent.

Please contact the Biomedical Scientist in the Microbiology Laboratory on 01244 362500 (option 1) if urgent testing is required for the following specimen types:

- Paediatric MSSUs for children **under** 3 years of age (Microscopy / Culture)
- Material from Sterile Sites – e.g. Synovial fluid, Peritoneal fluid (e.g. Ascites) CSF
- Pus from deep seated abscesses
- Pus
- Specimens from theatre

4.1 Taxis

The Microbiology laboratory operates a 24/7 service – see the details above. If an urgent specimen has missed the transport run, then a taxi may be required to transport the sample to the Microbiology Laboratory in Bromborough between 17-00hrs and 09-00hrs. Samples must be packaged in a robust container and no patient details should be visible on the outer packaging – refer to COCH and WUTH Transport policies.

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5.0 LABELLING REQUIREMENTS FOR REQUESTS (CERNER, ICE AND HANDWRITTEN FORMS)

Requests communicated to the laboratory are as follows:

- Cerner – order labels are attached to the sample (no request form required)
- ICE forms generated by the GP practices.
- Handwritten request forms from wards, clinics, or GPs
- All verbal requests to the laboratory **must** be accompanied by one of the above requests forms for the sample to be processed.

All Locations within each Trust and GP practice should make requests via the above Order Entry Systems – otherwise results may not be viewable electronically. The sample, request label, or request form should clearly state the following information for unequivocal identification of the patient and specimen:

- Patient name (in full – no abbreviations)
- Ward, Clinic, or GP name and number/address
- NHS number
- Date of Birth
- Sex
- Type of specimen
- Date and time specimen taken.

NB It is **ESSENTIAL** that the laboratory knows the date and time on which a specimen is taken: processing delayed specimens can yield unhelpful or frankly misleading results and they may be discarded (e.g., urine samples dated 2 days prior to day of receipt). When patients are given a request form and asked to provide a specimen **they should be asked to ensure that the date on which the specimen was collected is given on the container and the form.**

- Tests required (specify 'TB' if required)
- Only request 'Miscellaneous Microbiology' if the appropriate investigation is not listed on the screen and state the specific investigation required in the clinical details field.
- Antibiotic treatment (recent, current or intended)
- All relevant clinical details
- History of recent foreign travel, if applicable
- Risk status, if applicable * **see section 6.2**
- Date of onset and duration of illness, particularly for serology
- Specify anatomical site from which "wound" specimens were taken.
- Key epidemiological information, e.g., for faeces
- Request 'OCP' (ova, cysts and parasites) if appropriate

Cerner Requesting

CERNER is a paperless system that will not generate a request form.
All CERNER requests should have a status of collected in CERNER before sending to the laboratory. The specimens should be sent with the printed label on the specimen. All of the above details are necessary to include when making a CERNER or Excelicare request.

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If uncertain about the exact test and terminology, please give a detailed clinical history as this can help the Laboratory staff to decide the most appropriate investigation.

It is not acceptable to use a re-printed Cerner label. Each new sample requires its own request. Failure to do this may result in samples being rejected by the laboratory.

6.0 LABELLING REQUIREMENTS FOR SPECIMENS

- The specimen must be labelled with the patient details as on the request form.

- Patient name (in full – no abbreviations)
- Ward, Clinic, or GP name and number/address
- NHS number
- Date of Birth
- Sex
- Type of specimen
- Date and time specimen taken (24-hr clock).

6.1 Labelling multiple samples

Multiple samples taken at different times or from different sites on a single patient must be labelled with:

- with the recommended patient identifiers,
- the specimen types e.g. sputum, urine,
- the time (24-hour clock) when each sample is taken
- the site of specimen. e.g. swabs taken from different areas of the body
- Each different specimen or test request must have its own unique order number.

EXCEPTIONS:
Blood Cultures where 2 sample bottles are required. Label both samples with the patient identifiers and order only one unique order number.

MRSA samples where Swabs from various sites are combined into on sample collection. Label the one container with the patient identifiers and order only one unique order number.

- Please note that unlabelled and mislabelled specimens cannot be processed and will be rejected.

If the laboratory cannot unequivocally identify the sample and match it to a form, then it will be rejected.

The laboratory will inform senders by means of an electronic or printed report when a specimen has been rejected for the above reasons.

In certain circumstances it may be possible to add tests to samples that the laboratory has already received. It is assumed by the laboratory that the request for additional tests and the sending of samples has patient consent.

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6.2 Laboratory guidance on appropriate labelling of high-risk samples

Danger of Infection - High Risk Samples
High risk labels alert laboratory workers to samples which may need additional safety and handling precautions.

High Risk Labelling NOT required for BBV positive samples
It can now be confirmed that samples from BBV positive patients no longer need to be specially labelled or packaged.
The laboratories follow 'universal precautions' and treat all samples as potentially hazardous.

High Risk Labelling IS REQUIRED
All biological agents causing infection are classified into hazard groups 1-4 by the Health and Safety Executive (HSE). Those in groups 3 and 4 are deemed to be a serious hazard and infective samples taken from such should be labelled high risk. But the list of biological agents in these groups is extensive and includes many rare infections unlikely to be encountered in general practice in the UK. Below is a relevant summary of when labelling would be appropriate.
It is very important that the request contains **clear clinical details** so staff can help identify which samples may require additional precautions when processing.

Clinical details that should alert the clinician to the possibility of a 'high risk' pathogen

Suspected infection in these groups:

Bloody diarrhoea/dysentery	E Coli O157 is common and very infectious to laboratory staff.
Injection site infections	in IV drug users - risk of anthrax
Haemoptysis	If TB is suspected
Laboratory workers	especially those handling 'hazard group 3 or 4' organisms (the individual worker should be able to inform you of this)
Animal exposure	(farm animals/exotic animals). Animals and animal products or by-products from overseas are a particular concern.

Apart from E Coli O157 diarrhoea and bovine TB, it is unusual to get high risk infections from UK farm animals

Foreign travel mainly outside Western Europe*– particularly if basic or rural conditions, animal exposure, volunteer/healthcare work (visiting family)
Consider viral haemorrhagic fever in endemic areas.
(When should I suspect Viral Haemorrhagic fever (VHF)?
If the patient has a fever (>38 C) or history of a fever in the last 24hrs and has either returned from a viral haemorrhagic fever endemic area in the last 21 days or had contact with an individual, animal (or specimens from such) that is known or strongly suspected to have VHF).

VHF endemic areas include East and West Africa, Central Asia and the Middle East.
A detailed list can be found on pages 35-39 of the following document: Viral haemorrhagic

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fever: ACDP algorithm and guidance on management of patients - GOV.UK

***In cases of suspected viral haemorrhagic fever, the Regional Infectious Diseases Unit should be contacted before ANY samples are taken.**

What conditions caused by 'high risk' organisms can present in the UK?

Anthrax
Brucellosis
Diarrhoea associated with E Coli O157
Travel associated exotic fungal infections
Melioidosis
Tuberculosis
Histoplasma
Typhoid (Enteric Fever)
Viral Haemorrhagic Fevers
Rabies

This list is not exhaustive.

If a high-risk pathogen is suspected: -

1. **Please document clinical details clearly on the request.**
2. **Ensure containers are properly sealed and bagged.**
3. **Label transport bags as "high-risk" with a yellow high-risk sticker ****

**** The exception to this is patients with suspected viral haemorrhagic fever. These cases must be discussed with medical staff at the Regional Infectious Diseases Unit. They will provide a risk assessment and advise on sampling if necessary.**

The full Health and Safety Executive (HSE) guidance can be found at Provision of key clinical information on laboratory specimen request forms - HSE
A complete list of organisms and their Hazard Group can be found at The Approved List of biological agents: Advisory Committee on Dangerous Pathogens

Country specific information on recent outbreaks (that is updated regularly) is available on Travax: http://www.travax.nhs.uk

Any queries please send us an email on wuth.microdutysenior@nhs.net or call us on 01244363351 and ask to speak to the Duty Senior or Specialist biomedical Scientist out of hours.

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6.3 Storage of samples

The table below indicates how long samples are kept in the laboratory before disposal. Requests for extra tests must be received within the sample storage period and must be accompanied by a request form. Please telephone the laboratory before requesting extra tests to ensure the sample is available and still viable.

Sample	Time Kept
Faeces	1 week after primary culture. Aliquot of C diff toxin positive samples – min 3 months
Respiratory samples	1 week after primary culture
Flu samples	1 week after primary screening
Swabs, fluids and aspirates	1 weeks after primary culture
Urines	1 weeks after primary culture
CSF samples	1 month after collection (? CJD samples) stores securely in -70$_o$C freezer until Reference Laboratory report is received)
Blood cultures	Positive bottles – until all follow up work is finalised. Negative bottles – discarded after 5 days incubation.
Tissue / bone / cartilage	1 month after primary culture
Stained slides	1 week after primary culture
Postmortem tissue	1 month after culture
Mycology samples for culture	Generally, all samples are processed in KOH
MRSA/CPE/VRE screening swabs	1 week after PCR/primary culture
Left over serum from first pregnancy booking	-20°C 2 years
Left over serum or plasma (other than transplant-related)	Minimum 2 years -20°C
Left over serum or plasma from transplantation, post transplantation donor/recipient sera	Minimum 11 years at -20°C
Serum from accidental exposures to blood and bodily fluids	Minimum 2 years -20°C

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All clots	Minimum 1 week at 4ºC
Unprocessed samples (e.g., spares)	Minimum 1 week at 4ºC
Human milk and serum from milk donors	Milk -10 years at -80ºC Sera – 10 years at -20ºC

7.0 STANDARD PROCEDURES FOR THE SAFE COLLECTION OF SPECIMENS

These procedures concern all clinical staff who are qualified to collect diagnostic specimens from patients.

Firstly, check who the patient is before taking the sample, both verbally and using the patient's wristband.

N.B. *Staff must always follow aseptic techniques when handling blood, body fluids, excretions, or secretions, even when these have not been specified as infectious.*

Objectives

All staff must be aware of the potential physical and infectious hazards, associated with these procedures, and should therefore collect specimens:

1) Being mindful of personal safety, without injury or exposure of themselves and of collective safety, without exposing colleagues who are involved with the handling, transport and laboratory investigations of specimens, to physical or infectious hazards.

2) Staff collecting specimens must take care to prevent contaminating themselves, their environment, the external surfaces of the specimen containers, or the accompanying test request forms. If gross contamination of the hands with blood, faeces or other biological fluids is anticipated, then gloves should be worn. Hands should always be washed after taking specimens. If splashing into the eyes or on to mucous membranes is anticipated goggles should be worn.

3) In addition, specimens should be collected aseptically, without allowing contamination by extraneous and, therefore, irrelevant micro-organisms. Contaminated specimens can adversely affect the validity of many laboratory results. For example, the microbiological investigation of contaminated blood or other materials from sites, which are normally sterile, can commit patients to unwarranted courses of expensive and potentially toxic treatment.

Before you start

1) Ensure that the lighting conditions are adequate.

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2) Select the correct specimen container (s), appropriate for the type of specimen, and keep the container close to the site from which the specimen is to be obtained.

3) Complete, legibly and fully, all section of the label on the specimen container and, check the details on the computer-generated request form are correct or, where used, the test request forms.

4) If you suspect, or are aware of, an infection with a Hazard Group 3 pathogen (example of relatively common Hazard Group 3 pathogens are Hepatitis B virus, Human Immunodeficiency virus and *Mycobacterium tuberculosis*), or suspect Monkey Pox it must be mentioned in the clinical details sent with the specimen.

5) If you suspect, or are aware of, an infection with a Hazard Group 4 pathogen (Viral haemorrhagic fevers, e.g., Ebola and Lassa) do not attempt to collect any specimen. **Discuss with Medical Microbiology Consultant.**

When you have finished all waste generated from obtaining a specimen should be disposed of according to Local Waste Disposal Protocols.

7.1 Procedure for collection of a specimen of blood / blood cultures

Please refer to the Trust's intranet site for guidance on this procedure.

7.2 Procedure for the collection of pus or exudates

Where there are clinical signs of infection i.e., inflammation, oedema, pyrexia, pain or purulent. exudate, it is preferable to obtain a specimen of pus rather than to take a swab.

Pus or exudate can be drawn up in a syringe and transferred to a universal container.

Taking a Transwab (blue top) or Charcoal swab (black top), remove the swab and gently but firmly rotate it on the surface directly where infection is suspected. Do not take swabs from slough or necrotic tissue. Place the swab into the transport medium.

Ensure that the specimen containers are labelled accurately and place, with the completed request form, in the appropriate pockets of the clear mini-grip transport bag for transportation to the Department of Medical Microbiology (via Pathology).

Specimens should be transported and processed as soon as possible.

The volume of specimen influences the transport time that is acceptable. Large volumes of purulent material maintain the viability of anaerobes for longer.

The recovery of anaerobes in particular is compromised if the transport time is delayed.

If processing is delayed, refrigeration is preferable to storage at ambient temperature.

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7.3 Procedure for the collection of screening swabs (MRSA, CPE, VRE)

These swabs should only be taken on the advice of the Community Infection Control Team or to comply with individual hospital protocols. They are taken to ascertain whether a patient is colonised with potentially pathogenic bacteria e.g., MRSA, VRE, CPE. If clinical infection is suspected, please send another swab from ulcers, wounds etc. separately for MC&S.

MRSA culture
For routine MRSA screens nose and groin swabs are required. Axillae swabs are only tested from pre-pacemaker insertion patients on CCU and CCS.

Collection:

Nasal – rotate the swab gently but firmly around the anterior nares of each nostril.
One swab can be used for both nostrils.

Groin – rotate the swab gently but firmly over each area. One swab can be used for both groins.
MRSA PCR (CoCH only)
Only nose and groin swabs from patient on ITU at CoCH are tested for MRSA by PCR. Swabs from contact screens or any other patient are only tested by PCR if requested by the Infection Control Nurses at CoCH. **Pink topped liquid swabs are required for MRSA PCR** – contact Infection Control if guidance is required.

CPE / VRE culture
Using a Transwabs (blue or black top), take a rectal swab – refer to Trust guidelines for guidance on collection.

CPE PCR (WUTH only)
Refer to Infection Control policies for guidance on which patients require molecular testing for CPE. Using a **dual** swab (red top), take a rectal swab – refer to Trust guidelines for guidance on collection.

VRE PCR (CoCH only)
VRE PCR should be requested only based on advice from the Infection Prevention and Control Team. Using a **dual** swab (red top), take a rectal swab – refer to Trust guidelines for guidance on collection.

Ensure that swabs are labelled accurately. Place, with the completed request form, in the appropriate pockets of the clear minigrip transport bag for transportation to the Department of Medical Microbiology (via Pathology).

Specimens should be transported and processed as soon as possible.

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7.4 Procedures for the collection of Urogenital Samples

N.B. *If an expanded screen for sexually transmitted diseases is required, the patient should be referred to the local Sexual Health Service.*

7.4.1 Collection of urogenital samples for Microscopy, Culture & Sensitivity (MC&S)

High vaginal swabs and Cervical/Endocervical swabs
Place the patient in dorsal position, supported by a pillow and ask her to bring her heels together, bend her legs and then draw her heels towards her bottom.

Moisten the speculum with warm water and insert into the vagina to separate the vaginal walls. Wipe away any excess cervical mucus with a tissue.

HVS: Using a blue or black topped swab, sample as high as possible into the vault and swab the vaginal wall.

Cervical/endocervical swab: Using a blue or black topped swab, gently insert a swab into the endocervical canal and rotate to obtain any exudate. Try to avoid contact with the vaginal mucosa when removing the swab.

Remove speculum and wipe vaginal / vulval area with a tissue.

Ensure that the swab is labelled accurately and place with the completed request form, in the appropriate pockets of the clear minigrip transport bag for transportation to the Department of Medical Microbiology (via Pathology).
NB. Charcoal based transport swabs prolong the survival of *gonococci* compared to non-charcoal-based swabs.

Low vaginal swab
Place the patient in dorsal position, supported by a pillow and ask her to bring her heels together, bend her legs and then draw her heels towards her bottom.
Insert the swab into the lower part of the vagina and rotate gently but firmly.

Ensure that the swab is labelled accurately and place, with the completed request form, in the appropriate pockets of the clear minigrip transport bag for transportation to the Department of Medical Microbiology (via Pathology).

Urethral swabs
Avoid contamination with micro-organisms from the vulva or the foreskin. Small swabs are available for the purpose. The patient should not have passed urine for at least 1 hour. For males, if discharge is not apparent attempt to “milk” it out of the penis. Pass the swab gently through the urethral meatus and roll around. Place the swab in the plastic transport sheath containing the black charcoal containing Amies medium. **NB specimens for Chlamydia investigations should be collected after the swab for MC&S.**

All specimens should be transported and processed as soon as possible. If processing is delayed, refrigeration is preferable to storage at ambient temperature.

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7.4.2 Collection of urogenital samples for molecular investigations

Urogenital samples for molecular investigations should be collected as per collection for samples for MC&S, but the samples should be collected using the following specimen containers:

***Chlamydia trichomonas* / *Neisseria gonorrhoea* (CT/NG) and *Trichomonas vaginalis* (TV) PCR**

For all requestors

If Chlamydia/gonorrhoea infection is suspected, swabs or urine can be submitted for analysis. The sample must be collected/placed into the appropriate Roche Cobas **Un**i Swab/urine container. (available from NHS Supplies or wuth.ctngconsumables@nhs.net).

- Roche Cobas **Un**i Swab (clinical and self-taken samples)
- Roche Cobas **Un**i Swab (urethral, oropharyngeal & rectal samples)
- Roche Cobas DUAL swabs (for endocervical samples)
- Roche Cobas Urine Collection tube (for first catch urine from males or females)

NB Investigation for *Trichomonas vaginalis* (TV) can be performed on self-taken vaginal swabs placed in a Roche Cobas **Un**i Swab **BUT** TV processing will only be performed if specifically requested.

Following specimen collection, store the Cobas PCR Media tube containing the specimen swab at 2-30^{0}C. The specimen is viable for up to 3 months.

7.5 Procedure for the collection of sputum

The material required is fresh sputum from the lower respiratory tract, expectorated by deep coughing. When the cough is dry, physiotherapy, postural drainage or inhalation of an aerosol may be helpful. Saliva and postnasal secretions are not suitable. Early morning specimens for examination of *Mycobacterium species* should be collected on at least 3 consecutive days.

Routine sputum microscopy is not worthwhile, but will be done urgently were Staphylococcal pneumonia is suspected or where specifically requested.

Ensure that the specimen container is labelled accurately and place, with the completed request form, in the appropriate specimen transport bag for transportation to the Department of Medical Microbiology (via Pathology).

Collect specimens before starting antimicrobial therapy where possible.

BAL and sputum should be processed promptly to give the best opportunity to culture pathogenic organisms and reduce the risk of overgrowth with contaminants.

If processing has to be delayed up to 24 hours, refrigeration is preferable to storage at ambient temperature.

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Bronchial Lavage

Please inform the laboratory for urgent processing.

NB. Legionella/PCP investigations – please contact the Laboratory if required.

7.6 Collection of a mid-stream specimen of urine (MSSU) for culture and sensitivity

Ensure that the patient is physically clean.
If the patient has had the perineum washed in the last 12 hours (i.e., has had a shower or bath), further cleansing of the perineal area before urine collection is not necessary.

If the patient:

- Is incontinent and / or:
- Has had their bowels opened since washing the area:

The collection of urine must be postponed until the perineal area has been washed. Catch the middle portion of the urine in a clean wide-mouth receptacle. Such a receptacle need not be sterile: any container, previously washed thoroughly with detergent and hot water and stored dry, is suitable.

A sample of the middle portion of the urine must be poured into a 20ml **red** capped universal container (boric acid) with all sections on the label completed. Very small samples from paediatric patients only may be collected into a 20ml white capped sterile universal (white capped samples MUST be received in the lab **within 4 hours** of collection).

If processing is delayed for up to 48hr, refrigeration is essential. Alternatively, the specimen may be collected in a CE marked leak proof container with boric acid preservative. This increases the maximum permissible time for transport to the laboratory to up to 96hr.

7.7 Collection of a specimen of urine from a catheter (CSU)

When small volumes of fresh urine are required for laboratory investigations, the distal end of the catheter, or preferably the sampling port if present, must be disinfected with 70% isopropyl alcohol and urine aspirated with a sterile syringe.

The urine must be transferred to a 20ml red capped universal container (boric acid) with all sections on the label completed.
If large volumes of urine for laboratory tests are required, these should be obtained aseptically from the drainage bag.

7.8 Procedure for the collection of a specimen of faeces

When collecting a specimen of **Faeces,** it should be obtained in a convenient container and transferred into a sterile container with a wooden disposable spatula.

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Minimum volume of sample:

- A liquid specimen of 1-2ml is sufficient.
- 1 gram (large pea-size) of solid specimen

Rectal swabs are not a reasonable substitute for faeces: except for CPE/VRE screening.

Faeces for parasites – the recommendation is 3 specimens taken on different days for optimum recovery.

Ensure that the specimen container is labelled accurately and place, with the completed request form, in the appropriate specimen transport bag for transportation to the Department of Medical Microbiology (via Pathology).

For the detection of ova of Enterobius vermicularis (threadworm): use with a plain swab, moisten with sterile saline, wipe firmly around the anal margin and place the swab into a sterile universal container.

Important pathogens such as Shigella species may not survive the pH changes that occur in faecal specimens if not promptly delivered to the laboratory, even if refrigerated.
If processing is delayed, refrigeration is preferable to storage at ambient temperature.

7.9 Procedure for the collection of a pernasal swab

Gently insert the fine, flexible pernasal swabs (sky blue top) swab horizontally to the back of the nose. If obstruction is encountered, withdraw and re-insert through the other nostril.

Ensure that the swab is labelled accurately and place, with the completed request form, in the appropriate specimen transport bag for transport to the Department of Medical Microbiology (via Pathology).

Collect specimens before antimicrobial therapy where possible.

Specimens should be transported and processed as soon as possible. If processing is delayed, refrigeration is preferable to storage at ambient temperature.

7.10 Aspirates and fluids from normally sterile sites

Collect the specimen with a sterile syringe. Transfer a maximum 20ml into a sterile universal container. Ensure the cap is tightly screwed on.

Specimens should be transported and processed as soon as possible. If acute infection is suspected and the result may affect medical management, receive and process the sample within 4 hours. The result for microscopy should be made available within 2hr of the Gram stain. If processing is delayed, refrigeration is preferable to storage at ambient temperature.

7.11 Cerebrospinal fluid

? Meningitis - An adequate amount is essential – send at least 2-3ml. Label the samples as you collect them as the lab need to know which sample is the most valuable for cell count and culture. This is particularly important if *Mycobacterium tuberculosis* infection is suspected where small numbers of organisms may be present. For exclusion of mycobacterial CNS infection at

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least 6mls CSF is required: this will be processed by Microbiology at Manchester Royal Infirmary. If there are smaller volumes, then an automated comment will be produced indicating low volume. The results of microscopy and any positive cultures are always telephoned.

? Subarachnoid haemorrhage (SAH) if there is a clinical suspicion of SAH and the specimen is bloodstained send the 1st and 3rd samples so that differential red blood cell counts may be performed. The results of microscopy and any positive culture are always telephoned. Always inform the laboratory if SAH is a possibility.

Time between collection to microscopy and culture should occur within a maximum of 2 hours. Cells disintegrate and a delay may produce a cell count that does not reflect the clinical situation of the patient. Specimens should be transported and processed as soon as possible. Do not refrigerate specimen until after microscopy and bacterial culture have been performed. The specimen should then be refrigerated pending further investigation.

7.12 Wound Swabs

Decontaminate the skin to remove as much of the superficial flora. Using a blue or black topped transwab, remove the swab and gently but firmly rotate it on the surface directly where infection is suspected. Do not take swabs from slough or necrotic tissue. Place the swab into the transport medium. If pus is present send as much as possible in a sterile universal container.

Specimens should be transported and processed as soon as possible. If processing is delayed, refrigeration is preferable to storage at ambient temperature.

7.13 Collection of specimens for mycology investigations

Skin
Patient's skin and nails can be swabbed with 70% alcohol prior to collection of the specimen, this is especially important if creams, lotions or powders have been applied. The edges of skin lesions yield the greatest quantities of viable fungus. Lesions should be scraped with a blunt scalpel blade.

Nails
Good nail samples are difficult to obtain. It should be specified whether the sample is from the fingernails or toenails. Material should be taken from any discoursed, dystrophic or brittle parts of the nail. The affected nail should be cut as far back as possible through the entire thickness and should include any crumbly material. Nail drills, scalpels and nail elevators may be helpful but must be sterilized between patients. When there is superficial involvement (as in white superficial onychomycosis) nail scrapings may be taken with a curette. If associated skin lesions are present, samples from these are likely to be infected with the same organism and are more likely to give a positive culture.

Hair
Samples from the scalp should include skin scales and plucked hairs or hair stumps. Cut hairs are not suitable for direct examination as the infected area is usually close to the scalp surface. Plastic hairbrushes, scalp massage pads or plastic toothbrushes may be used to sample scalps for culture where there is little obvious scaling, but such samples do not replace a scraping for direct examination.

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Collect specimens before antifungal therapy where possible.
Specimens should be transported and processed as soon as possible.

Specimens should be kept at room temperature and transported and processed as soon as possible although, provided the samples are kept dry, the fungus will remain viable for several months. Samples should be allowed to dry out and kept at room temperature.

7.14 Blood for Virology/Serology investigations

For antibody and antigen assays collect blood in a blood collection tube (red or ochre cap) – 4mls (Wirral), - 8mls (Chester).

For viral DNA/RNA Polymerase Chain Reaction (PCR) tests please send two 4ml EDTA tubes (purple cap) – (Wirral and Chester).

β-D-Glucan - any tube with clotting accelerator (red or ochre cap).

Paediatric blood tubes

- Chester EDTA = Red
  Clotted blood = Brown
- Wirral EDTA = Purple
  Clotted blood = Red

For the various virology/serology investigations available refer to **Section 10 Investigations and Turnaround Times**

Specimens should be transported and processed as soon as possible.

If processing is delayed, refrigeration is preferable to storage at ambient temperature.

7.15 Swabs for viral investigations

Moisten the plastic shafted swab with sterile saline never with Viral Transport Media (VTM) before swabbing. Using a sterile saline moistened plastic shafted swab, swab the area concerned or vesicles, if vesicles present burst vesicle with sterile needle and swab fluid released. Snap off the swab tips into VTM.

Transport as soon as possible at ambient temperature.

If transport is delayed, samples may be stored at room temperature for up to 24 hours.

7.16 Fluids and Pus for viral investigations

Collect as much fluid/pus as possible in a universal container.

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7.17 Corneal Scrapes

Collection
A standard operating procedure is available in the Eye Clinic; the following is a summary of this document.

During Core Laboratory Hours – Mon – Sun 08-45 – 19-00
Two corneal scrape kits (containing a bijou of broth and a glass slide) are kept in the Ophthalmology Clinic and a further kit is kept in the A+E department. The lab sends these kits to Ophthalmology upon request. To request further kits please telephone the Microbiology Department between 9am-4pm Monday to Friday (**01244 362500**)

Specimens should be transported and processed as soon as possible.
If processing is delayed, refrigeration is preferable to storage at ambient temperature.

If specimens for investigation for amoebae cannot be processed within 8hr, it is preferable to store them at ambient temperature.
Do not freeze specimens.

7.18 Nose and throat swabs/Nasal Aspirations

A single swab can be used. Swab the throat first then nose and place into one pot of viral transport medium: OR

If 2 swabs in the pack, place BOTH the throat & nose swab into the same VTM.

Taking throat swabs: Ask patient to open mouth wide. Using swab, vigorously swab only the posterior pharyngeal wall.

Taking nose swabs: Tilt head back slightly and gently insert swab along the medial part of the septum. Rotate swab several times and remove.

The shafts of the swabs should be broken off at the break point so that they fit into the VTM container. Firmly secure cap.

Aspirates should be placed in a dry sterile specimen container. Ensure the cap is tightly screwed on.

Order the correct PCR tests and label the specimen accordingly.

Specimens should be transported and processed as soon as possible.

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8.0 TRANSPORT OF CLINICAL SPECIMENS FROM WIRRAL

8.1 Specimens collected and sent from Arrowe Park Hospital

Monday to Friday

From 09-00hrs. until 14-00hrs daily there is an hourly collection of Pathology specimens from wards by the portering staff.

After 14-00hrs bleep porters on 2145 to pick up specimens (except Blood cultures which should be sent by pneumatic tube or taken to Specimen Reception at Laboratory Medicine, Arrowe Park). Blood cultures must be sent to pathology immediately after collection to ensure they are stored in the correct conditions.

The last routine transport from Arrowe Park Hospital to the diagnostic Laboratory at Bromborough is at **16-45hrs**.

Weekend and Bank Holidays

At approximately 09-00hrs a single collection from the ward is made by the portering staff.

If specimens miss the collection, then they should be sent to the Arrowe Park Specimen Reception.

There is a scheduled pick-up of specimens, by van, from Arrowe Park Pathology Laboratory until 15-00hrs.

Urgent Specimens
If specimens require urgent processing, then please contact the Microbiology Department and inform the BMS of the patient, the ward and any tests required on Extension **4511**. Arrange delivery by telephoning the Porters to request urgent collection of samples to be taken directly to the Pathology Laboratory Specimen Reception. Refer to **Section 8.4 Packaging and Transport** for guidance on packaging samples for transport by taxi.

Urgent clinical advice is available from the Consultant Microbiologist (available through the Hospital switchboard out of hours). Refer to **Section 1** for further details.

8.2 Specimens collected and sent from Clatterbridge General Hospital

Monday to Sunday

Specimens need to be taken to the first-floor Blood Science Lab at CCC Drivers will collect CGH samples every hour from 09-00hrs. This Service will run between CGH, APH and the Microbiology lab at Bromborough on a continuous loop. The last collection from CCC is at 16-30. Any non-urgent samples that will not be ready for transport by 16-30 should be refrigerated and made ready for transport the next day.

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For URGENT specimens only after 18-30hrs please contact the Microbiology laboratory

8.3 Specimens collected and sent from GP Practices

Samples from General Practice for Laboratory Medicine will be collected by a hospital courier or SRCL/ERS Courier Service Monday to Friday only.

8.4 Packaging and transport

Before the specimens are collected by porters, couriers, volunteers, nursing and support staff ensure that specimens and request forms are placed correctly into the min-grip plastic bags. Specimens should be placed in the pocket of the plastic bag and grip seal sealed. The request form should be slid into the sleeve of the plastic bag. The specimen should then be placed in the large Blue Microbiology specimen bags (with an absorbent material to comply with United Nations standard Packing Instruction P620) for collection. All microbiology specimens that are not collected promptly should be refrigerated, unless otherwise stated in this guide.

Specimens that are to be transported by taxi from the hospital to the main Microbiology Laboratory must be packaged in a robust container and **no** patient details should be visible on the outer packaging – refer to the European Agreement Concerning the International Carriage of Dangerous Good by road (ADR2021).

N.B *The plastic transport bags, if properly sealed, are designed to contain accidental specimen leakage from the container. Spontaneous specimen discharge, due to defective materials, is rare. Most incidents of specimen leakage are due to the fact that neither the container nor the integral bag strips have been closed properly. If both container and transport bag are closed correctly, the practice of 'double bagging', even when an infection with a Hazard Group 3 pathogen is suspected, does not confer any additional safety advantage and is, therefore, unnecessary*

The containers supplied, comply with standards BS4851 and BS5213 for leakage and spontaneous discharge. Leaked containers frequently result in irreplaceable loss of specimens and, equally as important, staff to unwarranted hazards of infection.

Members of the public who come across large blue specimen bags containing specimens should telephone the lab.

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9.0 TRANSPORT OF CLINICAL SPECIMENS FROM CHESTER

Routine Specimens

Specimens are delivered to the Microbiology Dept (via Pathology) throughout the working day, Monday – Friday, from the Pathology Laboratory reception via hospital transport vans. However, the last collection of the day leaves there at 17-00hrs. Therefore, specimens must have reached the pathology laboratory reception by the porters, well in advance of this time. Samples will be collected from Pathology throughout the day on Saturday and Sunday up until 15-00hrs. Routine samples may be transported to Pathology via the pneumatic air tube system providing the samples are correctly packaged with secure lids, except for CSF samples.

Urgent Specimens

If specimens require urgent processing, then please contact the Microbiology Laboratory and inform the BMS of the patient, the ward and any tests required on Extension 2500. Arrange delivery by telephoning the Porters to request urgent collection of samples to be taken directly to the Pathology Laboratory Specimen Reception. Refer to **Section 9.1 Packaging and Transport** for guidance on packaging samples for transport by taxi.

Urgent clinical advice is always available from the Consultant Microbiologist (available through the Hospital switchboard out of hours). Refer to **Section 1** for further details.

9.1 Packaging and transport

See Section 8.4

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10.0 INVESTIGATIONS AND TURNAROUND TIMES

For specimen collection see **Section 7**

Specimen Investigation	Specimens and Comments	Referred to Ref Lab*	Turnaround times
Adenovirus PCR	Broncho-alveolar lavage CSF Eye swab Urine Urethral swab EDTA blood preferred.	2	2-5 days
Amoebic Antibodies	Clotted blood	6	5-7 days
Antenatal Screen: Hepatitis B surface antigen/HIV/Syphilis/ (Rubella)	Clotted blood Antenatal rubella no longer advised		1-5 days
Staphylococcal Antibody (Reference lab test-availability limited so needs discussion with Consultant Microbiologist)	Clotted blood	1	5-7 days
Anti Streptolysin-O antibody and anti streptodornase	Clotted blood	4	5-7 days
Arbovirus (Includes Flaviviruses such as West Nile, yellow fever, dengue and Alphavirus such as chikungunya, Ross River, EEE, WEE	Clotted blood EDTA Blood Urine REQUEST CAN ONLY BE MADE IN CONSULTATION WITH A MICROBIOLOGY CONSULTANT	3	5-7 days
Aspergillus Antibodies	Clotted blood (Immunology Request at Chester)		5-7 days
Aspergillus antigen (Galactomannan)	Clotted blood	10	2-5 days

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Aspergillus PCR	Bronchoalveolar Lavage Sputum EDTA Blood	2 4	2-5 days 5-7 days
Aspirates and fluids from normally sterile sites (joint, ascites, peritoneal and pleural fluids)			2-7 days Urgent Cell Count/Gram Stain usually within 2 hours from receipt
Avian Precipitins	Clotted blood (Immunology requests at Chester)		10 days
Bartonella Serology (cat scratch)	Clotted Blood	3	10 days
Bartonella PCR (cat scratch)	Serum EDTA Blood Tissue	3	10 days
BK/JC PCR Haemorrhagic cystitis Progressive multifocal leukoencephalopathy Renal transplant	EDTA Blood CSF	2	2-5 days
Blood Cultures for diagnosis of sepsis, bacteraemia and infective endocarditis Blood cultures must be sent to pathology immediately after collection to ensure they are stored in the correct conditions.	Blood culture set = Aerobic (blue or green top) AND anaerobic (purple top) blood culture bottles (adults / adolescent) 10ml blood per bottle **Inoculate O_2 bottle first** Paediatric bottle (yellow top) up to 4ml blood Culture is no longer extended beyond 5 days, if endocarditis is suspected contact the Consultant Microbiologist as it may be appropriate to refer an aliquot of the blood culture samples for 16s (pan-bacterial PCR) Normally sterile body fluids may also be inoculated into blood culture bottles.		Up to 7 days (incubated for 5 days before being discarded as negative)

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Bordetella pertussis Serology Pertussis (whooping cough)	Clotted blood	1	5-7 days
Bordetella PCR Pertussis (whooping cough)	Throat swab in viral transport media or pernasal swab	2	5-7 days
Brucella serology	Clotted blood	8	5-7 days
Bronchoalveolar Lavage (Washings)	Send washings in a sterile universal. container		2-7 days
Campylobacter Serology	Clotted blood	1	5-7 days
Candida PCR	EDTA Blood BAL	2	5-7 days
Candida Precipitins	Clotted blood	4	5-7 days
Catheter specimen of urine (CSU)	Transfer urine to a sterile universal container (>3ml)		48 hours
Cervical swab	For the culture of gonorrhoea use a Black topped Microbiology (Charcoal) swab and transport to the laboratory Immediately. (Urethral, rectal and throat swabs may also be collected and sent for gonorrhoea culture). For virology investigation send a swab in virus transport medium		2-4 days
Chlamydia (MIF) Serology	Clotted blood		3-5 days
Chlamydia & Gonorrhoea eye swabs	For investigation of *C.trachomatis* Infection/Gonorrhoea in the eye, send a swab from the conjunctiva in a Roche Cobas UNI swabs collection tube.		3-5 days

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Clostridium difficile toxin* *C.difficile PCR** ***See Appendix 1 for interpretation of results**	Detection of Clostridium difficile cytotoxin in faeces of patients with antibiotic associated diarrhoea, antibiotic-associated colitis or pseudomembranous Colitis Transfer 1 gram (large pea-size) portion of faeces, or 1-2 ml volume of liquid specimen, into a sterile universal container. Only diarrhoeal stools will be tested		24 hours
CMV IgM	Clotted blood		1-4 days
CMV IgG CMV IgG avidity	Clotted blood		1-4 days
CMV PCR	EDTA Blood preferred. Sputum, Placenta Urine Amniotic fluid Tissue	2	2-5 days
Corneal scrapes	Corneal scrape kits (containing a bijoux of broth and a glass slide). Please indicate on the slide which side has been inoculated using a pencil to write on the frosted area. Kits can be obtained from Microbiology during 9am – 4pm Monday to Friday.		2-10 days Urgent Gram stain usually within 2 hours from receipt
Covid PCR	Nose/Throat swabs in viral transport media (both swabs in same tube) Nasopharyngeal aspirate NB testing performed 24/7 at CoCH.		Cepheid 1-3 hours after receipt
Coxsackie B virus serology – no longer available, but serum may be tested for enteroviruses by PCR	Clotted blood EDTA Blood	2	3-5 days
Culture for bacterial infections	Pus is the ideal specimen or a biopsy of the infected tissue. Send in a sterile universal container. If only a small sample of tissue is available, add a few drops of sterile normal saline to prevent drying. If swabs are taken, use black topped Microbiology (Charcoal) swab or blue		2-5 days

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	topped Microbiology swab (Transtube) – refer to Wound and Ulcer Swabs		
Creutzfeldt-Jakob Disease (CJD) ONLY IN CONSULTATION WITH FIRSTLY THE NATION CJD REFERENCE UNIT (0131 537 2128) and SECONDLY MEDICAL MICROBIOLOGY CONSULTANT	>1ml CSF, only accepted if <150 RBC on microscopy. CSF sent to lab for cell count. Lab will freeze at -80°C and send via courier to: The National Creutzfeldt-Jakob Disease Research & Surveillance Unit Western General Hospital Crewe Road Edinburgh EH4 2XU See http://www.cjd.ed.ac.uk for Contacts		1-2 weeks
Cryptococcus antigen testing	Clotted blood >1ml CSF in a sterile universal container	2	2-3 days
Cerebro Spinal Fluid (CSF)	• Bacterial Meningitis >1ml CSF in a sterile universal container • Viral Meningitis/Encephalitis >1ml CSF in a sterile universal container • Sub Arachnoid Haemorrhage please send the first and third specimen >1ml CSF in a sterile universal container • Mycobacterial Meningitis 6ml CSF in a sterile universal container • PCR Screen: >1ml CSF in a sterile universal container Preliminary cell counts and Gram Stain Clotted blood results will be telephoned to the sending location as soon as possible after receipt of the specimen and released as preliminary results for viewing on	2	48 hours Urgent Microscopy usually within 2 hours from receipt 5 days 48 hours Urgent Microscopy usually within 2 hours from receipt 7-28 days 5 days

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	CERNER		
Delta Antibody (Hepatitis D)	Clotted blood	2	5-7 days
Delta PCR (Hepatitis D RNA)	EDTA Blood	1	7-10 days
Dengue Virus	Clotted blood (Antibody) EDTA Blood (PCR) Urine (PCR)	3	5-7 days
Diphtheria Antibodies	Clotted blood	2	1-2 weeks
Ear swab	Send a swab in black topped Microbiology (Charcoal) swab or in blue topped Microbiology swab (Transtube)		2-4 days
Early morning urine for tuberculosis	First catch urine in the morning collect in a sterile universal container, must send 3 consecutive samples		6-8 weeks
Enterobius vermicularis (Threadworm)	With a plain swab, moistened with sterile saline, wipe firmly around the anal margin and place the swab into a universal container		24 hours
Epstein-Barr virus serology – detection of EBV VCA IgG, VCA IgM, EBNA antibodies	Clotted blood		1-4 days
Epstein Barr Virus PCR	EDTA Blood CSF Tissue Throat swab in VTM	2	2-5 days
Eye swab	Send a swab in black topped Microbiology (Charcoal) swab or blue topped Microbiology swab (Transtube) For detection of Chlamydia *trachomatis* and/or *Neisseria gonorrhoea* by PCR refer to Sexual Health Screening Send a swab in virus transport medium for virology if required.		2-4 days
Enterovirus PCR	Clotted blood EDTA Blood CSF Vesicle swab in VTM	2	2-5 days

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	Throat swab in VTM Faeces		
Farmers Lung	Clotted blood (Immunology in Chester)		5-7 days
Faeces PCR (VTEC E.coli, Shigella, Salmonella, Campylobacter, Cryptosporidia, Giardia) Faeces culture Ova, cysts and parasites.	Transfer 1 gram (large pea-size) portion of faeces, or 1-2 ml volume of liquid specimen, into a sterile universal container E.g. to confirm positive PCR results or clearance of food handlers Please indicate any foreign travel / country of travel		2-3 days
Filariasis Antibodies	Clotted blood	6	5-7 days
Galactomannan (See Aspergillus antigen above)		10	
Glucan (β-D-Glucan)	Blood**** WAKO (1,3)-β-D-glucan assay: the fungal glucan test is indicated for assessing the likelihood of systemic fungal infection. In general, the glucan test has a high negative predictive value and a low positive predictive value. Therefore, in the absence of other evidence of an invasive fungal disease, a negative result may be used to rule out most invasive fungal infections, whilst a positive test result should only trigger further investigations, consideration of both host and clinical factors, and repeat testing		This assay is performed everyday Monday to Friday. Turnaround time within 2 working days

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Interpretation of test

Possible causes of false negatives:

• The WAKO (1,3)-β-D-glucan assay does not detect certain fungal species, such as the genus Cryptococcus, which produces very low levels of (1,3)-β-D-glucan. This assay also does not detect the Mucormycetes, such as Lichtheimia, Mucor and Rhizopus, which are not known to produce (1,3)-β-D-glucan. The yeast phase of Blastomyces dermatitidis produces little ((1,3)-β-D-glucan and may not be detected by the assay.

Tissue-localised or encapsulated fungal infections that limit the amount of (1,3)-β-D-glucan produced and/or limit its translocation into the bloodstream may result in low or undetectable serum concentrations.

Possible causes of false positives:

• Laboratory-based (mainly separating and sharing the sample in an inappropriate, non-BDG-free environment) and sample collection derived contamination

• Intravenously administered products, including drugs and blood fractionation products (such as serum albumin, immunoglobulins, and filtered blood plasma)

• Intestinal translocation of mycobiome-derived BDG (antigenemia in the absence of fungaemia) following intestinal barrier injury (due to chemotherapy-associated mucositis, intestinal ischemia, mesenteric hypoxia, microbial toxins, viral infection of intestinal tissue, metabolic toxicity, such as in uraemia, large total surface area burns, and protease-producing intestinal enterococci, or sepsis)

• Compromised hepatic function and BDG processing

• Parenteral nutrition contaminated during manufacturing processes (e.g., filtration)

• Invasive use of surgical materials (e.g., gauze and surgical sponges that contain glucan)

• Invasive nocardiosis

• Fungal glucan levels typically rise early in infection, then decline slowly, only returning to baseline well after successful disease resolution.

• Patients require 3-4 days for the restoration of baseline levels of serum ((1,3)-β-D-glucan after surgical exposure to BDG-containing sponges and gauzes.

Haemophilus Influenzae B (HIB) Antibodies	Clotted blood	2	2-3 weeks
HIB PCR	EDTA Blood CSF	2	5-7 days

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Helicobacter Pylori Stool Antigen	Transfer 1 gram (large pea-size) portion of faeces, or 1-2 ml volume of liquid specimen, into a sterile universal container The test must be carried out within 72 hours of taking the specimen. PLEASE ENSURE THE PATIENT RECORDS THE DATE AND TIME OF COLLECTION ON THE FORM/ SAMPLE		1-3 days
Hepatitis A IgM	Serology: detection of IgM antibody in jaundiced patients Clotted blood Positive serology may indicate recent infection. Confirmation will follow – HAV PCR on serum		1-4 days
Hepatitis A IgG	Immune status assessment: IgG serum antibody, when considering active or passive immunisation Clotted blood		1-4 days
Hepatitis B infection	Serology: detection of surface antigen and core IgM antibody in jaundiced patient Clotted blood		1-4 days Urgent 1-3 hours from receipt (if received between 9:00 – 17:30)
Hepatitis B PCR	Quantitative PCR: To indicate viral load Sequencing for genotype and antiviral Resistance EDTA Blood If EDTA not available use serum	2	1-4 days
Hepatitis B e Antibody/Antigen	Clotted blood		1-4 days
Hepatitis B immunity	Immune status: Assessment of surface antibody, or to verify sero-conversion, following vaccination Clotted blood		1-4 days

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Hepatitis B Surface Antigen	Clotted blood		1-4 days Urgent 1-3 hours (if received between 9:00 – 17:30)
Hepatitis C screen	Serology, detection of viral antibody Clotted blood		1-4 days Urgent 1-3 hours (if received between 9:00 – 17:30)
Hepatitis C PCR/ Genotype	Quantitative PCR: To indicate viral load Qualitative PCR for genotype EDTA Blood If EDTA not available use serum	2	1-4 days
Hepatitis E IgM Antibody	Clotted blood		3-5 days
High Vaginal swab (HVS)	Send a swab in black topped Microbiology (Charcoal) swab or blue topped Microbiology swab (Transtube) For suspected PID or detection of Chlamydia *trachomatis, Neisseria gonorrhoea* or *Trichomonas vaginalis* by PCR refer to Sexual Health Screening		2-4 days
HIV 1 & 2 Antibody and P24 Antigen	Clotted blood		1-4 days Urgent 1-3 hours (if received between 9:00 – 17:30)
HIV Viral Load	EDTA blood (For neonates pro-viral DNA may be requested-whole blood on EDTA, must not be separated)	2	2-5 days

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HIV Resistance Testing	Characterising the genotype of the HIV virus and enhancing this by matching to the database of phenotypes for the HIV gives a virtual phenotype of the HIV virus. This leads to an understanding of the resistance mechanisms that might be present. EDTA blood	2	7-10 days
HSV 1 & 2 Antibody	Clotted blood Both HSV total antibody and type specific antibody available.	2	2-5 days
HSV 1 & 2 PCR	>1ml CSF Neonatal blood Vesicles Respiratory samples EDTA blood tube	2	1-4 days
HTLV I/II Antibody	Clotted blood		2-5 days
HTLV-1 PCR	EDTA Blood	1	5-7 days
Human Herpes Virus 6 PCR	EDTA Blood CSF	2	5-7 days
Human Herpes Virus 7 PCR	EDTA Blood CSF	2	5-7 days
Human Herpes Virus 8 PCR	EDTA Blood Tissue Fluid (effusion)	1	5-7 days
Hydatid, Malaria, Schistosoma and Amoeba antibody tests	Clotted blood	6	5-7 days
Infection Control screen (MRSA screen)	Nose and groin swabs Send a swab in black topped Microbiology (Charcoal) swab or blue topped Microbiology swab (Transtube)		1-4 days
Infection Control screen (Resistant Gram-Negative	Rectal swab Send a swab in black topped Microbiology (Charcoal) swab or blue topped		1-4 days

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Organisms (CPE) screen)	Microbiology swab (Transtube)		
Infection Control screen (VRE screen)	Rectal swab Send a swab in black topped Microbiology (Charcoal) swab or blue topped Microbiology swab (Transtube)		2-4 days
Infection Control Screen rapid molecular testing (Cepheid)	CPE PCR: Red top dual swab (rectal swab) (APH only) MRSA PCR: Pink top liquid swab (nose & groin swabs) (Chester-ITU only) VRE PCR: Red top dual swab (rectal swab) (Chester-ITU only)		24 hours 2-3 hours (if received between 9:00 – 17:30)
Influenza Virus A/B PCR + Respiratory Syncytial Virus (RSV) PCR	Nose/Throat swabs in viral transport media (both swabs in same tube) Nasopharyngeal aspirate NB testing performed 24/7 at CoCH		24 hours 1-3 hours (if received between 9:00 – 17:30)
Intrauterine contraceptive device (IUCD)	Send the device in a sterile universal Container. **NB.** IUCDs are not routinely processed and will only be processed if clinical details state there is a suspicion of infection. Culture for *Actinomyces sp*		2-4 days 10-12 days
Joint Fluids	>1ml in a sterile universal container + lithium heparin tube for 'hot' joints ('hot joint' packs available from specimen reception at WUTH only) If the specimen is urgent preliminary cell count and gram stain will be telephoned to the sending location as soon as possible after receipt of the specimen and preliminary report released electronically.		2-7 days Urgent Microscopy usually within 2 hours from receipt
Legionella Antigen (detects *Legionella pneumophila* Serogroup 1 only)	>3ml Urine in a sterile universal		Same day as receipt

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Leptospira Antibody Leptospira PCR	Clotted blood EDTA Blood Urine	3	5-7 days 5-7 days
Lyme Disease (Borrelia burgdorferi) Antibody	Clotted blood		1-4 days
Malaria Antibody	Clotted blood	6	5-7 days
Measles IgM Antibody	Clotted blood	2	2-4 days
Measles IgG Antibody	Clotted blood		5-7 days Urgent 1-3 hours from receipt
Measles PCR Please inform lab about sample dispatch	>1ml CSF EDTA blood	2	1-4 days
Meningococcal Antibodies (vaccine Functional antibodies: Serological tests for specific antibodies after vaccination)	Clotted blood	2	2-3 weeks
Meningococcal & Pneumococcal PCR If urgent, please inform lab about sample dispatch	CSF EDTA Blood	2	1-4 days Urgent 1 day
Mouth swab	Send a swab in Blue topped Microbiology swab (Transtube) or Black topped Microbiology (Charcoal) swab For virology send the swab in a virus transport medium		2-4 days 1-4 days
Mumps IgG Antibody	Testing mumps immunity/past infection Clotted blood		5-7 days
Mpox PCR	Diagnosis of monkeypox virus	1 & 9	1-2 days from receipt

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	Viral swab of vesicles and placed in viral transport media		
Mumps IgM Antibody	Diagnosis of recent mumps Clotted blood		5-7 days
Mycobacteria	See TB (*Mycobacterium tuberculosis* / other Mycobacteria)	2	
Mycology culture	For skin, nail and hair clippings use black card, Dermapaks or sterile universal. For investigation of Candida infections in superficial wound/ENT sites, send a swab in Blue topped Microbiology swab (Transtube) or Black topped Microbiology (Charcoal) swab, request routine culture **including** Candida		2-4 weeks 2-4 days

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Mycology PCR	For information on: • Aspergillus antigen (Galactomannan) • Aspergillus PCR • Glucan (β-D-Glucan) refer to individual tests in this table. For panfungal PCR/ 18s – contact the Consultant Microbiologist		
Mycoplasma pneumoniae PCR	Respiratory sample (Sputum / BAL / NPA)	2	5-7 days
Mycoplasma pneumoniae IgM Antibody	Clotted blood		3-5 days
Nasal swab	Send a swab in Blue topped Microbiology swab (Transtube) or Black topped Microbiology (Charcoal) swab For virology, send a plastic shafted dacron swab in virus transport medium		2-4 days 3-5 days
Norovirus PCR	Only performed on unformed stools (Bristol stool chart 6 & 7) from in-patients (only performed on WUTH in-patients after Consultation with the Infection Control team) Or after discussion with consultant Microbiologist in Immunocompromised patients Transfer 1 gram (large pea-size) portion of faeces, or 1-2 ml volume of liquid specimen, into a sterile universal container		24 hours Urgent, usually within 4 hours from receipt
Parvovirus B19 IgG	Clotted blood		1-4 days
Parvovirus B19 IgM	Clotted blood		1-4 days
Parvovirus B19 PCR	EDTA blood Clotted blood	2	1-4 days

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	Amniotic fluid		
Pertussis culture (whooping cough)	Use a thin wired pernasal swab (pale blue top) and transport immediately to the laboratory for pertussis culture/PCR		5 days
Pleural Fluid	Culture and Sensitivity >1ml in a sterile universal container Tuberculosis culture >1ml in a sterile universal container		2-5 days 6-8 weeks
Pneumococcal Antibodies (Quantitative)	Clotted blood	2	2-3 weeks
Pneumococcal Antigen	>3ml Urine in a sterile universal		Same day as receipt
Pneumocystis jirovecii PCR	Broncho-alveolar lavage Sputum (ideally induced) If no respiratory samples: EDTA Blood Urgent Request must be discussed with a Consultant Medical Microbiologist	2	3-5 days Urgent 24 hours from receipt
Polio Antibodies	Clotted blood	1	5-7 days
Proviral DNA HIVPCR	EDTA blood	1	5-7 days
Pus	Transfer into a sterile universal container If pus cannot be obtained, then send a swab in Blue topped Microbiology swab (Transtube) or Black topped Microbiology (Charcoal) swab – refer to Wound and Ulcer Swabs		2-5days 5-7 days for extended culture
Rabies	For any request for Rabies diagnosis, prevention or immunity testing contact Consultant Microbiology		
Respiratory PCR (Biofire) **Biofire requests accepted from selected areas:** **Critical Care**	PCR for: Influenza A and B, Parainfluenza 1-4, Human Metapneumovirus, Adenovirus, Respiratory Syncytial Virus, Rhinovirus/Enterovirus, MERS, Coronavirus 229E, HKU1, NL63, OC43, SARS-CoV-2, Bordetella pertussis/		1 day Urgent Biofire 24 hours from receipt

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Haematology Paediatrics **In all other cases when Biofire testing is required a discussion with / approval from a Medical Microbiology Consultant is required.**	parapertussis, Chlamydia pneumoniae, Mycoplasma pneumoniae Nose/Throat swabs in viral transport media (both swabs in same tube (can be processed from same sample as covid or flu screen) Swab of nasal secretions or throat swab, send plastic shafted Dacron or rayon swab in viral transport media (swab and media supplies as a pack) Nasopharyngeal aspirates and Broncho alveolar lavage (send in a sterile universal container) Additional virus PCRs can be arranged by request through the Consultant Medical Microbiologists e.g. bocavirus. Supplies of swabs and Viral Transport media can be obtained from Pathology Specimen Reception (In outbreak situations supplies may be placed in other locations)		
Respiratory Syncytial Virus (RSV) PCR	Refer to information for Influenza Virus PCR		
Rotavirus antigen	Detection of rotavirus in faeces. Transfer 1 gram (large pea-size) portion of faeces, or 1-2 ml volume of liquid specimen, into a sterile universal container		24 hours
Rickettsia Antibodies	Clotted blood	3	5-7 days
Rubella IgG	Immunity check (routine antenatal screening no longer routine) or past infection Clotted blood		2-5 days
Rubella IgM	IgM antibody: to diagnose recent acute infection in symptomatic or asymptomatic individuals Clotted blood		2-5 days

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Schistosoma serology	Clotted blood	6	5-7 days
Schistosoma detection (from urine)	It is preferable to obtain total urine collected over the time period between 10.00h and 14.00h. Alternatively, a 24h collection of terminal samples of urine may be obtained.		24 hours
Screening swabs and surface swabs	Send swab in Blue topped Microbiology swab (Transtube), or Black topped Microbiology (Charcoal) swab		2-4 days
Seminal fluid culture	Sterile universal container		2-4 days
Sexual Health Screening Chlamydia / Gonorrhoea PCR (CT/NG)	For investigation of *C.trachomatis/Gonorrhoea* Infection in the eye, send a Roche Uni swab from the conjunctiva in a Roche collection tube. For detection of CT/NG from the throat, vaginal, urethral & anorectal sites use a Roche Cobas **Uni** swab. For detection in urine first catch urine is required, optimally this should be collected in a Roche urine collection tube.	9	3-5 days 3-5 days
Trichomonas vaginalis (TV)	Self-taken HVS in a Roche Cobas **Uni** Swab.	9	3-5 days
Mycoplasma genitalia	Not routinely available – contact Consultant Microbiologist for advice		
Sputum culture	Sputum from deep expectoration and not saliva is required. Send specimen in a 30ml sputum container or universal		2-4 days (5-7 days if fungal culture also required)
Strongyloides serology	Clotted blood	6	5-7 days
Syphilis serology	A combination of non-Treponema and specific Treponema antibody screening tests for Treponema pallidum Clotted blood		1-4 days (5-7 days if confirmation from ref lab required)

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Syphilis PCR	Virology swab in VTM: Ulcer Mouth Swab	2	3-5 days
Tetanus Antibodies (Quantitative)	Clotted blood	1	4 weeks
Throat swab	Send a swab in Blue topped Microbiology swab (Transtube), or Black topped Microbiology (Charcoal) swab For virology send the swab in virus transport medium (refer to respiratory PCR)		2-4 days 1-3 days
Tissue / bone / cartilage and biopsies	Sterile universal container If biopsy is small add 0.5ml of sterile saline to prevent it from drying out. Ensure there is NO formalin or other preservative in samples for culture: samples in formalin can still be used for bacterial, fungal and viral PCRs. (Depending on the nature of the tissue / bone / cartilage enrichment and extended culture maybe required which will take up to 7 days)		2-7 days 5-7 days for extended culture
TORCH Screen	Clotted blood		3-5 days
Toxocara Antibodies	Clotted blood	6	5-7 days
Toxoplasma Antibodies	Clotted blood	7	2-4 days
Toxoplasma PCR	EDTA Blood Amniotic fluid Tissue	2	1-4 days
TB (*Mycobacterium tuberculosis*) / other Mycobacteria	Recommended specimens are sputum, urine, pus or tissue. For sputum and urine send 3 early morning specimens taken on consecutive days Blood culture bottles available to send out to wards for direct inoculation of blood or bone marrow for TB culture, please contact the Laboratory for special bottle (inoculate ONE bottle a day for 3 consecutive days)	2	6-8 weeks Microscopy 2 days 6-8 weeks

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Urethral swab	For the investigation of gonorrhoea use a swab (orange topped Microbiology swab) transport to the laboratory immediately. For detection of Chlamydia *trachomatis* and/or *Neisseria gonorrhoeae* by PCR refer to Sexual Health Screening Do NOT order urethral swabs for MRSA culture (order MRSA screen and add urethra as the site)		2-4 days
Urine	Collect mid-stream of urine in a red capped (boric acid) sterile universal container (>3ml) Very small samples from paediatric patients only may be collected into a 20ml white capped sterile universal (white capped samples MUST be received in the lab **within 4 hours** of collection). Negative urine Positive urine (1 organism isolated) Positive urine (2 organisms isolated) For detection of Chlamydia *trachomatis* and/or *Neisseria gonorrhoeae* by PCR refer to Sexual Health Screening		24 hours 2-4 days 4-6 days
Urinary Legionella antigen & Urinary Pneumococcal Antigen	Collect mid-stream of urine in a sterile universal container (>3ml)		Same day as receipt
Varicella zoster IgG Antibodies	Varicella zoster IgG. Positive result indicates infection with VZV at some time or vaccination If antibody 'negative' high risk groups (immunosuppressed, pregnant individuals, neonates) with exposure <10 days PEP is indicated. Please refer to hospital policy. Clotted blood		2-4 days Urgent 1-3 hours from receipt (provisional result only)
Varicella zoster IgM Antibodies	Clotted blood		3-5 days
Varicella zoster PCR	EDTA blood CSF Lesions	2	2-4 days

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	Vesicle fluid		
VDRL	Refer to Syphilis serology		
Vesicles, ulcers and genital lesions	Send a swab in virus transport medium for PCR	2	2-4 days
Wound and ulcer swabs	Send a swab in Blue topped Microbiology swab (Transtube), or Black topped Microbiology (Charcoal) swab		2-4 days
Yersinia antibody tests (reference lab test- availability limited so needs discussion with Consultant Microbiologist)	Clotted blood	1	5-7 days

Specimens should be transported to the Laboratory as soon as possible after they are taken, even overnight so they can be placed in the correct storage conditions

***Reference Lab Referrals**

Tests are referred to a number of outside Laboratories. These are listed below:

1. UK Health Security Agency (UKHSA) Colindale, 61 Colindale Avenue, London NW9 5HT
2. UK Health Security Agency (UKHSA) Manchester Laboratory, Manchester Royal Infirmary, Oxford Road, Manchester. M13 9WL
3. UK Health Security Agency (UKHSA) Porton Down, Salisbury, Wiltshire. SP4 0JG
4. UKHSA Mycology Reference Laboratory, National Infection Services, UKHSA Southwest Laboratory, Science Quarter, Southmead Hospital, Bristol, BS10 5NB
5. UK Anaerobe Reference Laboratory, Public Health Wales Microbiology Cardiff, University Hospital of Wales, Heath Park Cardiff. CF14 4XW
6. Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA
7. Toxoplasma Reference Laboratory, Department of Microbiology, Singleton Hospital, Sgeti, Swansea SA2 8QA
8. Brucella Special Diagnostic Unit, Virology Department, Liverpool Clinical Laboratories, Mount Vernon Street Liverpool L7 8YE
9. Virology Department, Liverpool Clinical Laboratories, Mount Vernon Street Liverpool L7 8YE
10. Mycology Reference Centre Manchester, 2nd Floor Laboratory, Education and Research Centre, Wythenshawe Hospital, Southmoor Road, Manchester. M23 9LT

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11.0 KEY FACTORS WHICH AFFECT THE PERFORMANCE AND OR RESULT OF A MICROBIOLOGY TEST

- The technical competency, bias and experience of the staff performing the test.
- The patient sample, how it is taken, stored and transported to the laboratory.
- The homogeneity of the patient sample i.e., is there an even distribution of micro-organisms within the sample?
- Dilutions, how they are performed, what volume is used and how accurate is the equipment used to perform the dilution.
- Media and reagents, if they are not stored correctly, used in the correct way, expired and are not sensitive and specific enough they will have a detrimental effect on the result.
- Inoculation of media, volume of inoculum, media selection and spreading of inoculum will affect the result.
- Incubation conditions such as duration, temperature and humidity.
- Reading and interpretation of results.
- The uncertainty of measurement (UoM) is a quantitative indication of the quality of the result and how reliable and reproducible it is. Reports for UoM are generated every 12 months. All UoM reports are reviewed by the Consultant Microbiologists for clinical impact. If the reports indicate the results may have a clinical impact the users will be informed accordingly. Users can request to view the UoM information.
- If a change is made to an examination procedure which could affect the interpretation of a result, this will be communicated to users.

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12.0 CONTAINERS APPROPRIATE FOR TRANSPORT OF SPECIMENS FOR MICROBIOLOGICAL INVESTIGATIONS

SPECIMEN	CONTAINERS
Clotted blood for serology:	Wirral: 4ml OCHRE capped, clear plastic blood tube Chester: 8ml clotted blood (Red or Gold top) clear plastic tube
Blood for PCR (Viral DNA/RNA)	Wirral: 4ml LAVENDER capped clear plastic EDTA blood tube. Chester: 8ml EDTA (Purple top)
Blood Cultures	Wirral: Green (O_2) and purple (ANO_2) bottles Chester: Blue (O_2) and purple (ANO_2) bottles Paediatric (both sites): Single yellow bottle
Urine for MC&S and urinary antigens	Red capped boric acid container 20ml universal bottle (white cap) – **Paediatric urine only where a small volume is collected**
Body fluids e.g. joint fluid, CSF, pus	20ml universal bottle (white cap)
For faeces, pus, tissue / bone / cartilage and other semisolid specimens	50ml wide-mouth container (Wirral) Blue 30ml container with spoon (Chester)
For the collection and transport of specimens, when *Chlamydia trachomatis* is suspected	**All requestors including Wirral Sexual Health** Roche Cobas Uni Swab/urine collection tube
For the aerobic collection of small amounts of fluids, or exudates	Standard cotton wool-tipped rigid stem swab (blue top) & transport medium or Standard cotton wool-tipped rigid stem swab (black top) & charcoal transport medium
For sampling ear, nose or throat, or urethral discharge	Special cotton wool-tipped fine rigid wire swab (orange top) & transport medium
For sampling post-nasal space	Special cotton wood-tipped fine flexible wire swab (sky blue top)
For the anaerobic collection of pus, or exudates	Sterile universal container
For the collection and transport of swabs for virus tissue culture/PCR	Use viral collection kit (2 female swabs and viral transport media)
For the collection and transport of urine for cytomegalovirus (CMV) tissue culture	Early morning urine in 20ml universal bottle (white cap)

Please refer to Section 8.4 for specific packing.

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13.0 REFERENCE RANGES

Reference ranges are listed on the report, where applicable.

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14.0 APPENDIX 1 - INTERPRETATION OF *CLOSTRIDIOIDES DIFFICILE* TESTING RESULTS

CWMS microbiology laboratory combines two different tests to optimize sensitivity and specificity of *C. difficile* testing. The polymerase chain reaction (PCR) test (detects the genes encoding the *C. difficile* toxins) is followed by a toxin EIA test.
If the PCR is positive, it implies that the patient has *C difficile* in their gastrointestinal tract, with the capability to produce toxins. However, this method cannot determine if the *C. difficile* strain actually produces toxins. The EIA toxin test is suitable for the detection of the *C. difficile* toxins in the stool specimens. Please note, according to National Guidance the *C. difficile* toxin EIA test is not suitable as a stand- alone test for the diagnosis of *C. difficile* infection because of low sensitivity (that results in a high rate of false negatives).
Reporting and interpretation of *C. difficile* results:

1. **Toxin gene DETECTED/toxin production DETECTED**
   Both the PCR and toxin EIA tests are positive. In symptomatic patients this result confirms the diagnosis of *C. difficile* infection. Appropriate antibiotic treatment and infection control precautions are required.

   This will be reported as:

   C.difficile toxin gene DETECTED by PCR
   C.difficile toxin production DETECTED by EIA

   Laboratory evidence of Clostridioides difficile infection.

   Consistent with Clostridioides difficile infection.
   Please clinically evaluate the patient.
   Refer to local management guidelines for treatment and IPC precautions to reduce risk of further transmission.

   UKAS Accreditation 9595: See User Guide on Trust website

2. **Toxin gene DETECTED/toxin production NOT detected**
   The PCR test is positive, that means the patient carries toxigenic *C.difficile* strains in the gastrointestinal tract. However, the EIA toxin test remained negative.
   The patient might be an asymptomatic carrier (in which case the toxin test is true negative), or the patient has toxigenic *C.difficile* infection with a false negative EIA test.
   Clinical review and correlation are required. If the patient is symptomatic, appropriate treatment and infection control precautions are required.

   This will be reported as:

   C.difficile toxin gene DETECTED by PCR
   C.difficile toxin production NOT DETECTED by EIA

   May indicate Clostridioides difficile infection requiring treatment.

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Please clinically evaluate the patient.
Refer to local management guidelines for IPC precautions to reduce risk of further transmission.

UKAS Accreditation 9595: See User Guide on Trust website

3. Clostridium difficile NOT detected

The PCR test is negative. Alternative diagnosis should be considered. If high suspicion of C. difficile infection, sending a repeat specimen can be considered.

This will be reported as:

Toxigenic Clostridioides difficile NOT detected.

No laboratory evidence of Clostridioides difficile infection

Consider other infectious and non-infectious causes of diarrhoea. If symptoms persist without another established cause, C. difficile re-testing should be considered.

UKAS Accreditation 9595: See User Guide on Trust website

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