Blood and Blood Product Governance Group Newsletter Number 3 – September 2014

A GOOD DROP OF RED

Zero Tolerance

Why do I have to recollect that pre-transfusion blood sample?

Before a patient is transfused, a suitable blood sample must be obtained for crossmatching. For transfusion safety it is vitally important that the patient and their blood sample are clearly identified during this process.

Errors in pre-transfusion specimen collection can be fatal because they can initiate a chain of events leading to transfusion of the wrong blood. Following correct procedures for patient identification, specimen collection and labelling reduce the likelihood of error and preventable patient harm.

Hospital staff often feel that transfusion specimens are rejected (and require recollection) for seemingly trivial errors or omissions. However such specimens have been shown to have a significantly higher likelihood of containing the wrong patient's blood[1]. Pathology staff rely on strict adherence to identification and labelling procedures to ensure these specimens are not processed and patient safety is not compromised.

Wrong blood in tube (WBIT), the most serious type of blood sampling error, occurs when:

- Sample is taken from the wrong patient but labelled as per the intended patient, or
- Sample is taken from the intended patient but labelled as per another patient, or
- Mismatch between paperwork and request specimen

WBIT specimens are reported to the Blood Matters Program – Serious Transfusion Incident Reporting (STIR) system. The following case study is from a report to STIR.

A routine pre-transfusion sample was collected in the ED. One clinical staff member undertook the venepuncture. A second clinician then offered to help and labelled the tube by using information from a request form in the cubicle. On the request slip the first staff member signed and declared they had collected the sample from the correct patient. On arrival in the laboratory it was noted that the sample and the request had details for two different patients. On investigation it was discovered the request form had been left from the previous patient in the cubicle. Neither staff member had checked the identity directly with the patient when labelling the tube or confirming the request details against patient and sample.

Correct steps when taking a blood sample:

1. Identify patient
2. Collect sample
3. Label sample with full patient details
4. Add time and date of collection to the specimen label and on the request form
5. Compare patient details on sample and request form
6. Sign blood sample and request form declaration

Other information required by the laboratory

- Clinical notes must be listed so that the most suitable component can be issued to the patient.
- Transfusion history. It is useful for the scientist to know whether the patient has been recently transfused, is or has been pregnant, or received RhD immunoglobulin, all within the last 3 months.
- Group & Hold versus Crossmatch
  - Group & Hold is the first part of a crossmatch. Do not ask to G&H a number of units as units are not put aside with a group and hold. The patient's group is identified and antibody screening done.
  - Crossmatch. The number of units requested is put aside for the patient and will be available for a maximum of 72 hours from the time the pre-transfusion sample was taken. If you have requested more than 2 units and they have not been transfused in 48hrs, you may receive a call from the laboratory asking whether you are still planning to transfuse them. If not, they shall be returned to stock and available for other patients use.

Remember, simple mistakes with patient identification can be fatal. Take the time to get it right!

References:

1. Dzik WH. Technology for Enhanced Transfusion Safety. American Society of Haematology, 2005.