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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

16 July 2021

Dear Colleague

FOR ACTION: Updated guidance on Blood Transfusion Procedures with specific reference to patient identification. The Blood Health National Oversight Group (BHNOG) has reviewed the Guidance on Blood Transfusion Procedures with specific reference to patient identification in Wales and submitted this to Welsh Government. I am writing to notify you of this and the requirements set out in the attached guidance. (Doc 1)

Patient identification is essential in ensuring safe transfusion practice. Core patient identifiers that must be used at every step of the transfusion process

Positive patient identification (PPI) is a critical safety check; where possible patients must be asked to state their full name and date of birth as a minimum. Additional identifiers maybe required as per local policy. The Serious Hazards of Transfusion (SHOT)[3] Haemovigilance Scheme 9 steps of the transfusion process will be applied in Wales including the emphasis that PPI must occur at critical points of Sample Taking and Administration of blood products.

The collection of patient blood samples for pre-transfusion testing is a vital step in the blood transfusion process. It is essential that completion of the transfusion request form, collection of samples, labelling of samples and written verification of a full patient identification check is performed correctly in order to both ensure patient safety and maintain the quality patient identification during the transfusion process.

The attached ***quality requirements*** and criteria highlight essential aspects of the patient identification process and are mandatory. Application of these standards supports a unified approach to **zero tolerance** across Wales.

It supersedes guidance previously issued in WHC (2007) 042, in accordance with BSH guidance[1] and the Blood Health Plan[2].

Yours sincerely

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Doc 1. Transfusion Patient Safety – Patient Identifiers.

Transfusion Patient Safety - Patient identification

Highlights

- **Clarification of 'core' patient identifiers**
- **Emphasize critical points for positive patient identification**
- **Provides links to supporting resources**

Action

Chief executives to inform:

- Nursing directors
- Medical directors
- Transfusion practitioners
- Transfusion Lab Managers
- Clinical governance leads
- Service Managers
- Hospital Transfusion Committees

This document provides updated guidance on Blood Transfusion Procedures with specific reference to patient identification. It supersedes guidance previously issued in WHC (2007) 042, in accordance with BSH guidance[1] and the Blood Health Plan[2].

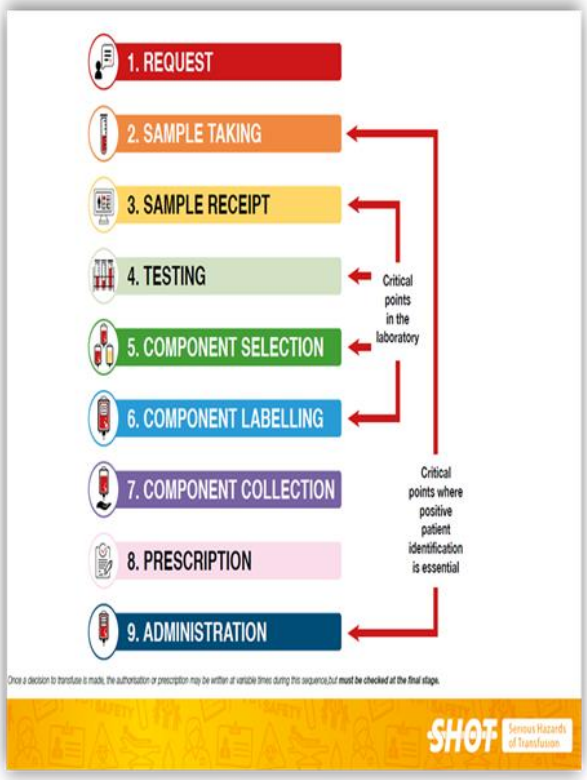
Patient identification is essential in ensuring safe transfusion practice. **Core patient identifiers** that must be used at every step of the transfusion process are:

- **Surname**
- **Forename**
- **Date of Birth**
- **Unique identification number** (NHS/hospital number)

Positive patient identification (PPI) is a critical safety check; where possible patients must be asked to state their **full name and date of birth as a minimum**. Additional identifiers maybe required as per local policy. The Serious Hazards of Transfusion (SHOT)[3] Haemovigilance Scheme 9 steps of the transfusion process (Figure 1) is applied in Wales including the emphasis that PPI must occur at critical points of Sample Taking and Administration of blood products.

Additional information and resources to support each step of the transfusion process in Wales are provided below.

1. **Request:** Authorisation for blood transfusion can only be made by qualified medical staff and Non-Medical Authorisation of Blood Transfusion (NABT)[4] practitioners
2. **Sample taking:** Should only be performed by health care professionals who are suitably trained and competency assessed[5] confirming that PPI matches the patient wristband and request form. **Sample labelling must occur at the patient's (bed) side.**



Steps 3-6 are critical within transfusion laboratories and covered in appropriate BSH guidelines.

7. **Component collection** Only suitable trained and competent staff should perform this duty[5]
8. **Prescription as described in step 1** and use of the All Wales Transfusion Record[6]
9. **Administration -** Only suitable trained and competent staff should perform this duty[1,5] confirming that PPI matches the patient wristband, blood component and All Wales Transfusion Record[6]

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Additional information

- All patients **receiving a blood transfusion MUST have a wristband containing the core patient identifiers.** This is true in both inpatient and outpatient basis.
- To ensure correct allocation of blood group to a patient it is necessary that their **blood group is tested on samples from TWO SEPARATE bleeding events[7].** Failure to do so can result in a Never Event of incompatible blood being transfused and serious patient harm.

References

1. https://b-s-h.org.uk/guidelines/guidelines/administration-of-blood-components/
2. https://gov.wales/nhs-wales-blood-health-plan-whc2017028
3. https://www.shotuk.org/wp-content/uploads/myimages/Transfusion-Aide-Memoire.pdf
4. https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2020/01/NABT-Policy-non-medical-authorisation-of-blood-component-transfusion-December-2019.pdf
5. https://wbs-intranet.cymru.nhs.uk/bht/all-wales-transfusion-competencies/ (password protected)
6. https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2019/02/awtr.pdf
7. https://www.shotuk.org/wp-content/uploads/myimages/SHOT-Bite-No-10-Why-2-Samples-July- 2018.pdf