



# e-Network Forum

## CALIFORNIA BLOOD BANK SOCIETY

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### ***Labeling specimens that may lead to compatibility testing***

A blood banker wrote that it is her institution's policy to **hand-write a patient's identifying information** directly on the sample tube label for all specimens that may lead to compatibility testing. The pre-transfusion sample tubes have a pre-applied label that is applied to the tube by the tube manufacturer, and these labels are firmly affixed. An exception to this policy has been made for **Surgery**; they can use **computer-generated imprinted labels** which they place over the pre-existing tube labels. While these computer-generated labels do stick well enough not to fall off, their **adhesive is not permanent enough** to prevent the labels from being peeled off. Some of the technologists at the inquiring blood banker's institution are concerned about computer-generated imprinted labels being placed erroneously on the wrong specimen, only to have the label peeled off and replaced with a new label, after an error in specimen or patient identification is discovered. The laboratory does not return specimens to the clinicians/nurses when an error in labeling is discovered, and it is documented that the specimen was rejected and the reason for the rejection. The rejected specimens are stored for a few days in case there is a question about the rejection or if follow up is needed; eventually the specimen is discarded. The inquiring blood banker reports that she has not been witness to someone peeling off a label and placing new identification on the tube, but she is aware that this has happened in the past, so she wants to know **if there are rules or regulations that prohibit the removal of a specimen label and the application of a new label**. She also wants to know **how other institutions prevent inadvertent testing** of mislabeled or inappropriately relabeled samples?



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Please submit comments to the [e-Network Forum](#).

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CBBS e-Network Forum Editor & Moderator

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**Addenda:**