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BLOOD**



# ELECTRONIC SAMPLE LABELLING DEBATING THE PROS AND CONS?



**RTC education event February  
2019**

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# BACKGROUND

## **BCSH pre compatibility guidelines 2012**

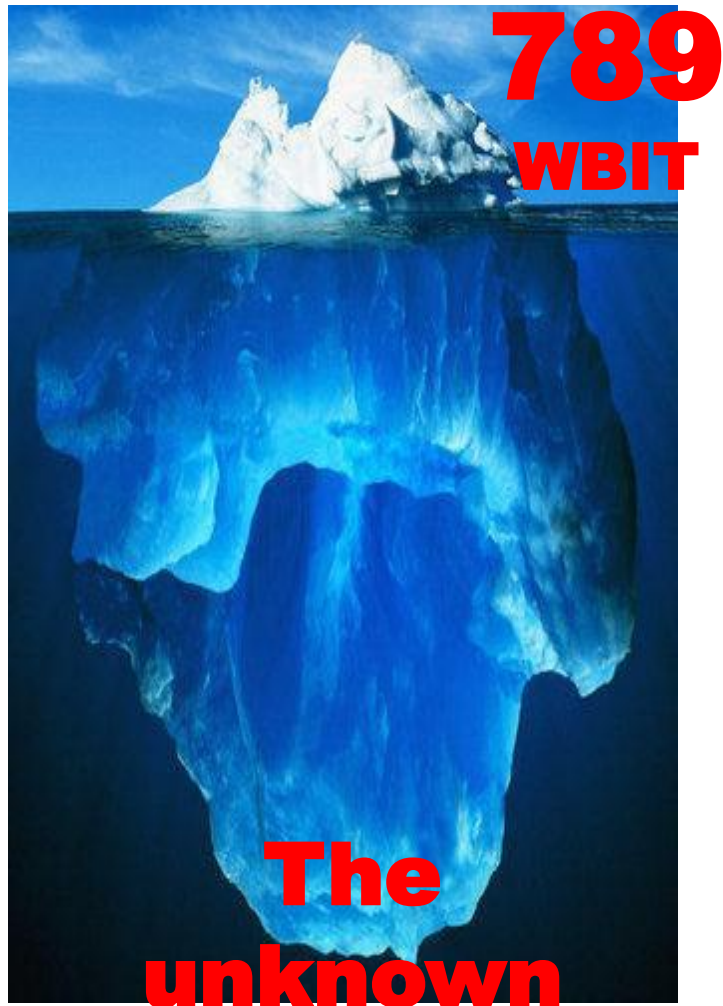
*“Unless secure electronic patient identification systems are in place, a second sample should be requested for confirmation of the ABO group of a first time patient prior to transfusion, where this does not impede the delivery of urgent red cells or other components”*

## **SHOT recommendation – 2014 report**

“Ensure a group check policy is in place as detailed in the BCSH guidelines for pre-transfusion compatibility”



WHY??



**Lab = canary in a coal mine**

# ABO Incompatible Transfusion

## Possibly Fatal

## Never Event



# Secure electronic patient identification systems

Cons – doesn't exist



## ? SECURE ?

- Certain to remain safe and unthreatened
- likely to continue and not fail
- to make certain something is protected from danger or risk





University Hospital Southampton

NHS Foundation Trust



## PEOPLE WILL FIND A WAY

- Not meaning to do harm
- Busy
- Challenged
- Lack of understanding



# CASE 1

- The closest UHS ever came to ABO never event – the sample was labelled with a ‘secure’ electronic system
- Paediatric new leukaemia - Sample 1 – electronic label – B+
- Request for 2 units blood and 1 unit platelets
- But wait – another sample arrives ?
- Sample 2 O+
- Units recalled from bedside – fast thinking BMS
- Sample 3 – O+

# CASE 1

- 2 year old new leukemic patient having sterile procedure
- Nurse draws the sample and leaves the room realising she hasn't labelled it
- Doesn't want to interrupt the sterile process and put patient at risk
- Labels from the notes
- Wrong wristband in the notes

# UHS DECIDES TO BACK A TWO SAMPLE RULE AND ABANDON THE SECURE ELECTRONIC ROUTE



## CASE 2

- Sample from Resus – labelled with secure electronic system
- 3 year old – clinical details ‘sudden arrest’
- Blood group O+    Historic group A+

## CASE 2



- BMS calls resus
- Nurse – that patient is in minors and is about to be discharged
- BMS – After an unexpected arrest?
- Nurse – No that patient has a minor infection
- Electronic system, two patients, one adult resus, one paediatric minor injuries.....
- How did this happen???? We still don't know



**These systems are not secure.  
We need a 'two sample rule'**



# BUT.....

- People will find a way around a two sample rule.....
- The lab can take control, second sample provided by the lab in a format that can not be stocked by hospital staff
- Easy



# BUT....

- Re - bleeding patients (paeds, difficult veins)  
Better a venesection than an ABO incompatible transfusion!
- Education and training  
Often ineffective
- New system developments such as bedside RFID  
Needs updating every time a patient is moved



# ELECTRONIC SAMPLE LABELLING USE

- Has a place in reducing rejections caused by hand labelling errors

**The best system is ‘bolt & braces’ –  
both electronic labelling and a  
laboratory controlled check group  
policy!**



# OVER TO JULIE

