Policy

Minimum Patient Identification Requirements for Pre-Transfusion Testing

NSWHP_PD_009

1. Purpose

1.1 To standardise the minimum patient identification and laboratory acceptability requirements for pre-transfusion testing in NSW Health Pathology.

2. Background

2.1 Numerous errors can occur during the collection and handling of blood specimens which pose significant and avoidable risk to the patient [7].

2.2 The consequences can be particularly serious in blood transfusion if identification errors result in a transfusion specimen containing another patient's blood.

2.3 It is essential that the patient and specimens are accurately identified.

2.4 This policy is based on Australian and New Zealand Society of Blood Transfusion and National Pathology Accreditation Advisory Council Guidelines and the NSW Health Blood – Management of Fresh Blood Components Policy Directive PD2012_016.

3. Scope

3.1 This policy is mandatory and applies to all NSW Health Pathology staff involved in the provision of pre-transfusion testing.

4. Policy Statement

4.1 Minimum Patient Identification Requirements for Blood Collectors

4.1.1 All staff collecting the specimen must be trained in collection procedures [3] and have completed Bloodsafe e-Learning Collecting Blood Specimens [6].

4.1.2 The patient's identity must be positively confirmed at the time of specimen collection by direct enquiry as follows:

a) If conscious and rational, the patient must be asked to:
   i. State and spell their full name
   ii. State their date of birth and
   iii. Confirm their address if used as an identifier[4].

b) For hospital inpatients:
   i. The patient details recorded on the specimen and request must be checked against their hospital identification wristband[4].
   ii. If an inpatient does not have a hospital identification band, a specimen should not be collected until this situation has been remedied or the patient has otherwise been appropriately identified[4].

c) Where discrepancies exist between patient identifiers in the Electronic Medical Record, wristband and on request forms/labels:
   i. Clerical errors or variations must be resolved before the specimen is collected
   ii. Electronically truncated long names should have accepted spelling verified with the patient. The request form must include the name spelled correctly and include characters, handwritten by the collector if necessary.

4.2 Request Form

4.2.1 The request form must clearly, and legibly, identify the patient with three unique patient identifiers:
a) Full name - both family and given name or names
b) Date of birth
c) Medical Record Number (MRN) [4].

4.2.2 If an MRN is not available, for example where the request originates outside of the hospital setting, the patient's address may be used as an alternative identifier [4].

4.3 Specimen

4.3.1 The specimen must be clearly and legibly labelled with the patient's details[4] as follows:

a) Handwrite patient details [Pre-printed addressograph (or similar) labels are not recommended but may be accepted at the discretion of the laboratory director]. [4].
b) Label the specimen tube immediately following collection and before leaving the patient [1, 4]. [If possible, the patient identifiers should be confirmed by the patient[2].]
c) The patient identifiers recorded on the request and specimen label must both agree [4].
d) When labelling the specimen three patient identifiers should be present where practicable. At least two identifiers must be used and must include the full name and at least one of either date of birth or MRN [2, 4].
e) Include the date and time of collection and the collector's name/initials/signature [1, 2 4] [must be the same person completing the collector's declaration on the request] [4].

4.3.2 At the time of collection of the specimen:

a) Two people, one of whom may be the patient, must check the name of the person from whom the specimen was collected against the name written on the specimen tube to ensure that they are identical [2 3].
b) If the patient is unconscious, irrational or unable to respond to direct questioning, the patient's responsible person, or a second staff member, must confirm the patient's identity [3].

4.3.3 Staff should refer to CLSI Collection of Diagnostic Venous Blood Specimens [7] where more detailed guidance on patient identification scenarios is required.

4.4 Minimum Acceptability Requirements for Laboratories

4.4.1 Specimens must be checked on receipt and laboratory staff must ensure that:

a) Three patient identifiers are present on the request form [2, 4].
b) The specimen is clearly and legibly labelled with the patient's details [4]. There must be no doubt as to the integrity of the labelling [4].
c) At least two patient identifiers are present on the specimen and must include full name and at least one of either date of birth or MRN [2, 4].
d) The specimen includes the collector's name/initial and date and time of collection[1, 2, 4].
e) The request form includes a signed collector declaration[1, 4].
f) The requestor and collector are identified [1, 2]. If absent, the requestor's name may be added at this time by the laboratory staff member.

g) There is concordance between identifiers on request form and the specimen label [2].
h) For electronically truncated long names the request form must include the full correctly spelled name. Where a name is truncated on the request form or specimen, specimen acceptance must be authorised by a Haematologist or authorised delegate.

4.5 Specimen or Request Acceptance and Rejection by Laboratories

4.5.1 NSW Health Pathology has zero tolerance of unacceptable transfusion specimens or requests.

4.5.2 Unacceptable transfusion specimens or requests that do not meet the above minimum requirements must be rejected and retained by the laboratory. They must not be used for subsequent pretransfusion testing.

4.5.3 The laboratory staff member checking and accepting the specimen or request must be identifiable.

4.5.4 Immediately after deciding to reject the specimen or request, laboratory staff must:

a) Contact the collector or medical/nursing staff involved with care of the patient to advise that:

i. The specimen or request has been rejected and give the reason and
ii. This policy requires that a new sample/request must be submitted to perform testing.

b) Record the details of the rejection notification.

4.5.5 If circumstances do not allow sufficient time for corrective action to meet the immediate needs of patient care, universal donor (group O) uncrossmatched blood can be offered for use in the interim.

4.5.6 Each Electronic Medical Record and Laboratory Information System has limitations in both the storage based on the fields in each database and the display of patient names, based on the dimensions of labels (used for specimens, products and wristbands).
Where a name is truncated on the request form or specimen, specimen acceptance must be authorised by a Haematologist or authorised delegate.

5. Roles and Responsibilities

5.1 All NSW Health Pathology staff involved in the provision of pre-transfusion testing must comply with this policy.

5.2 Each NSW Health Pathology site involved in provision of pre-transfusion testing must have effective systems in place to enable compliance with this policy.

5.3 Operations Directors must ensure that:

a) The requirements of this policy are applied, achieved and sustained

b) All staff are made aware of their obligations in relation to this policy and

c) All staff receive appropriate training to enable them to carry out their obligations in relation to this policy.

6. Legal and Policy Framework

1 NPAAC Requirements for Transfusion Laboratory Practice Fourth Edition 2019 (Tier 4)
http://www.health.gov.au/internet/main/publishing.nsf/Content/npaac-pub-transfusion

2 NPAAC Requirements for Medical Pathology Services Third Edition 2018 (Tier 2)
https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-npaac-docs-medpathserv-2018

3 NSW Health Blood – Management of Fresh Blood Components Policy Directive PD2018_042
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2018_042.pdf

4 ANZSBT Guidelines for Transfusion and Immunohaematology Laboratory Practice 1st Edition, revised January 2020
https://anzsbt.org.au/wp-content/uploads/2021/04/Guideline_-for_Transfusion_and_Immunohaematology_Laboratory_Practice_FINAL_Published_20210426.pdf

5 Identification Errors Involving Clinical Laboratories. Valenstein et al. Archives Pathol Lab Med, Vol 130, Aug 2006 https://pubmed.ncbi.nlm.nih.gov/16879009/

6 Bloodsafe e-Learning
https://www.bloodsafelearning.org.au

7 CLSI GP41 Collection of Diagnostic Venous Blood Specimens: Approved Standard – 7th Edition
https://clsi.org/media/1372/gp41ed7_sample.pdf

8 Medical Testing ISO 15189:2022
https://nata.com.au/files/2021/05/ISO-15189-Application-Document-Medical-Testing-Supplementary-Requirements-for-Accreditation.pdf

7. Review

This policy will be reviewed by 20/11/2025.

8. Risk

Risk Statement	If a transfusion specimen containing another patient's blood occurs due to an identification error the consequences could result in major harm to the patient.
Risk Category	Clinical Care and Patient Safety

9. Further Information

For further information, please contact:

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10. Version History

The approval and amendment history for this document must be listed in the following table:

Version No	Effective Date	Approved By	Approval Date	Risk Rating	Sections Modified
1.0	31/05/16	NSWHP ELT	31/05/16	High	New Policy.
2.0	30/08/2018	Clinical Governance Quality and Risk Committee	30/08/18	High	4.1.4 (e) and 4.2.1 (f) removed. Minor wording changes throughout.
3.0	28/09/2018	Policy Sponsor	28/09/18	High	Minor grammatical error at 4.3.1 e)

4.0	01/02/21	Executive Director Strategy & Transformation	01/02/21	High	4.1.2 (c) Discrepancies between patient identifiers added 4.4.1 (h) & 4.5.6 Electronically truncated names authorisation added 6.4 ANZSBT Guidelines updated 7. Review date updated
5.0	16/08/21	Director of Clinical Operations	09/08/21	High	6.Legal and Policy Framework: Reference list and links updated for references 1,2,3,4,5 and 8.
6.0	20/11/2023	Director of Clinical Operations	20/11/2023	High	Re-templated and review date extended. Re-published without further change.
7.0	04/12/2023	Director of Clinical Operations	01/12/2023	High	Legal and Policy Framework point 8 reference updated from 2012 to 2022.