Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Patient Safety Notification

Incorrect specimen/sample collection and labelling

184

The number of incidents relating to incorrect sample/specimen collection and labelling over a three-month period.

Types of specimen/sample collection and labelling error:

- **Mislabelled:** Service user identification or labelling error
- **Unlabelled:** No service user identification on specimen/sample
- **Non-compliance:** Not all unique identifiers present or testing laboratory requirements not met
- **Mis-collected:** Wrong service user's sample in tube

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Improving prevention of errors associated with specimen collection and labelling

Specimen and sample collection is a routine and essential part of medical care, allowing for laboratory analysis to inform diagnosis, treatment and monitoring of medical conditions. However, errors during specimen/sample collection, including labelling, can cause delays in processing of tests and, if not recognised, can lead to issue of incorrect results, diagnostic error, delayed or incorrect treatment or transfusion of incompatible blood. These have the potential to cause significant delays, errors and harm in the care and treatment of service users. The Clinical Risk Unit has noted the occurrence of incidents on NIMS relating to specimen and sample collection and labelling and has prepared the following advice.

Risk Considerations

A number of risk factors have been identified, which may contribute to the occurrence of incorrect specimen collection and labelling:

- **Lack of positive** patient identification while taking the sample
- Specimen/sample **not labelled** at the service user's bedside
- **Addressograph** stickers/chart confused with that of another service user
- Failure to check or correct inaccurate details on the service user's **identification wristband**
- No identification wristband present
- Service user's details on specimen/sample not **cross-checked** with accompanying paperwork/referral forms
- **Maternal and baby** samples confused
- **Obscuring** service user's addressograph on the specimen with barcode/other sticker
- **Use of pre-labelled specimen** containers resulting in wrong service user details for the specimen collected
- **Distractions or interruptions** during the labelling process

Advice for Safe Practice

- Ensure **uninterrupted** collection and labelling of specimens/samples as **one continuum** at the service user's bedside
- Ensure **positive patient identification** by confirming identification on service user's wristband and asking service user to confirm their details
- Check that service user **details on sample/specimen match** the details on **the referral/request form**
- Where possible, implement point-of-care-testing **barcoding systems**
- Optimise **availability of appropriate equipment** used in sample labelling (label printers, computer terminals)
- Check **testing laboratory policy** or guidelines on the acceptance and rejection of specimen samples, on **minimum requirements** for **collection and acceptable labelling criteria**
- Ensure **staff training to ensure awareness** of risks associated with labelling errors, in particular with staff responsible for taking sample/specimens

References:

1. *Healthcare Safety Investigation (2019), 'Wrong patient details on blood sample.' Healthcare Safety Investigation Branch, [cited 2020 March 11]. Available from here.*
2. *ISO:15189 (2022) 'Medical laboratories requirements for quality and competence', International Organization for Standardization.*
3. *Bolton-Maggs, P.H. B., Wood, E.M. and Wiersum-Osselton, J.C. (2015) 'Wrong blood in tube – potential for serious outcomes: can it be prevented?' British Journal of Haematology, 168(1), pp 3-13. Available from here.*

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