Positive patient identification and pretransfusion checking procedure

Blood Matters Audit 2025

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Background

The Blood Matters Program assists health services to ensure blood and blood products are administered to patients appropriately and safely in accordance with best practice guidelines.

The Serious Transfusion Incident Reporting (STIR) system has received an increase in notifications for wrong blood in tube (WBIT) and incorrect blood component transfused (IBCT) in FY 2024 (see table 1 below). Fortunately, ABO incompatible transfusions, a form of IBCT with the potential for significant morbidity and mortality, are reported infrequently; however, STIR continues to receive reports of components administered to a patient other than the intended patient. This indicates there is improvement to be made in the areas of patient identification and the pretransfusion check.

Table 1 WBIT and IBCT events for the financial years 2022 to 2024

Year	WBIT	IBCT
2023-2024	36	15
2022-2023	27	10
2021-2022	22	15

Patient identification and the matching of a patient to an intended treatment is performed routinely in all care settings. The development of safety routines for this common but critical task, help prevent mistakes that can cause harm or death (National Safety and Quality Health Service Standards, 2021) <https://www.safetyandquality.gov.au/our-work/communicating-safety/patient-identification>.

The pretransfusion checking procedure, which includes positive patient identification and blood component matching, is the last chance to ensure the right blood component is transfused to the right patient at the right time.

Commonly staff have undertaken a shared pretransfusion checking procedure where one person reads information aloud from one source and another checks that information against another source, which is not aligned with current guidelines and best practice.

The ANZSBT Guidelines for the Administration of Blood Products 3rd edition (2024) <https://anzsbt.org.au/wp-content/uploads/2024/02/Guidelines-for-the-Administration-of-Blood-Products-revised-Feb-2024.pdf> outline the requirements for positive patient identification, double independent checking and the pretransfusion checking procedure. Double independent checking was first included in these guidelines in 2018 to minimise the risk of error at the final check before transfusion.

Double independent checking: Clinicians individually and without requiring direct involvement of each other, check the prescription, patient and blood and blood product identification, and blood and blood product characteristics (including expiry, compatibility and special requirements (if any)). This process must ensure that each clinician is individually satisfied that, and responsible for, the correct product/ component is transfused in the correct way to the correct patient. The clinicians must agree before the transfusion is commenced.

Health services should have policies and procedures for blood administration that are aligned with national guidelines.

Aims

To identify if health service blood administration policies and practices are consistent with the Australian and New Zealand Society of Blood Transfusion (ANZSBT) Guidelines for the administration of blood products 3rd edition (2024).

Objectives

- To determine if health services have pretransfusion checking procedures and protocols, incorporating positive patient identification and double independent checking and alignment with the ANZSBT Guidelines for the administration of blood products (2024)
- To observe clinical staff performing pretransfusion checks to determine if double independent checking and positive patient identification as defined by ANZSBT guidelines is undertaken prior to blood component administration.

Method

The audit comprises two parts:

Part A – Audit of health service blood administration policy, specifically pretransfusion checking procedure, to determine if it is aligned with the ANZSBT Guidelines for the administration of blood products (2024). Part A is to be completed once for each health service.

Part B – Observation of the pretransfusion patient identification and component check prior to blood administration. Part B is to be completed for up to 20 individual, randomly selected patients who receive a transfusion between 1 March 2025 to 30 April 2025.

Inclusions: all patients receiving a transfusion that do not have an active massive haemorrhage protocol (MHP) or critical bleeding event.

Exclude: Patients with activated MHP or critical bleeding event.

Data entry is open and available to be completed from 1 March to 12 May 2025.

Data entry is electronic using REDcap.

Part A < https://redcap.lifeblood.com.au/surveys/?s=YP98FY4PPXPAYDDM>

Part B < https://redcap.lifeblood.com.au/surveys/?s=FCMXAYTHMXYC3JAC>

A data collection tool has been provided to assist in the collection of data prior to entry.

When entering data for part B, it is not necessary to input all records at once. However, it is necessary to complete all questions for an individual patient.

If experiencing problems entering data or if you have questions, please contact Blood Matters on 03 9694 0102 or email bloodmatters@redcrossblood.org.au

Victorian health services are expected (as outlined in the Victorian Department of Health Policy and Funding agreement) to complete both part A & B.

Definitions

Element	How it is defined
Blood components	Refers to fresh blood components - red blood cells, platelets, fresh frozen plasma, cryoprecipitate.
Blood products	Refers to fractionated plasma products such as immunoglobulins, albumin, clotting factors. *Please note the ANZSBT guidelines use the term blood product as an all-encompassing term for both blood components and fractionated products.
Positive patient identification	‘Positive patient identification’ is correctly identifying a patient to ensure that the right person receives their intended care. This involves the following: • Ask the patient (if conscious and competent) to state and spell their family name and given name in full, and their date of birth (DOB). • ensure that the stated family name and given names and DOB are identical to those on the identification band. • If the patient is unable to state and spell their name, ask a parent, guardian or carer (if present and able to do so) to verify the patient’s identity; ensure that the stated family name and given name and DOB are identical to those on the identification band.

Element	How it is defined
Double independent checking	A defined process where two clinicians individually and without requiring direct involvement of each other, check the prescription, patient and blood component identification, and blood component characteristics (including expiry, compatibility and special requirements, if any). This process must ensure that each clinician is individually satisfied that, and responsible for, the correct component is transfused in the correct way to the correct patient. The clinicians must agree before the transfusion is commenced. (ANZSBT Guidelines for the administration of blood products 3rd edition,2024)
DOB	Date of birth
MRN	Medical record number
EMR	Electronic medical record
ID	Identification
Shared checking	This occurs when one staff member reads information from one source e.g. the patient ID band while the other staff member reads the same information from another source e.g. the prescription. In this case each person has not independently fulfilled the requirements for patient identification. This is not recommended as safe pretransfusion checking.
Family name	Surname or last name
Given names	First name and/or middle name

Double independent pretransfusion check

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I check and YOU check

Two authorised staff complete the following checks:

√ Independently

√ At the patient's side

√ Immediately before the transfusion

Step 1
Patient Identification

- Ask the patient to state & spell their name and date of birth
- Check it matches the patient's identification (ID) band
- Check the patient ID + medical record number (MRN) on the ID band matches the compatibility label on the component
- Check the patient ID + MRN on the ID band matches the prescription (paper / electronic)

Step 2
Product and prescription details

- Check the patient blood group is compatible with component blood group
- Check the donation number on the Lifeblood label = donation number on compatibility label
- Check the component prescribed is the component received
- Check the component is within expiry date
- Check the crossmatch is within expiry date (RBC only)

Step 3
Pack check

- Check the pack is intact – no leaks
- Check there are no visible clots
- Check there is no discolouration

ANY discrepancy – clarify / rectify and then recheck

If both staff are independently satisfied that the correct component is being transfused to the correct patient in the correct way, the transfusion can commence

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https://www.health.vic.gov.au/patient-care/resources-and-education-blood-transfusion

References

Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. – version 2. Sydney: ACSQHC; 2021. Accessed Nov. 12, 2024. [Online] Available: https://www.safetyandquality.gov.au/sites/default/files/2021-05/national_safety_and_quality_health_service_nsqhs_standards_second_edition_-_updated_may_2021.pdf

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BloodSafe SA EMR Double independent check video <https://vimeo.com/599951929/ee654d8e61>

Double Independent Checking: Transfusion - Clinical Excellence Commission New South Wales information sheet https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0006/476520/Information-for-Clinicians-Double-Independent-Checking-BW.pdf

Patient identification and pretransfusion checking video <https://vimeo.com/303045235>

Pre-transfusion check (non EMR) poster <https://www.sahealth.sa.gov.au/wps/wcm/connect/39312629-55c8-4e8b-aebe-3b86a4a21945/Pre-Transfusion+Check+non+EMR.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-39312629-55c8-4e8b-aebe-3b86a4a21945-p7.2NBt>

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