

KINGSTON GENERAL HOSPITAL

NURSING POLICY

SUBJECT	Blood Components/Products - Independent Double Checks	NUMBER	B-4670
		PAGE	1 of 4
		ORIGINAL ISSUE	2005 July
		REVIEW	
		REVISION	

Background:

Mistakes happen even when people are doing their best. According to publicized data about blood administration, the general rate of errors of commission is 3 in 1000, the general rate of errors of omission when no reminders exist is 1 in 100, the general error rate in a highly stressed environment with rapidly occurring activities is 1 in 4. The institute for Safe Medication Practices Canada (ISMP Canada) recommends conducting independent double checks with selected high risk processes and high-alert drugs. Independent double checks are not intended to question the practitioners' skills or competence; rather, they acknowledge the high-risk nature or complexity of the work and the fact that all practitioners are only human and therefore fallible. Many Canadian hospitals have implemented independent double check processes in an effort to enhance patient safety.

The administration of blood and blood components and the management of the transfused patient are complex and multi-step processes with various opportunities for errors to occur. The Serious Hazards of Transfusion (SHOT) reports demonstrate that cases of incorrect transfusion often result from a sequence of errors involving failure to detect the incorrect identity of the patient and/or the blood component.

Policy:

Prior to infusing Plasma, Platelets and Red Blood Cells two practitioners perform an independent double check of the recipient's identity and blood component at the bedside.

EXCEPTION: In emergency situations where a second practitioner is not immediately available to conduct an independent double check, the patient may be transfused if the practitioner is of the opinion that an emergency exists and the delay would put the patient at risk of sustaining serious harm.

Procedure:

1. Before beginning the transfusion, two practitioners independently check the following information in the presence of the intended recipient: (also see illustrations in Appendix A)
 - 1.1. Recipient identification
 - 1.1.1. The name and blood transfusion (BT) number on the recipient's red blood transfusion identification bracelet are identical to the name and BT number on the KGH label attached to one side of the blood pack.
 - 1.2. Donor unit identification
 - 1.2.1. The donor unit identification number on the KGH label attached to one side of the blood pack agrees with the Canadian Blood Services label attached to the other side of the blood pack.
 - 1.3. ABO/Rh
 - 1.3.1. The ABO and Rh type on the KGH label attached to one side of the blood pack agrees with the Canadian Blood Services label attached to the other side of the blood pack.

- 1.4. Compatibility
 - 1.4.1. When performed, the compatibility test result on the KGH label attached to one side of the blood pack is verified to be 'compatible'.
- 1.5. Expiry Date
 - 1.5.1. The expiry date on the Canadian Blood Services label is checked to ensure that the blood pack is not outdated.
2. Discrepancies are addressed before beginning the transfusion.
 - 2.1. Notify the KGH Blood Bank about any unresolved discrepancies and return the blood pack.
3. Once there is agreement between the two practitioners that the information is correct, both practitioners sign the Blood Components/Products Transfusion Record.
 - 3.1. The co-signature indicates that the independent double check is in agreement with the initial check.

Related Policies and Procedures:

Nursing Policy B-4650 - Transfusion of Blood and Blood Products
Nursing Procedure B-4660 - Administration of Blood and Blood Products

References:

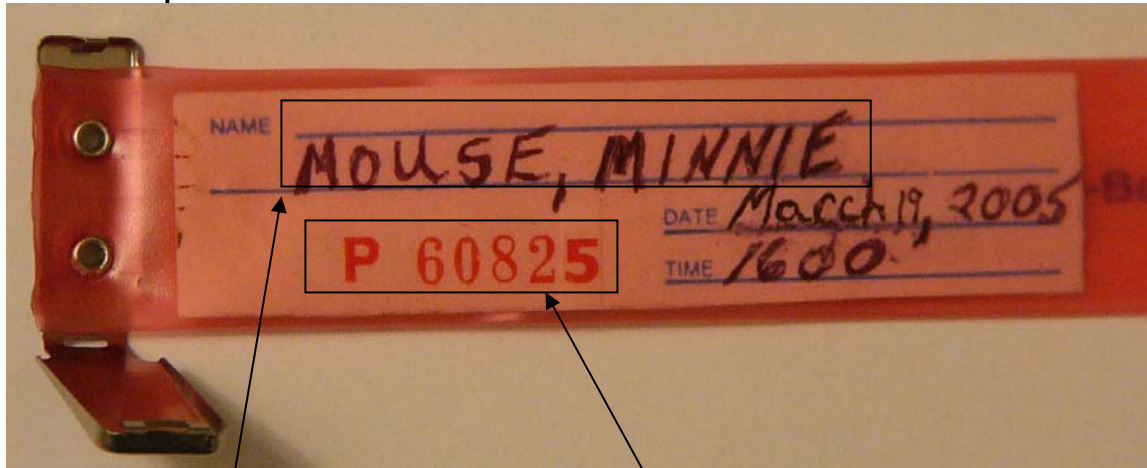
- American Association of Blood Banks (2002). *AABB Technical Manual*. (12th ed.). Arlington, Virginia:Author.
- College of Nurses of Ontario. (2004). CNO examines independent double-checks. The Standard, 29(4), Toronto, ON: Author.
- Institute for Safe Medication Practices Canada (2005). Lowering the risk of Medication Errors: independent double checks. 5(1)*
- Lin, L., Vincente, K.J., & Doyle D.J. (2001). *Patient safety, potential adverse drug events, and medical device design: a human factors engineering approach*. J Biomed Inform, 34(4):274-284.
- Nolan, T.W., (2000). *System changes to improve patient safety*. British Medical Journal, 320(7237):771-773.
- Williamson, L.M. et al. (2001). *The serious hazards of transfusion (SHOT) annual report*. Manchester, Manchester Blood Centre.
- World Health Organization Blood Transfusion Safety (1998). *The clinical use of blood :in medicine, obstetrics, paediatrics, surgery and anaesthesia, trauma & burns*, Geneva.

Authorizing Signature

Date

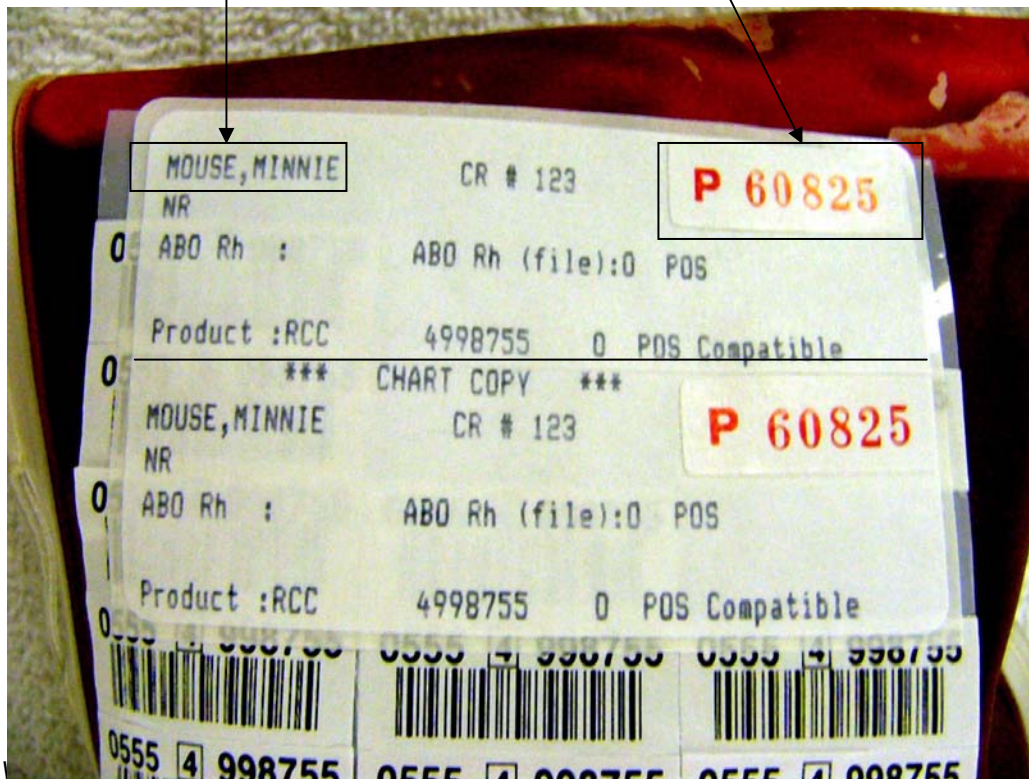
APPENDIX A

Recipient's Blood Transfusion Identification Bracelet



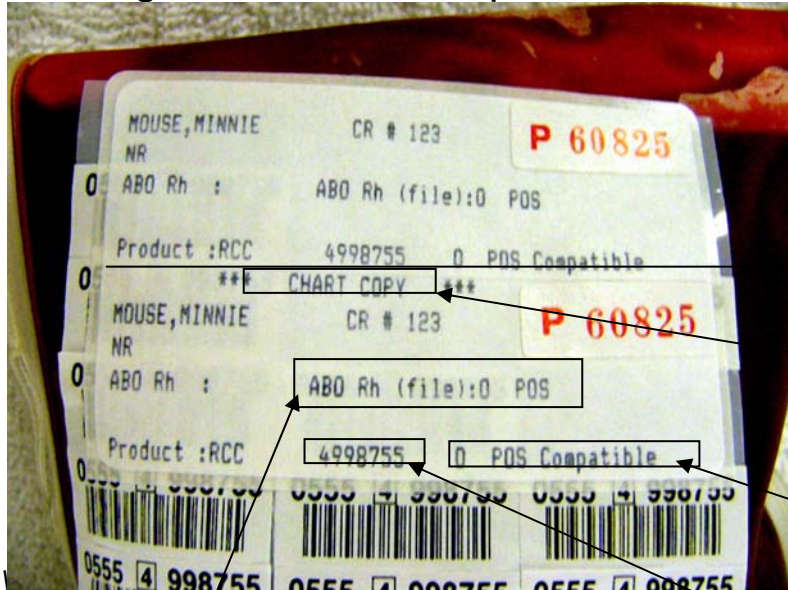
Recipient's Name

Blood Transfusion #
(BT#)



Kingston General Hospital's Label

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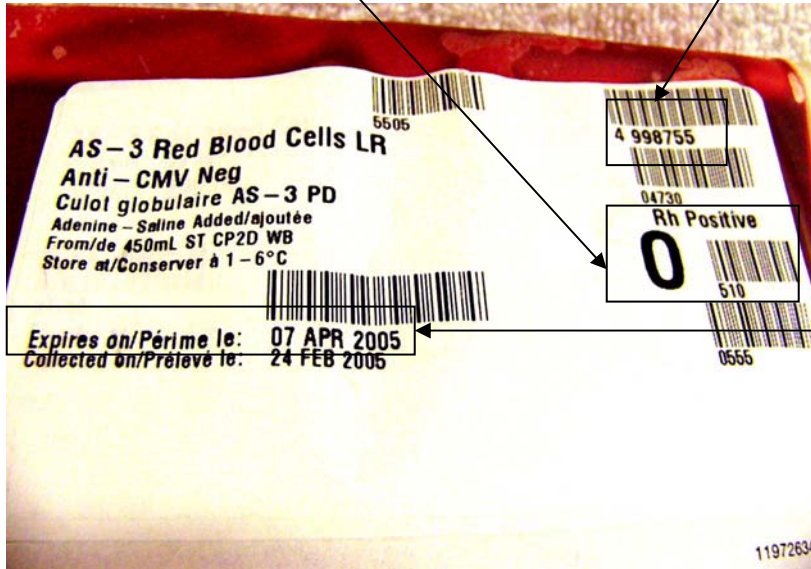


Note – This is the label for the chart

Compatibility test result

Donor Unit Identification #

ABO & Rh type (eg. O Rh positive)



Expiry Date

Canadian Blood Services' Label