



LABELLING A BLOOD SAMPLE FOR BLOOD TRANSFUSION Theory Booklet (Version 2)



Full Name of member of staff:	Name of Marker:
Job Title: Band:	Job Title: Band:
Ward / Department:	Ward / Department:
Ext Number/Bleep:	Ext Number/Bleep:
Signature of Member of Staff:	Signature of Marker: (only sign if achieved 90% or above)
Date Completed:	Date Passed: (Achieved 90% +)

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Version 2
 Review June 2015

Introduction

In November 2006 the National Patient Safety Agency (NPSA) released Safer Practice Notice 14. This document charges all NHS and independent sector healthcare organisations “to have implemented an action plan for competency-based training and assessment for all staff involved in blood transfusions”. In addition to passing the competencies, practitioners need to be able to prove that they have undertaken some formal training in handling blood and transfusing blood components.

All staff involved in sample collection should be competency assessed to NPSA SPN 14 (2006) standards.

To remain compliant with the NPSA Safe Practice notice 14 this competency should be repeated every 3 years unless you do not label samples for blood transfusion on a regular basis the competency should be repeated more frequently

This workbook has been designed to guide you through the relevant information to enable you not only to pass your blood transfusion competencies, but also to have a more in-depth understanding as to the rationale behind these competencies. It is vital that you undertake your own research in order to be able to complete the workbook. Suggested learning resources can be found in the reference section at the end of the booklet. There are alternatives to demonstrate competency-based training; you will need to discuss the options available in your Trust with your Transfusion Practitioner.

Do not complete this workbook if you have not completed the Trust venepuncture course.

All workbooks will be marked; the results will be fed back and will also be held centrally. Candidates will not be eligible to undertake the competency assessments until the workbook has been completed and a pass rate of 90% or more achieved. Candidates who fail to achieve 90% will be shown where they have gone wrong, and will have to re-submit the workbook.

Completion of this competency will enable the practitioner to label a blood sample for group and save (G&S) and cross – match.

Key elements of this competency are:

- Correctly identifying the patient when taking blood samples for pre transfusion compatibility tests.
- Understanding the minimum requirements on the blood sample and request forms.
- How to correctly label a blood sample.

Links to KSF – C1, C2, C3, C5, HBW 5, HBW 6, HBW7, G1

Please read the whole document prior to answering the questions

1) Ensuring Safety in Practice

When obtaining a venous blood sample from a patient you have a responsibility to ensure safety for your patient, yourself and all others who may be in the clinical environment. The key to ensuring safety is to be fully prepared before approaching the patient. Safety equipment includes Personal Protective Equipment (PPE) such as apron, gloves and protective eyewear if blood likely to splash. Other essential equipment includes a rigid tray to carry the blood sample equipment such as a vacutainer and needle sample bottles Request form skin cleaner tourniquet tape gauze ...and a portable sharps bin.

It is important to approach patients calmly and confidently when undertaking venepuncture procedures. Ensure that the patient's arm is well supported (e.g. with a pillow or arm rest) and that the patient is comfortable before commencing the procedure. Patients who are needle phobic require a particularly sensitive approach. These patients may sometimes jerk their arm away (hence the supportive pillow) and are prone to fainting (also known as a vaso-vagal episode or syncope) and it is important to ensure that they will not fall and hurt themselves should this happen.

NB. If you have a bed or a trolley nearby you might want to lie the patient down if they are likely to faint.

If a patient sitting in a chair reports feeling faint, place your chair directly in front of them and get them to lie forward on to your lap, this will enable blood to reach their brain faster and you will be able to prevent them from falling. (If the patient is an outpatient ensure you are familiar with the 'Procedure for patient collapse')

It is vitally important to maintain strict infection control measures such as washing your hands and following your hospital policy on cleansing skin prior to venepuncture. (Refer to the Trust Infection Control Policy)

Q.1a. What protective equipment is required to perform venepuncture safely?

1.

2.

3.

(3)

Q.1b. Name two actions that make venepuncture safer for patients who are needle phobic.

1.

2.

(2)

Q.1c. List the essential items you need to take to the patient's side to obtain a venous blood sample.

1.

2.

3.

4.

5.

6.

(6)

SERIOUS HAZARDS OF TRANSFUSION **SHOT**

Sample errors are nationally the most frequent near miss events reported to SHOT (Serious Hazards of Transfusion). These can include that the sample is taken from the intended patient, but labelled with another patient's details. Conversely the sample can be taken from the wrong patient and labelled with the intended patient's details. Other cases include those that are not fully labelled or which have one or more identifiers that belong to another patient.

In 2010 SHOT (Serious Hazards of Transfusion) reported 3 incidents of:

'Wrong Blood in Tube'. In these cases an incorrect patient was bled either for haemoglobin estimation or for a group and save/crossmatch sample and both cases resulted in incorrect or inappropriate transfusion. One case resulted in ABO – incompatible transfusion and another in D – incompatible transfusion. Four cases resulted in the wrong patient being transfused as the haemoglobin was actually that of another patient.

2) Patient Identification

Obtaining venous blood samples can be described as a 'Critical' task because the risk of making a mistake with patient identification at this stage can lead to patient death

It is important to identify the correct patient BEFORE drawing the blood sample.



All in-patients must wear an identification wristband/band with the Patient Minimum Dataset of: first name, surname, date of birth and unique patient identification number. (Hospital Number, NHS Number, Major Incident Number, A & E Number)
The request form should be checked against the wristband and checked and found to match, the form should also be checked to confirm it has been correctly completed by the requester, before the sample is taken

When obtaining venous blood samples from **all** patients, it is vitally important that you ask them to state their first name, surname and Date of Birth. This is known as **positive verbal identification**. You must not say the patient's name for them, i.e. 'are you Mrs. Smith?' because there is still a risk of patient misidentification. Therefore:

Positive identification of the patient is essential based on:

- Questioning the patient by asking their First name, surname and date of birth in the case of patients who are judged capable of giving an accurate, reliable response.
- Checking that the details on the patient's identification wristband match those on the request form and the answers to the questions above.
- Do not proceed unless all details match.
- **NO WRISTBAND NO SAMPLE** (Unless being bled by the phlebotomist in the outpatient/ phlebotomy department) in which case patient ID must be shown before the sample is take, such as an outpatient appointment letter/card to identify you have the correct patient against the correct request form.

If the patient cannot respond, is unconscious or a child, check the identification information on the wristband with the information on the request form and match, It is good practice to verify the identification with a second member of staff in these circumstances or a relative such as a parent/spouse, if present.

If a patient is admitted to the Emergency Department and is unidentified, then gender and unique patient ID number should be used at all times and a wristband with these details attached to the patient immediately.

Sample errors 409 reported cases: There were 386 cases due to Wrong Blood In Tube (WBIT). The remaining 23 errors related to samples being labelled incorrectly (omissions or errors in patient identifiers), which were not rejected at booking but were detected at a later stage in the process. Of 386 reports, the majority of samples were taken by a doctor, and in all but 4 cases these events could have been prevented by ID of the patient at the bedside at the time of blood sampling. Instead, reliance was placed on case notes, request forms or prescription charts that did not belong to the patient in question, for patient ID.

Blood samples must only be taken from one patient at a time to minimise the risk of error, all the patient's blood samples should be fully labelled at the patient's side immediately after taking the sample and before going on to do anything else. Remember, this is a critical task, do not allow yourself to be distracted.

Blood sample tubes must never be pre-labelled; British Committee for Standards in Haematology (BCSH Dec 2009) identifies this practice as a major cause of identification errors, leading to fatal transfusion reactions.

A nurse was instructed to take a blood sample from the patient in Bed 2. She was given no documentation and continued to label the sample with the information contained in the notes for that bed number. However, it was not appreciated until later that a different patient was now occupying Bed 2 and that the request should have applied to the patient in Bed 3.

During a trauma call, a doctor sampled the patient and gave the sample to a second person, verbally confirming the name and date of birth of the patient. This second person interrogated the PAS but selected a patient record with the same forename and family name but with a one digit difference in the date of birth, which was used to identify the sample.

Q.2a. What is the patient minimum data set obtained verbally from the patient to ensure positive identification of a conscious patient?	
1)	3)
2)	
(3)	

Q.4b In an emergency, the sample tube can be labelled away from the bedside after the blood is taken.
<i>TRUE / FALSE</i> (1)

Q.4c What details should be recorded on the sample tube and request form?	
1.	2.
3.	4.
5.	6.
7.	8.
(8)	

Q.4d What action would you take if the patient details on the request form did not match those the patient verbally gave you?	
1.	
2.	
(2)	

Q.4e State 5 precautions that avoid patient misidentification when obtaining venous blood samples. e.g who where and when is the sample labelled, what details are checked and how?	
1.	
2.	
3.	
4.	
5.	
(5)	

Practices leading to WBIT

Examples of how incorrect patient ID occurred, which could have been prevented by ID of the patient at the bedside, include:

- ■ Sample labelled by a second person away from the bedside.
- ■ Incorrect patient record selected on PAS in A&E.
- ■ Sample labelled with information from the incorrect prescription chart.
- ■ Sample labelled with information from the incorrect request form.
- ■ Sample labelled from the information given in the incorrect notes:
 - Wrong notes obtained from medical records on patient admission, 1 of which was only discovered when the patient entered the day case theatre.
 - Wrong notes selected by phlebotomist – patient was either in a different bed number than had originally been allocated or the notes had been filed against a different bed number.
 - Another patient's addressograph labels were filed in the notes that were used to identify the patient.

There were 4 cases where the error in patient identity could not have been detected by the phlebotomist:

- ■ Identity theft: a young male arrived unconscious in A&E and a driving licence found in his wallet was used to identify him for blood samples. However, when his parents arrived it transpired that the driving licence belonged to his older brother.
- ■ The records of 2 patients with the same name and date of birth had been merged within the Trust, only 1 of whom had a historic blood group.
- ■ 2 cases where patients shared the NHS number with another patient.

Q.4f If an emergency arises as you are labelling your patient's blood samples, e.g. another patient collapses in front of you, and you are forced to leave the 'critical task' of labelling, state what action you would take after the emergency is under control.

A.

(1)

- Ensure blood samples are sealed correctly to protect all staff that may handle them in the laboratory.
- Send blood samples in the most appropriate manner depending on the urgency of the request. Ensure the runner is aware the sample is to be delivered urgently.
- If urgent, then the transfusion laboratory should be notified by telephone. Instigate the Major Haemorrhage protocol if necessary. Ext 7080 (Refer to trust Guidelines for 'Initiating a Massive/Major Haemorrhage').
- Ensure the specimen bag which contains the sample also contains the completed request form.
- Ensure the red sample bags are used where applicable.

Q.5. If the sample was urgent how would you ensure its safe and efficient transport to the laboratory?

1.

2.

(2)

Q6 In the event of a major blood loss/haemorrhage which department would you call what is the extension number 24/7?

A

(2)

Useful Contact Numbers

Maria O'Connell, Specialist Practitioner of Transfusion
Phone 01268 524900
Ext 8114
Bleep 6271
maria.o'connell@btuh.nhs.uk

Blood Transfusion laboratory:	Ext 3535
Out of Hour's contact	Ext 7080
Major Blood Loss/Haemorrhage	Ext 7080
Chief in Blood Transfusion	Ext 4989
Senior BMS	Ext 3535

Alternatively seek advice from the Doctor or

Haematology Consultant who can be contacted: Bleep 6133 During Core Hours via switchboard out of hours.

If you should require any advice or assistance regarding taking a blood sample and labelling for blood transfusion please contact the following people:

David Stokes Manager (only if unable to contact any of the above)

OUT OF HOURS CONTACT Ext 7080

References

British Committee for Standards in Haematology (BCSH) (Dec 2009)
Guidelines for the administration of blood and blood components and the management of transfused patients.
Transfusion Medicine; 9, 227-239
<http://www.bcshguidelines.com>

McClelland, D. B. L (Ed) (2005)
Handbook of Transfusion Medicine (4th edition)
London:TSO
<http://www.transfusionguidelines.org.uk/>

Serious hazards of Transfusion (SHOT), Report 2010
<http://www.shotuk.org/>

NPSA Safe Practice Notice Notice, NPSA/2008/SPN14.
Right Patient Right Blood November 2006:advice for safer blood transfusions.