Safety Information 006/21

Patient identity checks before administration of blood products

(21 June 2021)

Distributed to:

- Chief Executives
- Directors of Clinical Governance

Expert Reference Group

Content reviewed by:

- NSW Blood and Blood Product Clinical Advisory Committee

Clinical Excellence Commission

Tel: 02 9269 5500

Fax: 02 9269 5599

Email: CEC-BloodWatch@health.nsw.gov.au

Internet Website: http://health.nsw.gov.au/sabs

Intranet Website: http://internal.health.nsw.gov.au/quality/sabs

Review date

June 2022

Background

The transfusion of blood products to a different patient, other than the one they have been cross-matched for, is a known risk, with the potential for serious harm or death.

Patients in all clinical settings receiving a blood product must be positively identified immediately prior to the administration of blood products. Staff must be vigilant in the checking procedures to ensure that the right blood is administered to the right patient.[1] Unconscious patients and others who are unable to participate in patient identity checking procedures are particularly vulnerable.

Situation

Incidents have been identified where patients were transfused with blood products cross matched and labelled for another patient. In some reported incidents the blood product was retrieved from a satellite blood fridge.

In all episodes:

- The patient was not positively identified by checking their armband
- Staff did not ensure that the name on the blood product compatibility label matched the patients' armbands

Key policy requirements

- NSW Health Policy Directive Blood Management section 2.3.2 requires facilities to implement patient identification procedures for:
  - retrieval of blood products from blood fridges
  - delivery to the clinical area
  - administration to the patient.
- When collecting blood products from satellite blood fridges, the Australian New Zealand Society of Blood Transfusion (ANZSBT) guidelines outline the required checking procedures, to ensure the correct blood product is retrieved from the blood fridge.
- These procedures must comply with ANZSBT Guidelines for the administration of blood products and, NSW Health Policy Clinical Procedure Safety
- Two staff members must undertake the pre-transfusion patient identity and pack verification checks immediately before administration.

Where identification bands are not visible during a procedure

Health services should develop local risk-based practices to ensure correct identification of the patient receiving a transfusion.

Local solutions should ensure that the armband used for confirmation during timeout procedures must be accessible after positioning and draping, in accordance with the NSW Health PD Clinical Procedure Safety.

Reference:

1. Australian and New Zealand Society of Blood Transfusion, *Guidelines For The Administration Of Blood Products*, 2019, Australian and New Zealand Society of Blood Transfusion,: Sydney.

Made Obsolete September 2022

Current policy: Patient Identification Bands (PD2021_033)

Patient identity checks before administration of blood products

(21 June 2021)

Suggested actions required by local health districts/specialty health networks

1. Distribute this Safety Information to all relevant clinical staff to ensure they are aware of the risks associated with misidentification of patients receiving a transfusion.
2. Table this Safety Information at relevant safety and quality committees.

   This should include:

   - The Blood Management Committee (or equivalent)
   - Relevant perioperative committees
3. Review local procedures for patient identification arm bands to ensure compliance with the following NSW Health Policy Directives and any subsequent versions:

   - Blood Management (PD2018_042)
   - Clinical Procedure Safety (PD2017_032)
   - Patient Identification Bands (PD2014_024) (under review)
4. Review or develop local risk-based practices to ensure correct identification of the patient receiving a transfusion, where patient identification bands are under drapes and inaccessible. The CEC Blood Watch team are available to support facilities in this process.
5. Review procedures in place to ensure correct and safe collection of blood products from satellite blood fridges.
6. Ensure all patient identification incidents related to transfusion are reported in the incident management system and reviewed by the facility blood management committee (or equivalent).