Detecting Specimen Labeling Problems
Suzanne H. Butch, Theresa A. Downs
University of Michigan Health System, Ann Arbor, Michigan

Introduction

The minimum requirements for an acceptable Type and Screen specimen are two patient identifiers (full name and medical record number) along with the date of specimen collection. In addition, there must be a method of identifying the person collecting the specimen and the date the specimen was collected. Requests that accompany the specimen must contain two patient identifiers and must be complete, accurate and legible. While requiring two blood types from separate phlebotomies may identify many mislabeled specimens, other methods are invaluable in identifying specimens labeled with the wrong patient’s identifying information. These specimens are referred to as “WBITs” meaning “wrong blood in tube”. Over reliance on ABO/Rh as the method of detecting mislabeled specimens may lead to a false sense of security. Using two specimens may not have the intended result when caregivers anticipate the need for the second draw and collect the “second” specimen in the same phlebotomy as the first specimen withholding the second tube until requested.

Method

We reviewed all of the occurrence reports for 2007 related to specimen identification problems. We categorized the reasons for specimen rejection and further investigated (WBIT). At present, approximately 50% of our specimens have a previous type on file. We do not require two blood types collected in separate phlebotomies before giving non-group O red cells.

Results

Of the 51,300 samples submitted for testing 476 labeling problems were reported in 2007. Of these 476 reports, there were 11 WBIT incidents. In each WBIT case, the patient identifying information on the tube and requisition matched. Only 1 of these cases was identified because of a typing discrepancy between the current ABO/Rh typing and history. Other cases were identified by the following: three cases where we were notified by the individual who submitted the specimen before testing was performed; in 4 cases the test ordered was not logical; one specimen received in a bag with other specimens considered to be mislabeled by another laboratory, one wrong patient identification assigned when patient was at the clinic and one wrong patient identification band placed on the patient in the emergency department.

Conclusions

- ABO/Rh typing discrepancies are one way of identifying WBIT specimens.
- Using other methods to identify these specimens may uncover additional WBIT specimens not recognized because of matching ABO/Rh types.
- This has implications for other sections of the clinical laboratory if specimens were collected at the same time as the blood bank specimens.