Government of Newfoundland and Labrador

Department of Health and Community Services
Provincial Blood Coordinating Program

POSITIVE RECIPIENT IDENTIFICATION	NLBCP-064

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Overview

Both the World Health Organization and the Joint Commission on Accreditation of Healthcare Organization have identified that patient misidentification is contributive to be causative of many medical errors. Serious complications during transfusion, including morbidity or mortality, can occur if patient misidentification occurs throughout any step of the transfusion process.

If incompatible blood is administered in a transfusion, the donor cells are treated as foreign invaders, and the patient's immune system attacks them accordingly, rendering the blood transfusion useless. An incompatibility can potentially cause a massive activation of the immune system and clotting system, which can perpetuate: shock, kidney failure, circulatory collapse, and death. Preventable 'wrong blood into patient' incidents are most often caused by human error and may cause fatal reactions due to ABO incompatibility.

Most mis-transfusion incidents are caused by identification errors which may occur at the time of pre-transfusion blood sampling, sample handling in the laboratory, collection of the component from the blood bank, or transfusion to the patient.

Positive recipient identification (PI) at all stages of the transfusion process from specimen collection, testing, and administration is essential.

Note: For the process of transfusion of blood components and administration of blood products, the term "Recipient" is used by the NL Blood Coordinating Program. The Regional Health Authorities (RHA) may use the term patient, client, resident, or recipient.

Policy

1. Continuous and unequivocal identification of the recipient and blood component or blood product shall be established from the sample collection through to transfusion.
2. At least two identifiers are used before providing any service or procedure. Identifiers include:
   - 2.1. Recipient's full name and date of birth;
   - 2.2. A unique identification number (e.g. MCP); and
   - 2.3. An authenticated photograph (e.g. driver's license, passport, resident photo ID, Government issued photo ID).

3. The RHA shall have a policy for positive recipient identification. The requirements of the RHA for patient identification must be satisfied.
4. The RHA shall have operational procedures for positive recipient identification whereby the recipient's identity is unknown, or in requirement of emergency transfusion situations.
5. The RHA shall establish a process for positive recipient identification for those individuals with no personal identification and/or those who are unable to communicate. When the patient and families are not able to provide this information, other sources of identifiers can include identification bands, health records, or government-issued identification. Two identifiers may be taken from the same source.
6. Prior to initiating a blood component/blood product transfusion, two health care providers (or one healthcare provider and an electronic identification system) shall, in the presence of the recipient, positively identify the recipient using two unique identifiers.

   6.1. The compatibility label/tag shall remain attached to the blood component or blood product until the transfusion is complete.
7. In the event of any discrepancy identified in the identifying information, the component/product is not transfused/ administered until the discrepancy is resolved.

Procedure

1. The prescriber will ensure the order for transfusion/administration of blood components/products includes the recipient's family and given name as well as a unique identification number.
2. Blood products and/or blood components to be obtained from the blood bank will be released upon completion of the following verifications:

   2.1. Request (electronic, verbal, or written) from the unit (with location) requiring the product/component has been received in blood bank.

   2.2. Porter/nurse will provide the recipient's name and unique identification number on arrival to the blood bank, in accordance with the RHA's policy (e.g. label with recipient name and MCP).
3. In preparation for transfusion, in the presence of the recipient, the transfusionist shall confirm and document that all identifying information linking the recipient and the blood component/product matches. This includes:

   3.1. The recipient (if able) will state his/her full name and date of birth.

   3.2. Verify the **recipient name** and unique **identification number** are an **identical** match (at a minimum) on:

- Recipient's identification band; and
- Issue/transfusion card.

3.3. Verify the **unit number** on the blood component or blood product tag is an **identica**l match on:

- Issue/transfusion card; and
- Compatibility label/tag.

3.4. Verify crossmatch details:

- ABO group;
- Rh type;
- Crossmatch interpretation;
- Special requirements/modifications, if applicable;
- Expiry date; and,
- Exceptions to compatibility (if any) are documented.

4. The transfusionist will verify and document that all identifying information linking the recipient and the blood component matches for **each** unit/dose at the time of **each** transfusion/administration.

Key Words

Identification, positive patient, transfusion, recipient

References

Accreditation Canada. (2016). Routine Operating Procedures Handbook. Pg. 17. Accreditation Canada, Ottawa. https://accreditation.ca/sites/default/files/rop-handbook-2016-en.pdf

Campbell, K., Muniak, A., Rothwell, S., Dempster, L., Per, J., & Barr, K. (2015). Improving Quality and Safety through Positive Patient Identification. Healthcare Quarterly, 18(3), 56- 60. doi: 10.12927/hcq.2015.24431

Canadian Society for Transfusion Medicine. (2017). CSTM Standards for hospital transfusion service. Version 4. Ottawa, ON: Author.

Canadian Standards Association. (2020). Blood and blood components, Z902:20. Mississauga, ON: Author.

Dean L. (2005). Blood transfusions and the immune system. In L. Dean, Blood Groups and Red Cell Antigens. Bethesda, MD: National Center for Biotechnology Information. Chapter 3. http://www.ncbi.nlm.nih.gov/books/NBK2265/

Joint United Kingdom Blood Transfusion and Tissue Transfusion Services Professional Advisory Committee. (2020). Transfusion Handbook: Safe Transfusion – right blood, right patient, right time and right place. Chapter 4. https://www.transfusionguidelines.org/transfusion-handbook/4-safe-transfusion-right-blood-right-patient-right-time-and-right-place

Maynard, K. (2014). Administration of Blood Components. In M. K. Fung, B. J. Grossman, C. D. Hillyer, & C. M. Westhoff (Eds.). Technical Manual (18th ed.). pp. 546-551. Bethesda, MD: AABB Press.

Stout, L., & Joseph, S. (2016). Blood Transfusion: Patient Identification and Empowerment. British Journal of Nursing, 25(3), doi.org/10.12968/bjon.2016.25.3.138