BLOOD MANAGEMENT COMMITTEE

CLINICAL PROCEDURE

BLOOD SPECIMEN & REQUEST FORM LABELLING FOR PRE-TRANSFUSION TESTING

Staff this document applies to:

Registered Nurses; Enrolled Nurses – Medication Qualified, and Medical Staff

An Enrolled Nurse – Medication Qualified is an EN who holds a Nursing and Midwifery Board of Australia (NMBA) approved qualification in administration of medicines. To participate in patient care and administration of blood or blood products, the Enrolled Nurse must have successfully completed the relevant Medication Qualified (IV) education, and the BloodSafe Clinical Transfusion Practice (CTP) e-learning package.

Related Austin Health policies, procedures or guidelines:

Patient Identification

Requesting Blood Components for Emergency and Non-Emergency Transfusion

Venepuncture - Peripheral Blood Specimen Collection

Key Point:

Errors made during the collection of a pre-transfusion specimen can be devastating, initiating a chain of events that may lead to an ABO incompatible blood transfusion. Robust patient identification, specimen labelling processes and mandatory criteria for labelling specimens and request forms, are all crucial to safe blood transfusion.

Purpose:

This document informs all staff of Austin Health policy related to the minimum patient identification criteria required for labelling a specimen and request form for pre-transfusion testing.

The document outlines the principles of positive patient identification and specimen labelling to ensure that the blood specimen is drawn from the intended patient. **All staff performing venepuncture must adhere to the criteria and processes outlined within this document at all times.**

Definitions:

- **Pre-Transfusion Testing:** Compatibility test prior to the administration of Red Blood Cells, Platelets, Fresh Frozen Plasma and Cryoprecipitate. This includes: ABO & Rh grouping, antibody screening and cross-matching.
- **Wrong Blood in Tube:** Blood contained in the specimen tube does not belong to the patient indicated on the specimen tube (and / or request form). The error is generally identified in the laboratory when the specimen blood group does not match the patient's historical blood group. The situation becomes unsafe when there is no historical blood group for comparison and this may lead to the issue and administration of an ABO incompatible blood transfusion.

Patient Identification:

ALL specimens and request forms for pre-transfusion testing **MUST** comply with the **MANDATORY PATIENT IDENTIFICATION CRITERIA,** as outlined below:

1. Request For Blood / Blood Products Request Form - MANDATORY LABELLING CRITERIA:	
DETAILS:	**REQUIREMENT:**
• **Correct and accurate Patient Surname and Given Name – In FULL:**	**MANDATORY**
• **Correct and accurate Patient UR Number:**	**MANDATORY**
• **Correct and accurate Date of Birth:**	**MANDATORY**
• **Collector's signature and Collector's printed name in the Collection Declaration Statement area:**	**MANDATORY**
• **Full date of collection in the Collection Declaration Statement area:**	**MANDATORY**
• **Time of collection in the Collection Declaration Statement area:**	**MANDATORY**

2. Pre-Transfusion Specimen Tube - MANDATORY LABELLING CRITERIA:	
DETAILS:	**REQUIREMENT:**
• **Correct and accurate Patient Surname and Given Name – In FULL:**	**MANDATORY**
• **Correct and accurate Patient UR Number:**	**MANDATORY**
• **Correct and accurate Date of Birth:**	**MANDATORY**
• **Collector's signature or initials:**	**MANDATORY**
• **Full date of collection:**	**MANDATORY**
• **Time of collection:**	**MANDATORY**

- If one or more of the mandatory labelling criteria is absent, then the specimen and request form will be rejected and a recollection will be required - including a new specimen and request form which conforms to the mandatory labelling criteria.
- All details must correspond completely and correctly between the blood specimen tube and the request form. **Where inconsistencies of spelling or numerical inaccuracy are present, the specimen will be rejected,** and a recollection will be required - including a new specimen and request form which conforms to the mandatory labelling criteria.
- In the absence of a valid Group & Screen, **un-crossmatched O-negative blood can be issued immediately in urgent situations only.**

Any query or discussion related to application of these criteria must be directed to the Austin Health Transfusion Nurse – ext: 3497; or the Laboratory Haematology Registrars – ext: 5981 / pg: 5981.

Principles of Positive Patient Identification:

Patients must always be identified immediately prior to specimen collection using the following process:

- Ask the patient to state their **FULL NAME, DOB and UR Number if known.**
- Check that the information provided by the patient (including UR Number) fully matches their Identification Wristband and the Request for Blood/Blood Products Pathology Request Form.

- **Note:** Unconscious patients **must** be identified using the Identification Wristband. Check the patient's FULL NAME, DOB and UR Number. If possible also verify the information by asking family, relatives or another member of staff who knows the patient.
- If there are any discrepancies **DO NOT PROCEED**. Rectify the problem immediately.
- Under no circumstances should passive modes of identification be used to establish the identity of a patient e.g. bed cards, hospital charts, or not checking patient identification because the patient is known to staff.

Principles of Specimen Labelling:

- Ensure that the request form has fully completed and accurate patient details written on it, or correct patient identification label attached.
- Assemble all the necessary equipment in order to take the blood specimen, label and package at the bedside.
- Positively identify the patient immediately prior to collecting the specimen.
- Label the specimen immediately following collection and **at the patient's bedside** as per mandatory labelling criteria above.
- Either label the specimen by hand using the identification details stated by the patient and the patient's Identification Wristband; or a Patient Identification Label may be used. Ensure that the identification details on the label are identical to the details stated by the patient and those on the patient's Identification Wristband.
- Ensure that you **sign/initial, date and time** the specimen as confirmation that the patient identification details are correct.
- Ensure that you **sign AND print your name, AND date and time** the Collection Declaration Statement on the Request Form.
- Package up the specimen immediately after labelling at the patient's bedside, and dispatch to Austin Pathology Department for processing.

Alerts:

- **DO NOT** label the specimen tube prior to taking the blood
- **DO NOT** walk around with unlabelled specimen tubes that are filled with blood
- **DO NOT** abbreviate the patient's name e.g. T. Smith; Bill in place of William, etc
- **DO NOT** take blood from more than one patient at a time
- **DO NOT** send samples from multiple patients in the same pathology specimen bag **– all samples will be rejected should this occur, and a re-collection will be required**

Evaluation:

- Failure to adhere to the mandatory minimum labelling criteria suggests that patient identification and specimen labelling procedures may have been compromised. **The specimen and request form will be rejected and a RISKMAN incident report will be generated in these instances.**
- Data on specimen and request form labelling errors are reported to relevant Wards / Departments via Quality Co-Ordinators, and to the Austin Health Blood Management Committee.

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Legislation/References/Supporting Documents:

1. Australian Commission on Safety and Quality in Health Care (ACSQHC) (November 2017), *National Safety and Quality Health Service Standards*, ACSQHC, Sydney.
2. Australian Red Cross Lifeblood website for health professionals, available at http://www.transfusion.com.au/home.aspx
3. Australian Red Cross Blood Service. Blood Component Information: Circular of Information 2015.
4. Australian and New Zealand Society of Blood Transfusion (ANZSBT): Guidelines for The Administration of Blood Components (3rd Edition) 2018
5. National Pathology Accreditation Advisory Council, Retention of Laboratory Records and Diagnostic Material, Seventh Edition, 2018.
6. National Pathology Accreditation Advisory Council, Requirements For Transfusion Laboratory Practice, Third Edition, 2017.
7. Serious Hazards of Transfusion (SHOT) website: http://www.shotuk.org/

Authorised/endorsed by:

Austin Health Blood Management Committee

Primary Person/Department Responsible for Document:

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