# LABELLING OF SPECIMENS SUBMITTED TO MEDICAL LABORATORIES POLICY

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## Documents to read alongside this Policy
- Cardiff and Vale UHB Patient Identification Policy (Ref No 176)
- Cardiff and Vale UHB Policy on Consent for Imaging, Examination and Treatment. (Ref No 37)
- Laboratory Service User Guides and the Laboratory Test Database (available on the intranet / clinical portal).
- Microbiology Cardiff user information (on Public Health Wales website)

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When using this document please ensure that the version you are using is the most up to date by checking on the UHB database for any new versions. If the review date has passed please contact the author.

**OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON**
<table>
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<tr>
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<td>14/10/09</td>
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<tr>
<td>2</td>
<td>14/06/12</td>
<td>04/06/12</td>
<td>Some sections clarified; requirement for full name of referring clinician, location and clinical details made mandatory (except where patient safety would be put at risk).</td>
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<td>3</td>
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<td>Updated to clarify specimen forms need to state the Consultant Initial and Surname not full name.</td>
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1. INTRODUCTION

Accurate labelling of specimens and accompanying laboratory request forms is very important for safe and effective patient care.

This policy describes the requirements for accurately identifying the patient from whom the specimen was taken, and the person and location where the result should be sent. These are the minimum requirements for accepting a specimen and logging it onto the laboratory database. Some laboratory tests have very specific requirements about how the specimen should be obtained, the preservative used (or not used) and the clinical information required to perform the correct test and interpret the results properly. In some circumstances, e.g. where sequential specimens are taken, it is important to identify not only the patient but also the individual specimen (by date or time taken). Each laboratory produces a user guide, which should be consulted before sending specimens for specialist tests (see Section 10.0 for details).

2. POLICY STATEMENT

Cardiff and Vale University Health Board is committed to achieving excellence in providing safe, effective, efficient and compassionate care. In order to achieve this it is necessary to ensure that effective procedures are in place to ensure that all samples taken for laboratory investigations can be accurately and unambiguously assigned to the correct patient, and that all necessary information for analysis, interpretation and reporting is provided.

Cardiff and Vale University Health Board is also committed to the health, safety and welfare of all its staff, by providing a safe workplace and systems of work. In order to achieve this it is necessary to ensure that staff have the necessary information when obtaining, transporting and processing hazardous biological materials.

3. AIMS AND OBJECTIVES

The aim of this policy is to ensure that robust arrangements are in place to ensure that samples taken for laboratory analysis or storage can be accurately and unambiguously identified, and that all necessary information is supplied for appropriate and timely analysis, interpretation and reporting.

4. SCOPE OF THE POLICY

This policy relates specifically to the labelling of specimens submitted to Cardiff and Vale University Health Board medical laboratories for investigation and/or storage for subsequent investigation, and encompasses all body fluids and tissues, except blood components, blood products, cells or tissues for the purposes of transfusion or transplantation, or for storage for possible subsequent transfusion or transplantation. Requirements for such transfusion related samples are described in the UHB Blood and Component Transfusion Policy (2011). Samples taken for point of care testing should follow the UHB Point of Care Testing Policy.
5. RESPONSIBILITY

The responsibility for requesting a laboratory investigation lies with an authorised practitioner (normally a clinician). It is the responsibility of the requester to ensure that specimen containers are correctly labelled and request forms completed to an acceptable standard (see below). If another person, e.g. a phlebotomist, obtains specimens from a patient on behalf of a requesting practitioner they must ensure that the labelling meets these standards (see below). It is also the responsibility of the person requesting an investigation or storage of a sample to ensure that they have obtained the necessary informed consent for all procedures requested (see the UHB Consent Policy).

Phlebotomists and Laboratory staff are required to adhere to this policy; they should therefore be treated in accordance with the UHB Dignity at Work Policy.

The Medical Director and Nurse Director have ultimate responsibility for ensuring effective clinical governance arrangements and the quality of patient care. This responsibility is discharged within the Divisions and Directorates via the Divisional Directors, Clinical Directors, and appropriate senior managers.

It is the responsibility of Divisional Quality and Safety Groups to implement this policy, ensuring that appropriate up-to-date guidance is available and implemented at directorate level, and that compliance is audited.

6. DEFINITIONS

For the purposes of this document, a specimen means the quantity of tissue, fluid, or other sample submitted for testing, together with its container and the request form.

Inappropriate labelling describes any situation where the information provided on the specimen container or request form is incorrect or not adequate for the purposes of the laboratory investigation requested. This includes the following categories:

- **Unlabelled specimens** have an absence of labelling on either the container or the request form, or have no request form.

- **Mislabelled specimens** have a mismatch between the patient information on the specimen container and the accompanying form, or between the information supplied and information from another source (e.g. a previous specimen from the same patient, or data on PMS)

- **Inadequately labelled specimens** have insufficient information on the tube or request form for either the proper identification of the patient or the specimen, or for the correct performance, interpretation and communication of the analysis.
7. PROCEDURE FOR LABELLING SPECIMENS

7.1 Specimen Collection

Phlebotomists will not bleed a patient without a completed and signed request form. The form must include full patient identification, Consultant’s initial and surname, location and clinical details. Incomplete request forms will be returned for completion before blood is collected.

Staff must ensure they have correctly identified the patient, following the relevant UHB procedures and protocols, before taking a sample.

Specimen labelling should be performed in the presence of the patient. Pre-labelling empty sample containers and leaving filled containers unlabelled for any period of time poses a high risk of mislabelling. In the event of the requesting clinician, or other member of staff, becoming aware of any errors in sample identification discovered after the specimen has been sent for processing, this must be reported to the laboratory as soon as possible to prevent incorrect information remaining on the laboratory databases.

When using an addressograph label, staff should take special care that they are the correct ones for the patient.

The person who takes the sample should sign the request form and record the date and time the sample was taken.

7.2 Labelling the Request Form

7.2.1 General

Specimens will not be processed by the laboratory without an appropriate request form.

Laboratories require a minimum data set before a specimen can be registered to ensure safe and accurate retrieval of data. It is the requesting clinician’s responsibility to enter these details legibly on the appropriate form.

In certain special situations, e.g. where patient anonymity must be protected, there are agreed protocols for specific investigations which do not require patient names.

In an emergency situation where the identity of the patient cannot be established or Patient Management Systems (PMS) are not working, the requesting clinician must notify the laboratory in order that temporary arrangements can be made, in compliance with the agreed protocol.

7.2.2 Minimum Data Set

An addressograph label should be used whenever possible.

The following information is essential for patient identification:

1. Patient’s NHS number and/or hospital number, AND
2. Patient’s name (surname and first name – not initial), AND EITHER
3. Patient’s address (minimum first line), including postcode, if known, OR\(^1\)
4. Patient’s date of birth

\(^1\)If the patient is from a communal address, the date of birth is required

**The following is essential for prompt and accurate reporting:**

5. Clinician’s Initial and Surname with overall responsibility for the patient (usually a Consultant or GP)
6. Ward / Department and Hospital, or other address to which the report should be sent
7. Relevant clinical information

**The following information is required for scientific and clinical interpretation:**

8. Date and time specimen **taken** (NOT when requested)

**The following Information is required to contact the requestor (e.g. for critical results or in the event of problems with the sample):**

10. Legible name and extension/bleep number of requesting clinician

### 7.3 Addressograph Labels

Addressographs must only be used for specimens taken from the person whose details are on them. They must not be modified or altered for use for other people's specimens, e.g. partners or siblings. The only exception to this is for certain requests regarding fetuses, when the mother’s addressograph may be used with the fetal origin of the specimen clearly stated.

### 7.4 Labelling the Specimen Container

Each specimen container (NOT the lid or cap) must be labelled **by the person taking the specimen** with:

1. Patient’s name (surname and first name – not initial)
2. Patient’s date of birth
3. Patient’s hospital number or NHS number (if available)

An addressograph is the preferred method of labelling in all areas of the laboratory service except the transfusion laboratory/blood bank where handwritten details are required.

### 7.5 Recording the Collection of Specimens

When a blood sample is taken the date and time of collection and the name of the person who took the sample should be entered into the appropriate places on the request form. This information is important for ensuring the suitability of samples for analysis and appropriate interpretation of data. It is also useful in the event of enquiries about sample collection.
7.6  Biohazard Specimens
For specimens from patients who are known or suspected to be infected with a hazard group 3 agent (primarily blood-borne viruses) the container (and ideally the request form also) must be clearly identified, preferably with a yellow hazard ‘danger of infection’ warning sticker. (N.B. hazard group 4 agents can only be handled by specialist laboratories.) All infectious or potentially infectious samples should also be double bagged. For samples other than blood, all UHB Procedures (especially Infection Prevention and Control Procedures) and National Guidelines relevant to the infectious agent (e.g. MRSA, TSE) should be followed. If in doubt, guidance should be sought from the laboratories or Infection Prevention and Control Team before taking samples. Failure to identify hazardous specimens is a breach of the duty of care under Health and Safety legislation. Patient confidentiality should be preserved by ensuring that the identity of patients is kept confidential in its packaging while being transported to the laboratory.

Forms and sample containers must be kept separated and not placed into the same plastic bag/compartment.

8. PROCEDURE FOR HANDLING INAPPROPRIATELY LABELLED SPECIMENS
(For definitions see 6 above)

8.1  Feedback to Requestors
A member of laboratory staff will attempt to contact the requesting clinician when practicable, and/or a report will be sent requesting a repeat sample.

8.2  Unlabelled Specimens
All unlabelled specimens will need to be retaken. Only rarely will exceptions be made when retaking is not a reasonable option, there are compelling clinical reasons, and there is clear evidence of patient identity. Such a specimen will need to have the patient’s identity confirmed by the person responsible for collecting the specimen and that person will have to sign a laboratory record confirming this, thereby accepting responsibility for the identity of the specimen.

8.3  Mislabelled Specimens
All specimens with different patient’s details on the request form and the container, will have to be retaken. Only rarely will exceptions be made when retaking is not a reasonable option, there are compelling clinical reasons, and there is clear evidence of patient identity. Such a specimen will need to have the patient’s identity confirmed by the person responsible for collecting the specimen and that person will have to sign a laboratory record confirming this, thereby accepting responsibility for the identity of the specimen.

8.4  Inadequately Labelled Specimens
Where specimen labelling falls short of the full requirements of patient identification, initial and surname of Medical Practitioner, location and clinical details, samples will not be analysed, except, at the discretion of the laboratory, when:
  • repeat sampling is not feasible, and
• not analysing could seriously compromise patient care (e.g. unrepeatable samples, such as CSF), and
• patient identity can reasonably certainly be deduced.

A member of laboratory staff will attempt to contact the requesting clinician (if that person can be identified from the form) and:

1. If there is an overriding clinical reason for processing the specimen, offer the opportunity to come to the laboratory and complete the labelling. The person completing or correcting the labelling must be the person who took the specimen, must be able to satisfy themselves of the identity of the specimen and must sign a laboratory record confirming this, thus accepting responsibility for the identity of the specimen.

2. Inform the clinician that if this is not done within one day (or shorter period if the analyte is less stable), the specimen may be discarded. Cellular pathology specimens may be retained unprocessed for a limited period.

3. Keep the specimen in a designated place for the agreed period of time.

4. If specimens have to be discarded (or retained unprocessed for longer than one day) a record will be made in the laboratory computer system and an appropriate notification made to the requesting ward/department/practice.

A similar procedure will apply to all specimens that have been received in the laboratory for which, during processing, a member of the laboratory staff has good reason to doubt the identity of the specimen.

9. RECORDING OF LABELLING INCIDENTS

The laboratory will keep a record of all inappropriately labelled specimens. This record will include: precise details of the inappropriate labelling; the name and address of the patient; the name of the requesting clinician; the ward, unit, or practice; and the Consultant in charge of the case. Where the laboratory agrees to analyse an inadequately labelled specimen, the name and department/section of the person taking responsibility for the specimen will also be recorded.

Labelling incidents will be treated as clinical incidents and dealt with according to the UHB Incident, Hazard and Near Miss Reporting Policy.

When repeated labelling incidents can be identified as originating from a single Unit or Practice, an appropriate Consultant, General Practitioner or Practice Manager will be informed.

10. RESOURCES

No resources are being made available specifically in response to the revision of this policy. The procedures described are already best practice in the UHB. This revision represents a more rigorous application of those practices, and decreased tolerance
of substandard practice in the interest of patient safety. Some resampling of patients is anticipated.

11. TRAINING

All new medical practitioners and other health care professionals should be made aware of local guidance and the importance of correct patient and sample identification. It is the responsibility of Divisions to ensure that staff have access to appropriate training, and observe all UHB Policies and Procedures. Training of new medical practitioners and other health care professionals in laboratory usage should continue at induction. No facilities for any additional formal training required as a result of this policy will be available.

12. REVIEW

This policy will be reviewed at least every 3 years and more frequently if any developments or changes in practice inform the Health Board otherwise.

13. MONITORING AND AUDIT

The quality of information supplied with specimens will be audited regularly as part of the Laboratory Medicine internal audit programme and results reported to the Divisional Quality & Safety Group.

14. DISTRIBUTION

This policy will be available for viewing via the UHB intranet. A copy will also be provided to all Divisional Directors, for onward distribution and circulation to staff as necessary.

15. EQUALITY

An equality impact assessment has been undertaken to assess the relevance of this policy to equality and potential impact on different groups, specifically in relation to the General Duty of the Race Relations (Amendment) Act 2000 and the Disability Discrimination Act 2005 and including other equality legislation. The assessment identified that the policy presents a low risk to the UHB.
16. BIBLIOGRAPHY


Cardiff and Vale University Health Board *Blood and Component Transfusion Policy 2011*. (Ref No UHB 068).

Cardiff and Vale University Health Board *Consent to Examination or Treatment Policy* (Ref No 100)

Cardiff and Vale University Health Board *Patient Identification Policy* (Ref No 176)

Cardiff and Vale University Health Board *Data Protection Policy* (Ref No 2)

Cardiff and Vale University Health Board *Infection Control Policy for Viral Hepatitis* (IPCD Policy No 10)

Cardiff and Vale University Health Board *Methicillin Resistant Staphylococcus aureus (MRSA) Policy* (IPCD Policy No 9)

Cardiff and Vale University Health Board *Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeldt-Jakob Disease)* (IPCD Policy No 2)

Cardiff and Vale University Health Board *Point of Care Testing Policy* (Ref No 71)

Cardiff and Vale University Health Board *Incident, Hazard and Near Miss Reporting Policy* (Ref No )


Laboratory Service User Guides are available on the intranet and clinical portal. Genetics and Toxicology also have their own websites. The Laboratory Test Database is also available on the intranet.

Microbiology Cardiff user information is available on Public Health Wales website.