Quick Reference Sheet for Policy: Labelling and Safe Handling of Pathology Samples and Request Forms - CPDI061 version 5.0

This policy applies to all tests and investigations with the exception of blood samples for transfusion tests which generate a blood group for which policy EDC012 should be consulted. The table below shows the minimum required information for labelling of samples and request forms

Sample	Request form
Required Information	**Required Information**
Patients full Name* or Unique coded identifier** Date of Birth* and /or Hospital Number / NHS Number* Date of Collection (and time of collection where relevant) Destination for Report **Blood Culture bottles should be labelled as follows.** ☺Full Name* # Patient Hospital Number* Date and Time of Collection. ***Mandatory Information** **e.g. in the event of a major incident, an unidentified patient or where unique identifiers are used instead of patient names	Patients full Name* or Unique coded identifier** Date of Birth* & Gender. Hospital number / NHS number * **(must be included wherever possible, if a unique identification number is not available for a patient, please state this in the space provided)** The Full Surname and initial of the Forename of the Patients Consultant or an approved Healthcare Practitioner with requesting authorisation. Alternatively the unique identification code can be used* and/or Destination for the report* Date of Collection (and time of collection where relevant) Sample type (and anatomical site if appropriate) and investigations/tests required Relevant clinical information about the patient and request including relevant drug therapy (dose & time) Telephone /Bleep number for results. NHS / Private Patient ***Mandatory Information** **e.g. in the event of a major incident, an unidentified patient or where unique identifiers are used instead of patient names

Samples received in the laboratory will only be processed providing they have been collected in an appropriate approved container. Containers should comply with a recognised British Standard, be robust and leak proof in normal use.
The container must have been closed securely and not be contaminated on the outside. Samples failing to comply with this requirement will only be processed if they fall into the category ‘samples that cannot be repeated’.

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The Pennine Acute Hospitals NHS Trust

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Policy for Labelling and Safe Handling of Pathology Samples and Request Forms

What is this document for?	This document explains the requirements for correct labelling of Pathology samples and request forms for all tests and investigations except those which are covered under EDC012: Policy for Requesting, Collecting and labelling of blood samples for the transfusion tests, which generate a blood group
Who needs to know?	This policy is applicable to all staff requesting Pathology investigations and collecting samples to accompany that request. Pathology requests may be paper based or electronic.
Related PAHNT Documents:	Incident Reporting & Investigation; including Serious Incident Framework (EDQ008) Policy for Requesting, Collecting and labelling of blood samples for the transfusion tests, which generate a blood group (EDC012) Integrated Care Pathway for Patients Assessed as Being at Risk of Viral Haemorrhagic Fever (CPME089) Standard Operational Procedure for the collection of blood cultures (CPDI085) Standard Precautions Policy (CPDI086) Clinical Standards Policy for Diagnostic Tests (EDC067)
Related Legislation/ Obligations:	Health and Safety Executive – Safety Notice – HID 5 – 2011: Provision of key clinical information on laboratory sample request forms DOH: The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance

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Ratified by:	Chris Sleight, Divisional Director,Division of Diagnostics & Pharmacy on behalf of the Divisional Quality Governance Committee 
Date Ratified:	05.07.2017

Replaces:	Pathology Sample & Request Card Labelling Policy CPDI061 v 4.0
How is this different from the previous document?	Now includes advice on safe handling of samples when transporting to the laboratory
What dissemination & training arrangements have been made?	This policy will be available to all Trust staff via the Trust Document Management System. External users of the laboratory will be able to access the document via the Pathology pages of the Trust Intranet site. Pathology staff will access the policy via the Pathology electronic Quality Management System (QPulse) Directorate Managers and Clinical Leads must ensure that staff who might make requests or collect samples for Pathology receive instruction regarding the requesting of these investigations.
Review arrangements:	Review every 3 years or earlier should a change in legislation best practice or other circumstance dictate
Safety Arrangements:	Compliance & effectiveness of this policy will be via accident, incident & complaints monitoring, in addition to compliance audits. Staff experiencing difficulties with implementing this policy should contact their line manager.

Priority Level: 1
Impact Level: Trustwide
Keywords: Pathology samples, specimens, labelling, tests

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1. What is this Policy for?

1.1 The purpose of this policy is to ensure that the correct investigations are performed on the right patient and that samples are collected and handled safely. The safety of both patients and staff is the intended outcome of compliance with the policy.

1.2 Unlabelled and mislabelled samples are the most commonly encountered error in Pathology departments and samples are frequently received either completely unlabelled or where the labelled samples do not correspond with the request card accompanying them. In addition to these errors samples may later be proved not to have been collected from the intended patient. It is the responsibility of the healthcare professional attending the patient to confirm the identity of the patient. All these occurrences may potentially lead to patient harm due to incorrect diagnosis or the wrong treatment and in extreme cases may cause severe harm to the patient including death.

1.3 In addition to ensuring that the patient identifiers are correct it is essential that the name of the healthcare professional requesting the examination is clearly identified on the request card. In a large organisation there can be a number of requestors with the same or similar names and the person making the request is the person responsible for accessing and acting upon the results of that examination. In order to achieve this it is essential that the full name including initials or a unique identification code for the requestor is included on the request card. The Consultant unique identification codes are available on the Pathology pages on the Trust Intranet.

1.4 It is also a requirement that the location for a hard copy of the report is included on the request card. It is essential that the Pathology department has been informed where to send a copy of this report if required.

2. Why do I need to know?

2.1 The responsibility for requesting a Pathology investigation or test lies with an authorised and trained practitioner (normally a clinician). It is the responsibility of the requester to ensure that samples are correctly labelled and request forms are completed to the standards described in this policy. The completion of request cards and the collection of samples may be delegated; however the clinician delegating this task is accountable for any requests made or samples collected in their name.

2.2 Samples and request cards not meeting the minimum required criteria for identification will not be processed, these samples will be retained for an appropriate period of time. It is not always possible to inform the requestor by telephone of this outcome, however if the request is marked urgent the requestor will be informed where possible.

2.3 Laboratory staff will work to this policy when accepting samples. Samples which do not comply with the policy will be rejected. Any queries or issues should be referred to a Pathology manager.

2.4 Samples received in the laboratory will only be processed providing they have been collected in an appropriate approved container. Containers should comply with a recognised British Standard, be robust and leak proof in normal use.

The container must have been closed securely and not be contaminated on the outside. Samples failing to comply with this requirement will only be processed if they fall into the category 'samples that cannot be repeated'.

3. What is the policy?

3.1 Labelling of samples and request forms

3.1.1 Pathology staff must establish minimum identification criteria prior to performing investigations on a sample, samples failing to meet these minimum criteria will only be processed in exceptional circumstances.
The quick reference sheet at the front of this policy outlines all the information required to provide a complete and quality examination of the sample received.
If the mandatory information is not supplied the sample will be rejected.
Failure to provide other relevant information may result in an incomplete report or inappropriate clinical advice being issued

3.1.2 For all inpatients confirm identity by checking the identification bracelet and compare this with the request form. If an identification bracelet is not present on an inpatient, the ward manager should be informed and the procedure abandoned until the identification bracelet is present

3.1.3 Check that the details on the request form are complete.
Enter the name or identification code of the person collecting the sample in the space provided on the request form.
The sample container must be accurately labelled and checked in the presence of the patient at the time the sample is collected. Sample containers must not be pre-labelled due to the risk of collection into the wrong container.
The collection of samples, dispersal into containers and labelling of these containers must be carried out as one continuous, uninterrupted, event involving one patient only.

3.1.4 Pre-printed addressograph labels which are contained in the patient notes must not be used to label sample containers. They can be used on request cards providing additional information to complete the minimum required criteria is hand written

3.1.5 Labels generated whilst in the presence of the patient using a unique label printer are acceptable; these must contain all of the required information for sample labelling and must only cover the tube manufacturer's primary label. This includes the labels generated by the T Quest and HealthViews software. If you are considering introducing any other labelling system please inform the Pathology department. The exception to this is blood transfusion where sample labels are not acceptable and all samples must be hand written as per Trust Policy EDC012 'Requesting, Collecting and labelling of blood samples for transfusion tests, which generate a blood group'.
When using label printers care must be taken to ensure that the labels are correctly aligned in the printer so that all the patient information is printed on the label.
Samples which are received with barcodes only and without eye-readable data will be rejected.

3.1.6 Samples from neonates must be labelled with the baby's details only. Labels which contain details of both mother and baby or mother's details only will not be accepted.

3.1.7 Only staff that have undertaken a Trust venepuncture training programme or been assessed as competent should collect blood samples. Under no circumstances can blood be transferred from one collection tube to another. This can seriously affect the results obtained and may result in patient harm

3.1.8 Blood cultures should be taken following the 'Standard operational procedure for the collection of blood cultures' (CPDI085) by staff who are trained to do so. When labelling blood culture bottles ensure that the barcode on the bottle is not obscured by a label.

3.2 High Risk Samples

3.2.1 **Health and Safety Executive – Safety Notice – HID 5 – 2011**: **Provision of key clinical information on laboratory sample request forms** states:
Where a laboratory sample or sample is considered likely to contain a human pathogen, it is important that the appropriate level of laboratory containment is provided in order to ensure the effective control of the risk of exposure / infection. Samples processed for microbiological analysis and considered likely to contain Hazard Group 3 or 4 pathogens must be processed within appropriate containment conditions.
Samples liable to result in propagation or culture of Hazard Group 3 pathogens for example must be processed in a Containment Level 3 laboratory with associated management arrangements.
Samples should be supplied with relevant clinical details from requesting clinicians. This can be used to inform the assessment and further laboratory processing e.g. the types of organisms that might be present in samples from a returning traveller or those associated with an outbreak scenario.
In clinical laboratories, samples are sorted and processed on the basis of the information provided. If clinical details are inaccurate or incomplete or there is delay in disclosing new information to the laboratory then this can result in samples being processed under insufficient laboratory containment conditions.

Departments that request Pathology investigations must ensure that:

- Clinical details supplied on sample request forms contain clear information regarding the nature of the test being requested and sufficient detail to inform laboratory staff upon the safety precautions they need to take in order to process the sample without risk of infection.
- Clinical details include history of recent foreign travel including the date and country or region visited.
- If, during patient intervention, further information becomes available that has implications for the safety of laboratory staff then this is communicated immediately to the laboratory so that appropriate steps regarding containment can be taken

3.2.2 Samples that are from patients suspected of having a Viral Haemorrhagic Fever are always classified as 'HIGH RISK'. There is a separate policy to cover the way that these samples are handled depending on risk factors identified by the Infectious Diseases Consultant in charge of the patient. Please do not attempt to take any patient samples until the 'Integrated Care Pathway for Patients Assessed as Being at Risk of Viral Haemorrhagic Fever' (CPME089) has been consulted.

3.2.3 Samples for the investigation of tuberculosis, typhoid fever and Middle East Respiratory Syndrome (MERS), are considered 'HIGH RISK' and an appropriate biohazard sticker MUST be attached to the sample and the request form. When

sending samples for microbiological analysis from individuals known or suspected of having these infections the clinical details entered on the request card must be adequate to convey information about the suspected hazard to the staff handling the samples

3.2.4 Samples from individuals known or suspected of having Blood Borne Viruses (BBV) categorised as Hazard Group 2 or 3 such as hepatitis and Human Immunodeficiency Virus (HIV) are NOT classified as 'HIGH RISK' in the laboratory as the infectious agents in these samples are not propagated and do not pose a risk to the laboratory staff handling them.

3.3 Unconscious patients

In cases where the unconscious patient has been through the admissions procedure and an identity bracelet has been fitted, it is acceptable to omit the verbal identity confirmation; the person collecting the sample must confirm the patient's identity on the identification bracelet.

3.4 Unknown patients

The A&E unique identification number, and where possible a hospital number should be generated for the patient. These numbers should be used on all samples, request cards and included on the patient's identity bracelet.

3.5 Major Incidents

During major incidents involving patients whose identity is not known to Pennine Acute Hospitals, or during times where IT systems are unavailable, emergency numbers are available to the accident and emergency departments and to the maternity units.

This unique identification number will normally be allocated to the unknown patient via PAS to allow subsequent clinical interventions involving other IT systems such as LabCentre and EPMA to uniquely identify the patient and allow safe clinical care. This number will be printed on the patient's identity bracelet and must be used on all specimens, request cards etc. During times of IT downtime, the emergency numbers can still be allocated and paper records kept.

3.6 Important considerations

3.6.1 A member of staff collecting a sample from a patient is accepting responsibility for ensuring that the sample has been collected from the correct patient and that all the details are accurate

3.6.2 It is vital that any inconsistency found in the information used to identify the patient is checked prior to any procedure being undertaken

3.6.3 Sample containers must not be pre-labelled; samples must be labelled at the patient's side by the person who takes the sample.

3.6.4 Handwriting on sample containers and request forms must be legible; alterations must be neat, legible and signed

3.6.5 Laboratory staff will not amend details on a sample or request form

3.6.6 Users will not be invited to the laboratory to re-label samples

3.6.7 Samples will not normally be returned to users for labelling

3.7 Samples that cannot be repeated

3.7.1 Failure to comply with the requirements of this policy presents serious governance issues and samples and request cards that do not comply with the minimum identification and requestor criteria will not normally be analysed.

3.7.2 There are some samples that are exceptions to the rule. These may include:

- Bone marrow biopsy
- CSF and other sterile body fluids
- Paediatric samples
- Blood Gas samples
- Dynamic function tests
- Calculus – renal analysis
- Samples collected prior to commencement of therapy e.g. blood cultures
- Samples collected during surgical procedures

These samples are usually collected during individual procedures, the identity of the patient undergoing the procedure can be established and it is unlikely the sample could have been collected from a different patient. Under these rare circumstances such samples may be processed, the report will state that the sample did not comply with the minimum identification criteria and the reason it did not comply along with the results of the examination. Senior and/or experienced laboratory staff in each laboratory discipline will, based on the above criteria, take the decision regarding the processing of samples that have been incorrectly labelled.

3.8 Packaging, handling and delivery of laboratory samples

3.8.1 Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation. Staff who handle samples must be aware of the need to correctly identify, label and store samples prior to forwarding to laboratories. In addition they must be aware of the procedures needed when the container or packaging becomes soiled with body fluids.

3.8.2 Appropriate Personal Protective Equipment (PPE) must be worn when collecting samples. Samples must be collected into an appropriate approved container which must then be closed securely and not be contaminated on the outside.

3.8.3 Following collection and labelling samples should be placed in an individual transparent plastic bag and sealed. Staples, pins and metal clips must not be used for this purpose. It must be possible to open the bag without the use of a sharp pointed instrument.
Request cards must not be placed in the bag with the sample, nor stapled to the bag. Request cards for large containers e.g. 24-hour urine container or Histology pots should be taped securely to the bag containing the sample container.

3.8.4 When carrying samples, staff must use secure sample transport carriers. The carrier should have a lid that can be fastened, be made of impervious material, which can be easily cleaned and disinfected.
Enough absorbent material must be contained with the samples to absorb any potential leakage.

Under no circumstances should anyone transport samples in their hands or pockets.

Carriers should:

- Not be used for any other purpose than carrying samples.
- Not be over filled.
- Be cleaned and disinfected regularly and always following contamination.

The outside of the carrier should be marked with appropriate Biohazard information, and contain a telephone number to contact in case of emergency or other problem. FGH: 83447, NMGH: 43287 and ROH: 78376

3.8.5 If a spillage occurs it must be dealt with immediately using the recommendations in the 'Standard Precautions Policy' (CPDI086). In cases of formalin spillage during normal office hours the laboratory should be contacted on 78356; at other times the Fire Service should be called.

3.8.6 The pneumatic air tube system is a safe, efficient and rapid method of transporting samples from wards and departments to the laboratory.
It is fundamental to establish the suitability of each sample type for transportation by this method. Only carriers supplied with the system can be used to transport samples, Histology samples in formalin should not be transported via the air tube and consideration should be given to using an alternative to the air tube for any sample that cannot be repeated.

4. What do I need to do?

4.1 Training arrangements

Directorate Managers and Clinical Leads must ensure that all newly appointed healthcare workers within Pennine Acute Hospitals NHS Trust who might make requests or collect samples for Pathology, receive instruction regarding the requesting of these investigations in their local induction programme. It is vital that all staff are aware of the reasons for compliance with this policy and the consequences of non-compliance in terms of adverse patient outcome and professional accountability.

4.2 Staff collecting samples

All staff are required to comply with this document and bring to the attention of their immediate manager any difficulties they encounter in using this document. Report any adverse incidents via the Trust Incident Reporting and Investigation policy (EDQ008)

4.3 Laboratory staff

4.3.1 Before accepting a clinical sample, laboratory staff must ensure that the minimum required criteria for requestor and sample identification are met. Stringent standards are put in place to ensure the safety of the patient; they are intended to ensure the right investigation is performed on the right sample. Laboratory staff must not endanger the patient by working outside these standards.

4.3.2 Biomedical scientists must be aware of the importance of relevant clinical information when validating and authorising results, especially when cumulative records are available. An unexpected test result can highlight the possibility of an incorrectly labelled sample or request form and should be investigated immediately.

5. How will we know if the policy is being used effectively?

- Key standard: There will be no reported incidents of delay in diagnosis resulting from the rejection of samples which have not been labelled or transported correctly.
- Method: audit of number of samples rejected by each Pathology discipline, monitoring of incident reports
- Team responsible for monitoring: Technical managers in each Pathology discipline, Pathology Quality Governance Group
- Frequency of monitoring: Monthly
- Process for reviewing results and ensuring improvement in performance: Wards or departments with a sample rejection rate of >5% are informed and an incident raised if performance does not improve. Incidents raised if samples are received which do not comply with the HSE safety notice

6. List of Abbreviations and Terms used

BBV: Blood Borne Viruses
CSF: Cerebrospinal fluid
DOH: Department of Health
ePMA: electronic Prescribing and Medicine Administration system
FGH: Fairfield General Hospital
HIV: Human Immunodeficiency Virus
HSE: Health & Safety Executive
MERS: Middle East Respiratory Syndrome
NMGH: North Manchester General Hospital
PAS: Patient Administration System
PPE: Personal Protective Equipment
ROH: Royal Oldham Hospital

7. References

7.1 Supporting References

The Health & Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance: Department of Health (2015)
The Approved List of biological agents: HSE Advisory Committee on Dangerous Pathogens, Third edition (2013)

8. Appendices

Appendix 1 – Equality Impact Assessment

The Pennine Acute Hospitals NHS Trust

Equality Impact Assessment for Policy for Labelling and Safe Handling of Pathology Samples and Request Forms CPDI061 v 5.0

To be completed by the Lead Author (or a delegated staff member)

For each of the Protected Characteristics & equality & diversity streams listed answer the questions below using Y to indicate yes and N to indicate no:	Age	Disability	Ethnicity / Race	Gender	Gender Reassignment	Marriage & Civil Partnership	Pregnancy & Maternity	Religion/belief	Sexual orientation	Human Rights	Carers	Please explain your justification
1. Does the practice covered have the potential to affect individuals or communities differently or disproportionately, either positively or negatively (including discrimination)?	N	N	N	N	N	N	N	N	N	N	N	No part of this policy affects, or has the potential to affect any of the equality categories unfairly
2. Is there potential for, or evidence that, the proposed practice will promote equality of opportunity for all and promote good relations with different groups?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
3. Is there public concern (including media, academic, voluntary or sector specific interest) in the document about actual, perceived or potential discrimination about a particular community?	N	N	N	N	N	N	N	N	N	N	N	

Your Name: Jane Fielding	**Your Designation: Interim Performance & Quality Manager, Pathology**	**Signed*:** JE Fielding	**Date:** 9th August 2017

To be completed by the relevant Equality Champion following satisfactory completion & discussion of answers above with author

Equality Champion: Joanne Stephenson	**Directorate: Radiology**	**Signed*:** Joanne Stephenson	**Date:** 10/08/17

*Please scan or insert electronic signature