

## TRANSFUSION VERIFICATION AND IDENTIFICATION REQUIREMENTS

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive revises 2011-011 VHA Transfusion Verification and Identifications Requirements. Additionally, it provides policy for establishing transfusion verification and identification requirements for accurate identification of the intended patient, blood specimen, and blood products to ensure transfusion safety regardless of the patient location.
- 2. SUMMARY OF MAJOR CHANGES:** There are no major changes. Minor changes are as follows: removal of Social Security Number (SSN) term per reduction in SSN use initiates, general format changes per VHA Handbook 6330.01 and general language changes for clarification per user feedback.
- 3. RELATED ISSUES:** VHA Handbook 1106.01 and VHA Handbook 1004.01.
- 4. RESPONSIBLE OFFICE:** The Office of Pathology and Laboratory Medicine Services (10P4D) is responsible for the content of this VHA directive. Questions may be addressed to 202-632-8418.
- 5. RESCISSIONS:** VHA Directive 2011-011, dated March 4, 2011, is rescinded.
- 6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of June 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

Poonam Alaigh, M.D.  
Acting Under Secretary for Health

**DISTRIBUTION:** Emailed to the VHA Publications Distribution List on June 29, 2017.

**CONTENTS**

**TRANSFUSION VERIFICATION AND IDENTIFICATION REQUIREMENTS**

1. PURPOSE:..... 1

2. BACKGROUND:..... 1

3. DEFINITIONS:..... 1

4. POLICY: ..... 1

5. RESPONSIBILITIES:..... 2

6. REFERENCES:..... 4

## TRANSFUSION VERIFICATION AND IDENTIFICATION REQUIREMENTS

### 1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy requirements for accurate identification of the intended patient, blood specimen, and blood products to ensure transfusion safety regardless of the patient location.

### 2. BACKGROUND

a. VHA policy has established standard operating procedures (SOP) to be used when blood products are transfused (see VHA Directive 1185, Transfusion Utilization and Program). Accreditation agencies: such as AABB (formerly known as American Association of Blood Banks), College of American Pathologist and the Joint Commission, requires positive patient identification and specified transfusion requirements and verification before blood administration. These include specific visual verification by two individuals that the blood product is accurately identified as the blood product assigned using compatibility testing by a blood bank or blood center to a specific patient. Based on agency policy, the two person identification may be substituted for a physical identification and a supplemental supporting electronic identification. The expansion of Bar Code Assisted Positive Patient Identification (PPI) into the transfusion process provides an electronic system that utilizes technology to improve the accuracy of patient and blood product verification. The Transfusion Verification (TV) software application verifies patient identification, accesses the electronic blood administration record, and verifies that the blood product is the correct unit for the patient.

b. The collection of a properly labeled blood specimen from the correct patient to be used in blood product compatibility testing is critical in ensuring safe blood transfusions. Errors in labeling specimens for compatibility testing and patient misidentification for transfusion can result in serious patient morbidity or mortality.

### 3. DEFINITIONS

- a. **Blood Products.** Human blood or blood components intended for transfusion.
- b. **Independent Verification of the Patient's Identity.** In the presence of the patient, two qualified individuals must each independently verify and document the patient's identity using two patient identifiers according to the facility SOP.

### 4. POLICY

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

## 5. RESPONSIBILITIES

VA medical facility Directors are responsible for ensuring that:

a. The VA medical facility uses the VA-approved Blood Bank software package and TV software application which incorporates significant designs and critical safeguards to protect patients during the administration of all blood products in Veterans Affairs medical facilities VA clinics, Community Based Outpatient Clinics (CBOCs), VA Community Home or domiciliary and in contract clinics.

b. Only qualified individuals perform transfusion administration activities. **NOTE:** *For blood product administration, determination of qualified individual(s) should be role-based, risk-based and in accordance with the scope of practice, credentialing, and privileges of said individual(s).*

c. Personnel who participate in the administration of blood products are trained in transfusion procedures to include the use of TV software , when and where implemented, and in the recognition and management of adverse reactions.

d. 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.

e. Specifically designed SOPs for collecting and labeling the blood specimen used for compatibility testing, and ordering, processing, transporting, and transfusing blood or blood products are in place to ensure accurate identification of the patient, the patient blood specimen, and the specific blood product(s) throughout the entire transfusion process. The process is as follows:

(1) **Patient Identification Band.** All patients undergoing compatibility testing and/or blood product administration should be issued a patient identification band. The patient identification band at a minimum, must display in a human readable format the patient's full name and patient's unique identifier, and a bar code that contains the patient's unique identifier.

(2) **Positive Patient Identification for Specimen Collection.** Before the collection of a required blood specimen used for compatibility testing, the patient must be positively identified utilizing the patient's full name and unique patient identifier by the staff member performing the collection. Protocols must be in place to ensure positive identification and accurate specimen labeling at the time of collection.

(3) **Informed Consent.** Prior to ordering the necessary blood products for transfusion, informed consent must be obtained as specified in VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

**(4) Identification at Time of Release from the Transfusion Service.** The Transfusion Service or delegated personnel who issues the blood products and the transporter must verify that the following information is correct: name and unique patient identifier, 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 Blood Transfusion Record Form (BTRF) (when used), Caution Tag, and in the VA Blood Bank software package. Patient Identifiers must match identically to the recipient's patient identification brought by the person transporting the product to be transfused.

**(5) 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 unique identifier of the patient who will receive the transfusion must be displayed on a caution tag or label that is physically attached to the blood product. This positive and unique identification of the patient must exactly match the information on any documentation that accompanies the blood product. The caution tag attached to the blood product, the BTRF (when used), 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.

**(6) Identification at the Bedside.**

(a) Before administering a blood product, the patient must be positively identified by the staff member performing the blood administration. To ensure a right patient, right product match, the TV software application must be used, where implemented.

(b) Before any blood product is transfused, a qualified individual using the TV software application must verify that:

1. Patient identification with active patient participation is conducted and documented whenever possible. In cases where patients cannot provide the correct responses themselves, another person with knowledge of the patient, such as a family member, must be asked to state the full name and acceptable unique identifier(s) of the patient. For emergencies, these procedures must be applied to the extent necessary to ensure correct patient identification. Once active patient identification is performed, the staff member who has performed the identification must stay with the patient until blood administration begins.

2. The patient identifiers on the patient identification band are identical to the unique identifiers on any documentation that accompanies the blood product and that all patient identifiers match those of the associated blood product.

3. The unique identity of the blood product and the ABO and Rh type agrees on the blood container and on the attached caution tag and BTRF (when used).

4. The transfusion can only proceed after the patient and blood product identification steps have been completed. Any discrepancies in the bedside identification process must be fully reconciled and documented prior to the

administration of the blood product. The BTRF (when used) must be completed and signed at the time of the transfusion.

5. If the blood product is found not to be the correct product for the patient, it must be returned to the Blood Bank immediately to prevent wastage. If new blood products are subsequently issued for the patient, the entire process is repeated for the new products.

6. In cases of downtime, emergency or where the TV software application has not been implemented, the steps listed must be performed using the two-person independent verification process by qualified personnel.

#### **(7) The Blood Transfusion Record.**

(a) Documentation of the activities of the transfusion episode is required. Use of the TV software application will facilitate capture, recording, and output of those events to the patient's electronic health record.

(b) In cases of downtime, emergency, or where the TV software application has not been implemented, the BTRF must be used for documenting the processing and administration of blood products. It must contain the patient's full name and unique patient identifier, blood product type and unit number, 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.

## **6. REFERENCES**

- a. VHA Handbook 1004.01.
- b. VHA Handbook 1106.01.
- c. Primer of Blood Administration. AABB (formerly know as American Association of Blood Banks). September 2012.
- d. Standards for Blood Banks and Transfusion Services, current edition. AABB. Bethesda, Maryland.
- e. Transfusion Checklists, current edition. College of American Pathologist. Chicago, Illinois
- f. Laboratory Standards, current edition. Joint Commission. Chicago, Illinois.
- g. Use of TV Software Application. Refer to the Bar Code Expansion (BCE) Strategic Guide SharePoint site for implementation guidance and end user documentation.  
[\[https://vaww.portal2.va.gov/sites/bcro/BarCode/Pages/BCE%20Strategic%20Guide.as](https://vaww.portal2.va.gov/sites/bcro/BarCode/Pages/BCE%20Strategic%20Guide.as)

[px](#)]. **NOTE:** *Where the TV software application has been implemented, in case of downtime or emergency, follow established contingency of operation protocols.*