

March 4, 2011

**TRANSFUSION VERIFICATION AND IDENTIFICATION REQUIREMENTS
FOR ALL SITES**

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for implementing requirements for accurate identification of the intended patient, blood sample, and blood component(s) to ensure transfusion safety regardless of the patient location.

2. BACKGROUND

a. VHA policy has established standard operating procedures (SOP) to be utilized when blood products are transfused. These include specific visual verification by two individuals that the blood product is accurately identified as the one assigned using compatibility testing by a blood bank or blood center to a specific patient. Additional policies have been established for some locations, such as in operating rooms, where blood product bar code scanning is used as an added electronic process for ensuring definitive identification blood products matched to specific patients prior to transfusion. The collection of a properly-labeled blood sample from the correct patient is absolutely critical in ensuring safe blood transfusions. Errors in compatibility testing and patient misidentification for transfusion can result in serious morbidity or mortality.

b. When surgery is performed, the Veterans Health Information System and Technology Architecture (VistA) Surgery Package is used. The correct process is described in subparagraph 4a(10).

3. POLICY: It is VHA policy that facility Directors are responsible for ensuring the patient, the blood sample, and the blood product involved in a transfusion event are correctly identified.

4. ACTION: Facility Directors are responsible for ensuring that:

a. Specifically designed SOP for ordering, processing, transporting, and transfusing blood or blood products are in place to ensure accurate identification of the patient, the blood sample, and the specific blood product(s) throughout the entire transfusion process. The process is as follows:

(1) **Patient Identification Wristband.** All patients reporting for hospital admission or ambulatory procedure must be issued a patient identification wristband that contains the patient's full name, full Social Security Number (SSN), and a bar code that displays the patient's full SSN.

(2) **Positive Identification by Staff.** Before the collection of a required blood sample, the patient must be positively identified by the staff performing the collection. The staff collecting

THIS VHA DIRECTIVE EXPIRES MARCH 31, 2016

VHA DIRECTIVE 2011-011

March 4, 2011

blood must ask the patient to verbally state name and full SSN. These responses must be checked by staff against the patient identification band. Whenever possible, in cases where the patients cannot provide the correct responses themselves, another person with knowledge of the patient, such as a family member, needs to be asked to state the full name and full SSN or other acceptable unique identifiers as the date of birth (DOB) of the patient. Once active patient identification is performed, the staff member who has performed the identification must stay with the patient until blood collection is completed. When the blood collection is complete, before leaving the patient, the blood sample container must be labeled at the minimum, with the following information: patient's full name, full SSN, collector's identification, and date of collection.

(3) **Before Administration of Blood.** Before administering each and every blood product, the patient must be positively identified by the staff performing the blood administration. Whenever possible, in cases where patients cannot provide the correct responses themselves, another person with knowledge of the patient, such as a family member, needs to be asked to state the full name and full SSN or other acceptable unique identifiers (i.e., DOB) of the patient. Once active patient identification is performed, the staff member who has performed the identification must stay with the patient until blood administration begins. For emergencies, these procedures need to be applied to the extent necessary to ensure correct patient identification.

(4) **Informed Consent.** Prior to ordering the necessary blood products for transfusion, signature informed consent must be obtained as specified in VHA Handbook 1004.01.

(5) **The Generic Blood Transfusion Record Form (BTRF).** The BTRF for Blood or Blood Component Transfusion is used for documenting the processing and administration of blood products. It must contain the: full name and full SSN of the patient, blood component and quantity ordered, and the name of the responsible provider. The BTRF accompanies each blood product requested and becomes part of the patient's medical record. Local policy may be established to facilitate an alternate electronic entry of required regulatory elements from the BTRF to the patient's medical record. *NOTE: In this Directive BTRF and Standard Form (SF) 518, Blood or Blood Component Transfusion, and Caution Tag or Caution Label are used interchangeably.*

(6) **Identification at Time of Release from the Transfusion Service.** The Transfusion Service or delegated personnel who issues the blood components and the transporter must verify that the following information is correct: name and SSN of intended patient, ABO and Rh type of patient, blood product unit number; ABO and Rh type of unit number, and if performed, the interpretation of compatibility tests. This information must be identical on the BTRF, Caution Tag, and VistA or VistA Blood Establishment Computer Software (VBECS). Patient Identifiers (full name and full SSN) must match identically to the recipient's patient identification brought by the person receiving the blood to be transported to transfusionist.

(7) **Transportation of Blood Products.** When blood products are to be transported from the Blood Bank or from any temporary storage refrigerator, to another location, the full name

and full SSN of the patient who will receive the transfusion must be written or printed on a caution tag or label that is physically attached to the blood product. This positive and unique identification of the patient must match exactly the information on the BTRF that accompanies the blood product. The BTRF, the caution tag attached to the blood product, and the document identifying the patient must all be checked and the information correlated to ensure the product is the correct one for the specific patient.

(8) **Identification at the Bedside.** Before any blood component is transfused, two qualified individuals must verify that: *NOTE: Qualified individuals are defined by the local VA facility, but generally include physicians, professional nurses, nurse anesthetists and physician assistants. Two Nursing personnel may qualify so long as both are professional nurses. Other personnel may be qualified for this task provided they receive special training and supervision. All personnel other than physicians, professional nurses, and nurse anesthetists need to be designated in writing by name and position title and approved by the facility Director.*

(a) The patient identifiers on the patient wristband are identical to the unique identifiers on BTRF that accompanies the blood products.

(b) The unique identity of the blood product agrees on the blood container and on the caution tag attached.

(c) The ABO and Rh type on the primary label of the blood product agree with that recorded on the attached form.

(9) **Identification in the Operating Room**

(a) The two-person verification occurs again in the Operating Room after the bar code scanning of the blood product (see subpar. 4a(10)). *NOTE: Bar code scanning of the blood product, when done, is never a substitute for the manual two-person verification.*

(b) The transfusionist records on the BTRF that this information has been checked and found to be correct as described in the BTRF. The caution tag attached to the blood product must remain attached until the transfusion has been terminated.

(10) **Bar Code Scanning of Blood and Blood Products in Operating Rooms.** When using bar coding as part of the process for blood transfusion administration in the Operating Room, the following steps must be followed to ensure accurate and complete identification of the patient when the patient arrives at the Operating Room for a procedure:

(a) Access the patient's information or encounter using the Surgery Package on VistA.

(b) Enter into the Surgery Package "Operations" menu and go to the "Select Patient" prompt.

(c) Conduct a visual check of the patient's identification wristband to ensure that the patient is scheduled for the room and the procedure.

VHA DIRECTIVE 2011-011

March 4, 2011

(d) Scan the SSN bar code on the patient's wristband. This brings up a list of procedure(s) for which the patient is scheduled.

(e) Verify that the correct patient has been accessed to the Surgery Package.

(f) Select the correct procedure.

(g) Bring the blood product to the scanner and open the "blood product identification" menu on VistA.

(h) Scan the ABO blood-type bar code. Ensure that what is displayed on screen is the same ABO blood-type as the label on the blood product.

(i) Scan the blood product identification number.

(j) Verify that the VistA message says "No discrepancies found." If a "No discrepancies found" message is not obtained, the blood product cannot be transfused until two qualified individuals confirm that they have correctly identified the patient and the blood product.

(k) Perform the two-person verification of matched blood product to patient identification. This process matches the BTRF to the unique identifiers of the patient and blood product. The BTRF must be completed and signed at the time of the transfusion.

(l) Initiate the transfusion after the preceding steps have been completed.

(m) If the blood product is found not to be the correct product for the patient, it is returned to the Blood Bank. If new blood products are subsequently issued for the patient, the entire process is repeated for the new products.

b. All clinical services related SOPs include specific processes to ensure that complete identification and verification of the patient, the blood sample, and the blood product are performed prior to transfusion.

c. When surgery is performed, the VistA Surgery Package is used. **NOTE:** *For those sites that have an effective operational bar code scanning system, use of this bar code scanning system as an identification verifier prior to the administration of all blood products is strongly encouraged.*

d. The facility Transfusion Service uses the VA-approved Blood Bank software package which incorporates significant designs and critical safeguards to protect patients.

e. New employee education and periodic in-service training programs are conducted to ensure that all personnel involved in the handling of blood products are:

(1) Familiar with the risks of inappropriate transfusion, and

(2) Well-informed of the policies and SOPs in place to minimize these risks.

f. All facility policies and SOPs are readily available for all personnel involved in the handling of blood products.

5. REFERENCES

a. VHA Handbook 1004.01.

b. VHA Handbook 1106.1.

c. Primer of Blood Administration. (AABB) Advancing Transfusion and Cellular Therapies Worldwide. 2008.

6. FOLLOW-UP RESPONSIBILITY: Diagnostic Services Strategic Healthcare Group (115) is responsible for the content of this Directive. Questions may be directed to 202-461-7359.

7. RESCISSIONS: VHA Directive 2005-029 is rescinded. This VHA Directive expires March 31, 2016.

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