Department of Veterans Affairs **VHA DIRECTIVE 2005-029**
Veterans Health Administration
Washington, DC 20420 **July 1, 2005**

TRANSFUSION VERIFICATION AND IDENTIFICATION REQUIREMENTS FOR ALL SITES

1. PURPOSE: This Veterans Health Administration (VHA) Directive implements 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 an individual blood product is accurately identified as the one assigned via 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. All clinical services' related SOP are to 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.

b. When surgery is performed, the Veterans Heath Information System and Technology Architecture (VistA) Surgery Package needs to be used. 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. The correct process is described in subparagraph 4a(9).

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) 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) Before the collection of a required blood sample and/or the transfusion of a blood product, the patient must be positively identified by the staff performing the collection or transfusion. The staff administering or collecting blood must ask the patient to verbally state name and full SSN. These responses must be checked by staff against the completed consent form and patient identification band, as applicable. This must occur immediately before blood administration or collection. Whenever possible, in cases where patients cannot provide the correct responses themselves, another person with knowledge of the patient, such as a family member, should be asked to state the full name and full SSN of the patient. When the blood collection is complete, the blood sample container must be labeled before leaving the patient, at the minimum, with the following information: patient's full name, full SSN, collector's identification, and date of collection.

(3) Once active patient identification is performed, the staff member who has performed the identification must stay with the patient until blood administration or collection begins. For emergencies, these procedures need to be applied to the extent necessary to ensure correct patient identification.

(4) Prior to ordering the necessary blood products for transfusion, informed consent must be obtained.

(5) The Standard Form (SF) 518, Blood or Blood Component Transfusion, is the formal document for tracking the processing of blood products from the initial request to the follow-up of any post-transfusion complications. 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 Transfusion Service accepts only complete, accurate, and legible requests. This SF 518 becomes part of the patient's medical record and accompanies each blood product requested.

(6) **Identification at Time of Release from the Transfusion Service.** The Transfusion Service personnel who issues the blood components must verify that the following information on the SF 518 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.

(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 SF 518 that accompanies the blood product. In the Operating Room, the SF 518, 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**

(a) Before any blood component is transfused, two qualified individuals must verify that:

1. The patient identifiers on the patient wristband are identical to the unique identifiers on SF 518 that accompanies the blood products.

2. The unique identity of the blood product agree on the blood container and on the caution tag attached.

3. The ABO and Rh type on the primary label of the blood product must agree with that recorded on the attached form.

4. The two-person verification occurs in the Operating Room after the bar code scanning of the blood product. ***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 SF 518 that this information has been checked and found to be correct as described in the SF 518. The caution tag attached to the blood product must remain attached until the transfusion has been terminated.

(9) **Bar Code Scanning of Blood and Blood Products in Operating Rooms.** When using bar coding as a component part of blood transfusion administration in the Operating Room, the following steps must be followed to ensure accurate and complete identification of patients:

(a) When the patient arrives at the Operating Room for a procedure, the patient needs to be accessed to the Surgery Package on VistA.

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

(c) Visually check the identification wristband of the patient to ensure that the patient is scheduled for the room and the procedure. Then scan the SSN bar code on the patient's wristband. This brings up a list of procedure(s) for which the patient is scheduled.

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

(e) Select the correct procedure.

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

(g) 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.

(h) Scan the blood product identification number.

(i) 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.

(j) Perform the two-person verification of matched blood product to patient identification. This process matches the SF 518 form to the unique identifiers of the patient and blood product. The SF 518 form must be completed and signed at the time of the transfusion.

(k) Initiate the transfusion after the preceding steps have been completed

(l) If the blood product is found not to be the correct product for the patient, it must be 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. The facility Transfusion Service uses the VA-approved Blood Bank software package which incorporates significant designs and critical safeguards to protect patients.

c. New employee education and periodic in-service training programs are conducted to ensure that all personnel involved in the handling of blood products are familiar with the risks of inappropriate transfusion, and well-informed of the policies and SOP in place to minimize these risks. In addition, all facility policies and SOP must be readily available for these employees.

5. REFERENCES

a. VHA Handbook 1106.1.

b. Primer of Blood Administration. (AABB) Advancing Transfusion and Cellular Therapies Worldwide. 2002.

6. FOLLOW-UP RESPONSIBILITY: Diagnostic Services Strategic Healthcare Group (115) is responsible for the content of this Directive. Questions may be directed to 202-273-8420.

7. RESCISSION: VHA Directive 2000-024 and VHA Directive 98-033 are rescinded. This VHA Directive expires July 31, 2010.

S/Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

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