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Llywodraeth Cymru
Welsh Government

To: Medical Directors Health Boards & Trusts
Dean of the Medical Deanery
Dean of the School of Nursing
Dean of the School of Midwifery

September 2018

Dear Colleague

Labelling of pre-transfusion blood samples

ISSUE

The Blood Health National Oversight Group (BHNOG) has written to me to express concerns within the hospital transfusion community in Wales regarding the labelling of pre-transfusion blood samples. I have agreed to highlight their concerns with you regarding this serious issue.

BACKGROUND

The British Society for Haematology (formerly British Committee for Standards in Haematology) published *Guidelines for pre-transfusion compatibility procedures in blood transfusion laboratories* in 2012. One of the key recommendations was:

> *'Unless secure electronic patient identification systems are in place, a second sample should be requested for confirmation of the ABO group of a first time patient prior to transfusion, where this does not impede the delivery of urgent red cells or other components.'*

The rationale for this recommendation is:

> *'Safety of transfusion begins with collection of the sample. It has been estimated that 1 in 2000 samples is from the wrong patient, commonly known as 'wrong blood in tube' [WBIT] (Dzik et al., 2003; Murphy et al., 2004). SHOT [serious hazards of transfusion haemovigilance scheme] near-miss data confirm that this continues to be a serious problem (SHOT).'*

It is possible to identify a WBIT if a current patient sample is a different ABO or RhD group to a historical record on a hospital's Laboratory Information Management System (LIMS). If there is no historical record this is not possible. This is why it is recommended that a second sample for confirmation of the ABO group be taken from a 'first time patient' for whom a transfusion is being requested. **This ABO confirmatory sample must be taken at a separate phlebotomy**

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episode to the first sample, with all correct patient identification checks being performed for **both phlebotomy episodes**.

CONCERN

Evidence from investigations undertaken when a WBIT has occurred identifies a practice of taking two pre-transfusion samples in the same phlebotomy episode, with one of the samples being labelled with a different time.

I am aware that each of the health boards in Wales that provides transfusion laboratory services has a policy regarding ABO confirmation and the need for a check sample taken at a separate phlebotomy episode, prior to the issue of ABO and RhD grouped or cross-matched blood components for transfusion.

It is this policy that some sample takers would appear to be attempting to circumvent, undermining the safeguard this was designed to introduce.

ACTION

Having raised this concern, I would ask that you re-iterate the importance of full, correct and accurate documentation, from the perspective both of patient safety and professional accountability.

Please confirm that you have sought assurance from your Quality & Patient Safety Committee as appropriate.

Yours sincerely

DR FRANK ATHERTON