

# Patient Safety Alert

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## CORRECT PATIENT IDENTIFICATION PRIOR TO BLOOD TRANSFUSION

Ensuring correct patient identification at all times is fundamental to the delivery of safe health care. Using person specific identifiers to confirm that patients receive the service or procedure intended for them can avoid harmful incidents such as allergic reactions, medication errors, and wrong person procedures (adapted from Accreditation Canada).

### RECOMMENDATIONS

The Ministry of Health recommends:

- **All regional health authorities and health care organizations must have a process in place to ensure correct patient identification prior to administering blood products. The process will include at least two person specific identifiers are used to confirm the patient receives the procedure intended for them.**
- **The process will be in accordance with applicable standards from *Canadian Standards Association and Accreditation Canada*. Appropriate staff will be trained in the process and comply with the process.**

Supporting Documents:

1. Canadian Standards Association – Blood and Blood Components CSA Z902-15 (See 10.2.1)
2. Accreditation Canada Required Organizational Practices 2017 (v2) – Client Identification

### **Background of the Critical Incident**

A blood transfusion was ordered for patient A. Due to the high volume of patients on the unit, a relief nurse was called in. The regularly scheduled nurses were in the process of checking the transfusion tag for patient A against the physician order. Once completed, the regularly scheduled nurses accepted the offer of the relief nurse to hang the blood at the bedside and initiate the transfusion. This allowed the regularly scheduled nurses to take their break.

The relief nurse attended to patient B who was in the bed next to patient A to initiate the transfusion. The relief nurse explained the procedure to patient B and their companion who did not question the transfusion. The transfusion tag showed it had been checked against the physician order in the chart of patient A by two nurses and the tag signed. The relief nurse did not check the blood tag to the patient identification band prior to initiating the transfusion. Almost immediately, the relief nurse recognized

patient B was not the same patient identified on the transfusion tag and stopped the transfusion. Patient B received a blood transfusion, estimated to be 5 ml, which had not been ordered and for which patient B had not been cross matched. Patient B's blood type was compatible with the transfused blood type and did not experience an adverse event at the time.

### **Analysis**

The critical safety task of verifying the patient identification prior to administration of the blood product was broken up into two incomplete tasks and more importantly, not performed at the patient's bedside. Each nurse did a segment of the safety check, however, no one person had performed one complete safety check as described in the region's policy.

The order in which the safety check occurred increased the likelihood that an error in patient identification could happen. If an appropriate check (label – order – ID band) by a nurse was completed at the bedside followed by another check by a second nurse at the bedside, any error in patient identification would likely have been detected and corrected prior to administration of the blood.

### **Contributory Factors**

There were two patients with similar clinical concerns located side by side in the same room.

The relief nurse who initiated the transfusion was called in to work and did not receive shift report and therefore was not familiar with the specific care plans of the patients. From the relief nurse's brief knowledge, a blood transfusion for patient B was within reason.

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Patient safety alerts may be issued by the Ministry of Health following the review of at least one critical incident reported to the Ministry. A critical incident is defined as a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a regional health authority, Saskatchewan Cancer Agency or health care organization.

The purpose of a patient safety alert is to recommend actions that will improve the safety of patients who may be cared for under similar circumstances. Recommendations are intended to support the development of best practices and to act as a framework for improvement and can be adapted to fit the needs of the health service organization. When possible, policies or initiatives that have been developed by RHAs or the Saskatchewan Cancer Agency will be shared, to encourage adoption of similar policies or actions.

issuing facility and the receiving facility in maintaining traceability of the blood component to its final disposition.

### 9.5.3 Within a facility

Operating procedures shall be in place that clearly define

- a) individuals who may sign out blood components from the transfusion service and transport them to the recipient's location;
- b) transportation conditions and acceptable time frames for blood components to be in transit;
- c) acceptable time frames from the time blood components are released from the transfusion service until the time the transfusion is completed (Clauses 11.4.5 and 11.4.6 shall apply); and
- d) appropriate processing and storage procedures.

## 10 Requests, pre-transfusion testing, selection of components, and acceptance criteria

### 10.1 General

#### 10.1.1

The facility shall have operating procedures for acceptance of blood components into the facility.

#### 10.1.2

The facility shall have operating procedures for

- a) the management of requests for blood components;
- b) pre-transfusion testing of the recipient;
- c) pre-transfusion testing of the blood components intended for transfusion;
- d) the selection of blood components for use; and
- e) confirming essential identifying information at time of pickup (See Clause 10.2.4).

These procedures shall be consistent with the requirements in Clause 10.2 to 10.10 and shall be maintained as specified in Clause 4.6.1.6.

### 10.2 Requests

#### 10.2.1

Requests for blood components shall be documented and shall contain sufficient information to allow for unequivocal identification of the recipient. Verbal requests may be accepted in emergency circumstances but shall be followed up with the appropriate written or electronic documentation. The request shall include at least the following information:

- a) the first and last names of the recipient or equivalent information if these are not available (see Clause 10.2.2);
- b) the identification number of the recipient or equivalent information if this is not available (see Clause 10.2.3);
- c) the recipient's location;
- d) the blood component being requested;
- e) the required volume or quantity of the component; and
- f) special requirements, if any.

### 10.2.2

If any of the information required by Clause 10.2.1 is incomplete, inaccurate, or illegible, the request shall not be accepted by the transfusion service unless an alternative procedure, as provided for in Clauses 10.2.5 and 10.2.6, is being used.

### 10.2.3

The request should also include the clinical indication for the blood component.

### 10.2.4

The operating procedures for pickup of blood components shall include steps to ensure there is sufficient information to link the blood component with the request and the intended recipient. Blood components shall not be released for pickup without the necessary information, which shall include at least the following:

- a) full name of the recipient;
- b) recipient identification number; and
- c) name of the blood component or product being issued.

### 10.2.5

There shall be an operating procedure concerning recipient identification in emergency transfusions and for other situations where the patient's identity is unknown.

*Note: Such situations can occur in emergency rooms*

### 10.2.6

There shall be unequivocal identification of the recipient before drawing blood samples for pre-transfusion testing. This shall include verification of the recipient's identification number or, if this not available, the alternative procedure in Clause 10.2.7 shall be used. If inaccuracies or discrepancies are discovered during the identification process, blood samples shall not be collected until the inaccuracies or discrepancies have been satisfactorily resolved.

### 10.2.7

There shall be a written procedure for the establishment of positive identification in situations where recipients do not have an identification number.

*Note: Such circumstances can occur in instances where specimens are drawn outside of the health care facility or when pre-operative tests are performed on an outpatient basis.*

## 10.3 Recipient blood samples

### 10.3.1

The name, initials, or computer identification code of the person drawing the blood sample shall be documented, as well as the date and time of collection. This information shall be retained for one year in a place where it can be readily retrieved if needed (e.g., the patient's chart or the transfusion record or the written or electronic request for the sample).

### 10.3.2

At the time of blood sample collection, in the presence of the recipient, the tube shall be labelled with the recipient information. The recipient information on the label shall include at least two identifiers, one of which shall be the recipient name. The person taking the sample shall verify that the information on the label of the sample matches the identity of the recipient. All documentation that accompanies a

## CLIENT IDENTIFICATION

*This ROP is found in most service-based sets of standards, see table on page 71.*

**Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.**

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### GUIDELINES

Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.

The person-specific identifiers used depend on the population served and client preferences. Examples of person-specific identifiers include the client's full name, home address (when confirmed by the client or family), date of birth, personal identification number, or an accurate photograph. In settings where there is long-term or continuing care and the team member is familiar with the client, one person-specific identifier can be facial recognition. The client's room or bed number, or using a home address without confirming it with the client or family, is not person-specific and should not be used as an identifier.

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., "What is your name?"). When clients and families are not able to provide this information, other sources of identifiers can include wristbands, health records, or government-issued identification. Two identifiers may be taken from the same source.

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### TESTS FOR COMPLIANCE

Major At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.

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### REFERENCE MATERIAL

- Allworth, S., Lapse, P., Kelly, J (2008). Technology Solutions to Patient Misidentification - Report of Review. Australian Commission on Safety and Quality in Health Care. Sydney, Australia. [www.safetyandquality.gov.au/wp-content/uploads/2012/01/19794-TechnologyReview1.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/19794-TechnologyReview1.pdf)
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