One at a time

Take a second before you take a 2nd

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INTRODUCTION

In the Hywel Dda University Health Board, duplicate group and screen samples are the leading cause of rejected samples in blood transfusion.

On highlighting this to the hospital senior clinicians via email, a response was received confirming that doctors were taking two samples at the same time and sending them to the lab at different times, while completing the request forms with fraudulent times.

Our aim was to establish clinicians understanding of the principle of the second conformation sample, and why they habitually took 2 samples when often only 1 was required. Also, to re-assert that the potential for a wrong blood in tube (WBIT) remains a threat to patients when deviating from procedure.

A wrong blood in tube can result in an ABO incompatible transfusion- which may result in death,

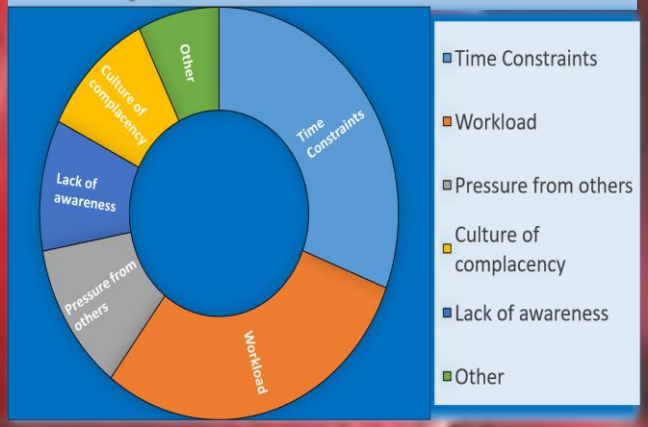
METHOD

Internal audits were reviewed, showing that duplicate samples were an issue, and that there was habitual taking of two samples rather than confirming with the blood bank if a second sample was needed.
A questionnaire was distributed to evaluate clinicians understanding of the requirement for a confirmatory sample. It explored reasons why they take both samples at the same time; including time constraints, staffing levels and pressure from others.

Results

3 WBIT were identified in 2023

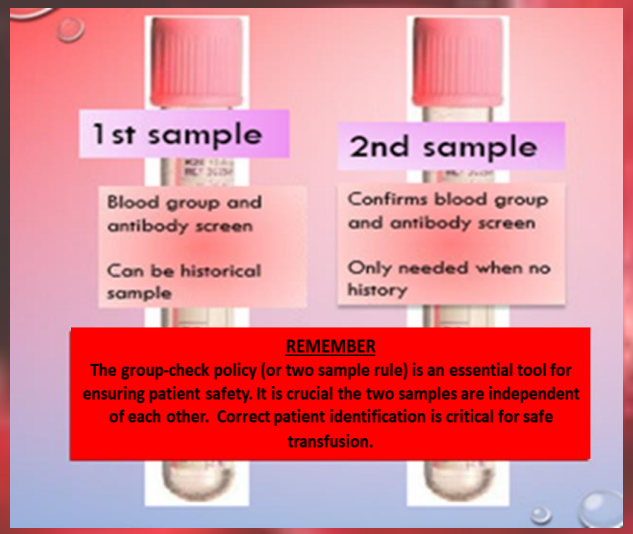
Why is this "Common Practice"?



31,260
Samples arrived in the Hywel Dda Blood bank in 2023

1812
Samples were rejected

42%
Rejected samples were due to duplicates.



TAKE NOTE

Completing the group and screen paperwork with a fabricated time is fraudulent and may be a matter of professional compliance as well as patient safety

"You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.
You must make sure that any documents you write or sign are not false or misleading." GMC

Call the blood bank before you take a sample- they can tell you how many samples you need

CONCLUSION

From the audit results and questionnaires, we can provide targeted education to establish and reinforce the clinician's understanding that taking both samples during the same phlebotomy event puts the patient at risk of an incompatible transfusion.

Poster for clinical staff area

Specific for clinicians involved in sampling