Patient Identification and Identification of Blood, Body Fluids, and Tissue Samples

(Formerly CP 4)

Wake Forest® Baptist Health	**DOCUMENT TYPE:** ☒ Procedure	**ORIGIN DATE IN TITLE 21** See Title 21
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APPLICABLE LABORATORY(S)):

☒ North Carolina Baptist Hospital (NCBH)
☐ Lexington Medical Center (LMC)
☐ Davie Medical Center (DMC)
☐ Wilkes Medical Center (WMC)
☐ High Point Medical Center (HPMC)
☐ Westchester
☐ Clemmons

PROCEDURE STATEMENT

This procedure provides guidelines to staff concerning patient identification and identification of blood, body fluid, and tissue samples.

SCOPE

i. Procedure Owner/Implementer: Central Processing Lab
ii. Procedure Prepared by: Central Processing Management
iii. Who Performs Procedure: Central Processing Team Members

DEFINITIONS

A. Procedure: A process or method for accomplishing a specific task or objective.
B. WFBH Lab System: Wake Forest Baptist Lab System is a health system that includes Wake Forest Baptist Medical Center and all affiliated organizations including Wake Forest University Health Sciences (WFUHS), North Carolina Baptist Hospital (NCBH), Lexington Medical Center (LMC), Davie Medical Center (DMC), Wilkes Medical Center (WMC), High Point Medical Center (HPMC), Lab at Westchester and Lab at Clemmons.
C. BADID: Improperly labeled specimen

POLICY GUIDELINES

A. Procedure

Note: Appropriate personal protective equipment (PPE) must be worn when handling biohazardous specimens

General Guidelines

1. All specimens received in the lab will be labeled with a minimum of two unique patient identifiers.
    a. These identifiers can be a combination of patient name, medical record number, or date of birth.
    b. If specimens are labeled with three identifiers, and one of the three identifiers is a mismatch, contact the pathologist/resident for further instructions:
    Weekdays (8am-5pm), page the pathologist assigned to Clinical Laboratory Questions (pager # 6302). After hours, weekends, and holidays, page the pathology resident on-call (pager # 9627).

2. Paper and electronic orders with non-instrument ready barcode labels should be sent to the laboratory in bags containing only that patient's specimen(s). Bags containing two different patients will be rejected by Central Processing.

3. All samples should be accompanied with orders for the specimens.

4. Any identification discrepancies shall be resolved prior to releasing results on the patient's sample.

5. Mislabeled incidents shall be evaluated and handled by Central Processing staff.

6. An Incident/Credit Report and/or RL6 shall be completed for all mislabeled specimen incidents.

Misidentified or Partially Labeled Specimens

1. Specimens that are determined by the lab or ordering location to be unlabeled or labeled with the incorrect patient identification as noted in the general guidelines will need to be recollected.

2. Irretrievable specimens should be referred to a pathologist to determine the acceptability of the sample. The charge nurse or provider taking care of the patient should be notified about the labeling problem and should request permission to relabel. Follow the "Requests to Relabel Irretrievable Specimens" process below.
    a. Irretrievable samples may include:
        - CSF
        - Body cavity fluids (pleural, peritoneal, pericardial, etc.)
        - Joint fluids (synovial)
        - Tissue
        - Blood or urine cultures collected before antibiotic therapy
        - Amniocentesis
        - Cordocentesis
        - Peak/trough therapeutic drug monitoring samples
        - Intravascular catheter tips for culture
        - Bronchoscopy and transtracheal cultures
        - Aspirated abscesses

- Outreach specimens

3. All mislabeled specimens and a report of their disposal shall be reported to the charge nurse or the nurse taking care of the patient.

4. Phlebotomy shall be notified in the event a mislabeled specimen is collected by a phlebotomist.
    a. Inpatient samples will be recollected.
    b. Central processing/client services staff will notify the respective outpatient clinic about the incident so they are aware that the sample cannot be used. Incidents that are discovered after clinic hours will be reported the next day.

5. All mislabeled/unlabeled samples should be marked as BADID and placed in the designated rack in the Spin refrigerator.

6. Receipt of all samples and the tests ordered on the samples must be documented in the LIS by receiving and crediting with the appropriate code. This includes samples with labeling errors.

Sample and Requisition Do Not Match

1. Incidents involving samples where the label ID and the requisition ID do not match shall be evaluated by Central Processing.
    a. Notify the floor of the situation to help determine whether or not the sample is labeled correctly.
    b. A sample cannot be used if the incorrect requisition was sent with a correctly labeled sample.
    c. A sample cannot be used if it is suspected or determined to be mislabeled (i.e. the requisition is correct, but the sample is not).
    d. If there is uncertainty about the identity of the sample, assume that it is mislabeled and reject for testing.
    e. Document the incident on an Incident/Credit Report or RL6.

2. **Outreach Specimens:**

    a. If the requisition is incorrect, but all specimens are properly labeled and match the face sheet demographics, request a new requisition be submitted.

Main Lab Handling of Mislabeled Specimens

1. Lab sections that encounter a known or suspected mislabeled specimen shall forward the sample to Central Processing. The sample shall be accompanied by an Incident/Credit Report that includes information including status of the specimen, who has been called, whether or not the sample has been cancelled in Beaker, tech name, date/time, and any other relevant information.

2. Central Processing is responsible for investigating and contacting the ordering location as necessary to make them aware of the situation and determine whether other samples may be impacted.

3. Tests that have been resulted cannot be cancelled by lab staff. Result correction must be used to notify providers that results were from a BADID specimen.
    a. A note should also be entered indicating the person notified of the invalid results and the time called.
    b. This should be handled by a technologist at the resulting bench.
    c. Result corrections shall be documented on an Incident Credit Report form. Refer to the Incident Credit Reports procedure. A copy of the Incident Credit Report may be used to complete an RL6. The original Incident Credit Report form should be retained by management of the impacted testing area (i.e. chemistry, hematology).

Requests to Relabel Irretrievable Specimens

1. The following protocol shall be followed in the event an irretrievable specimen is received that is NOT properly identified AND the floor requests to correct the error.
    a. The request to relabel shall come from the nurse or the physician taking care of the patient.
    b. Complete a Request to Relabel form, documenting the requestor's name, pager/phone number, correct patient's name, MRN, specimen type, test(s) requested, a description of the problem, date and time pathologist was paged.
    c. Obtain the name and number of the person requesting that the labeling error be corrected. Inform them that you will contact the pathologist on call.
    d. Weekdays (8am-5pm), page the pathologist assigned to Clinical Laboratory Questions (pager # 6302). After hours, weekends, and holidays, page the pathology resident on-call (pager # 9627).
    e. Inform the pathologist/resident of the details of the labeling incident. The pathologist shall call the requesting person to gather information and determine whether or not relabeling is approved. Provide the pathologist with a name and phone number for a lab contact person.
    f. The pathologist shall contact the lab staff to inform whether or not the specimen labeling error is approved to be corrected. No labeling correction can take place without this approval. Document the decision on the Request to Relabel form.
    g. Relabeling must be completed in the laboratory by the person that collected the specimen, or their designee approved by the pathologist.
    h. The person correcting the labeling error must sign and print his/her name on the Request to Relabel form at the time the correction is made.
    i. The pathologist/resident must also sign the form at his/her convenience. Completed forms must be reviewed and signed by the medical director. Forms are never discarded.
    j. **Specimens cannot be returned to the ordering location for relabeling.**

REFERENCES

None

RELATED PROCEDURES/POLICIES

Incident Credit Reports

ATTACHMENTS/LINKED DOCUMENTS

Request to Relabel

REVISION DATES: REVIEW CHANGE SUMMARY AS REPRESENTED IN TITLE 21.