Laboratory News
Please circulate to all members of staff within the practice
NHS Greater Glasgow and Clyde
Issue 9
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North Glasgow Sector

New telephone numbers at GRI

Following the Telephony Transformation Programme, some contact numbers have changed at the GRI site. Existing numbers for Biochemistry and Haematology have changed. Microbiology and Virology will be upgraded at a later date – further updates will follow. The current contact numbers for the GRI laboratories are listed below:

Biochemistry

General enquiries/ clinical advice	0141 242 9500 (NB. Options have also changed)
For non-urgent Biochemistry add-on requests, please email: NorthGlasgow.BioChem@ggc.scot.nhs.uk	

Haematology

Routine Haematology	0141 242 9601 / 9602
Routine Coagulation	0141 242 9605
Blood transfusion	0141 242 9603
Laboratory Manager	0141 242 9529

Microbiology

General enquiries	0141 201 8551

Virology

General enquiries	0141 201 8722

Paper Request Forms

We continue to receive the joint Biochemistry/Haematology request form from some surgeries. This joint form should **not** be used in the North Glasgow sector. Please order the correct forms from PECOS using the codes below:

Biochemistry forms **G05159**
Haematology forms **G05192**

Remember : All samples should be placed into clear plastic sample bags. One bag per patient. Samples for different laboratory departments should be placed in the appropriate transport bags.

Incorrect blood sample labelling

Blood sampling from patients, whether in hospital or in the community, is a regular and important part of healthcare. Correctly linking the blood sample to the patient from whom it was taken is essential. If the sample in the tube does not belong to the patient whose name is on the tube and this is not detected then there is a risk that results will be associated with the wrong patient.

Unfortunately over the last 2-3 months on several occasions blood samples received by the laboratories from the community have been identified as being incorrectly labelled with the name of a different patient. This has happened in different locations across North Glasgow and for a variety of different reasons; however the underlying cause was a failure to check the patient's identity against the label applied to the sample. This resulted in additional work for the Medical Practices and Laboratories to investigate these incidents. A significant number of patients had to have repeat blood sampling to ensure that results were associated with the correct patient. These events were only discovered as the results were abnormal in each case and resulted in some unnecessary hospital admissions. There is a risk that other occurrences have not been detected.

We would be delighted with your feedback on issues that you would like us to address in the newsletter. We are also keen to reach as large an audience in primary care as possible. Do you have suggestions how we can widen distribution? Comments or suggestions can be sent to:

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