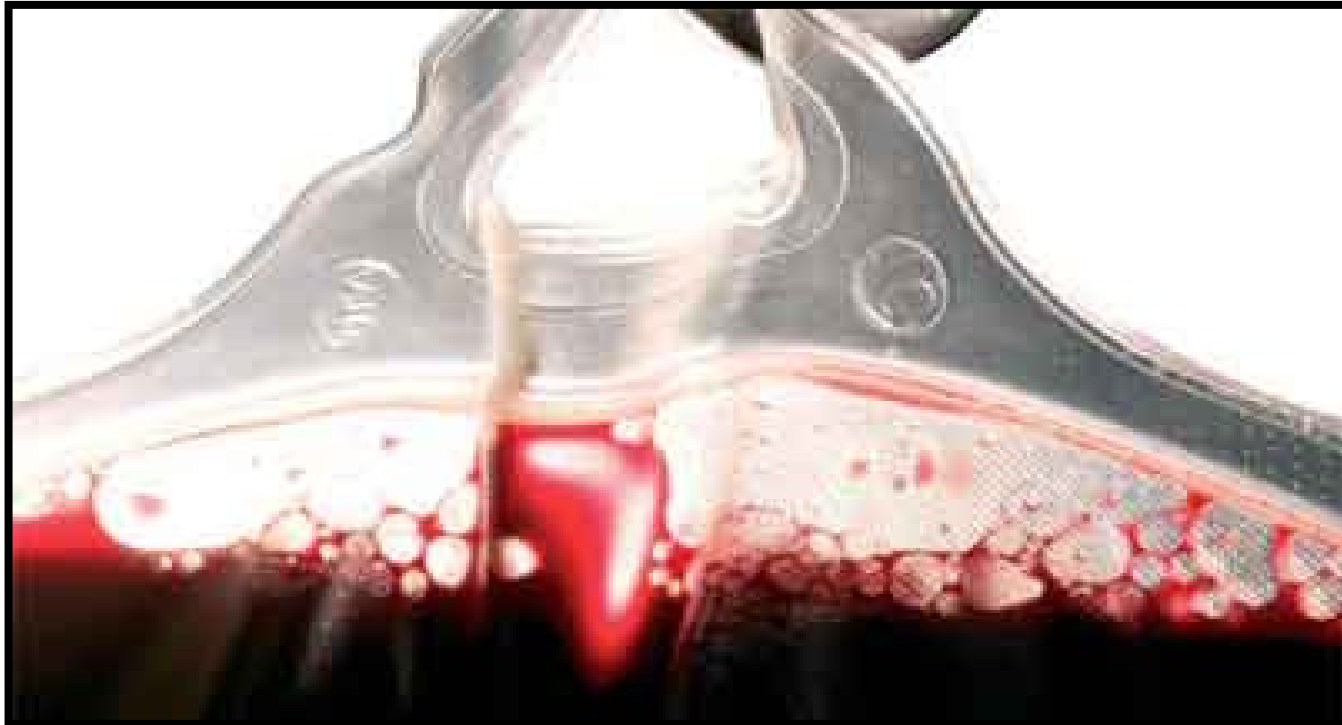
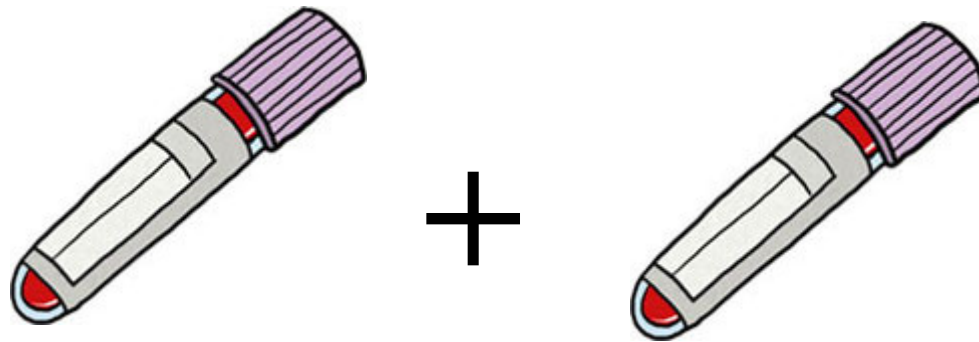


Two Sample Rule!



Louise Jefferies
Transfusion Practitioner
Weston Area Health Trust

Do you ask for a second sample?



ABO Incompatible Transfusion

- Can be fatal or cause severe harm but is avoidable
- DoH “Never Event” since 2011
- Wrong Blood in Tube is a known cause of ABO incompatible transfusion
- Training, assessments and incident reporting have not improved practice or reduced errors with sampling



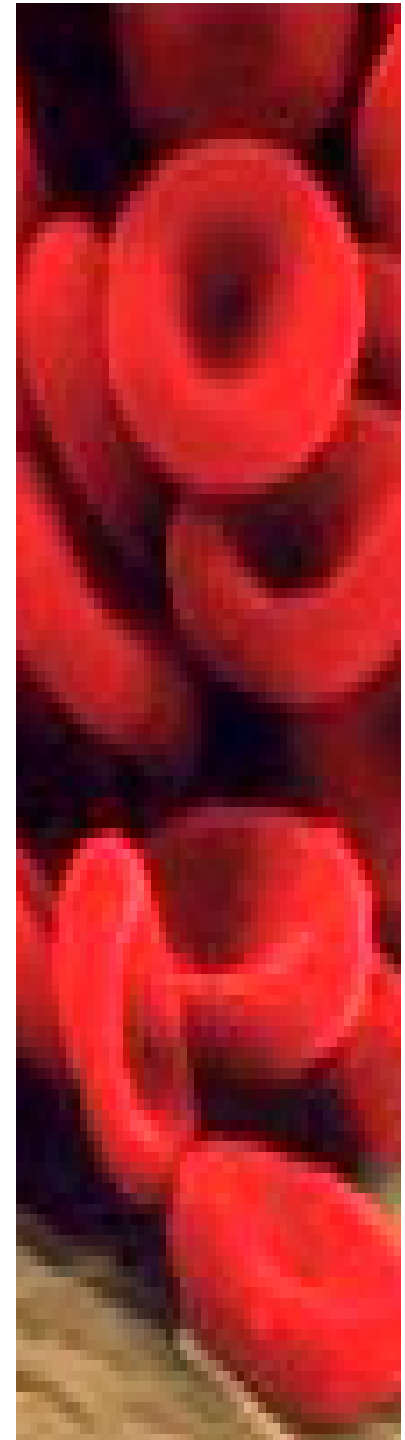
Wrong Blood in Tube Incidents (WBIT)!

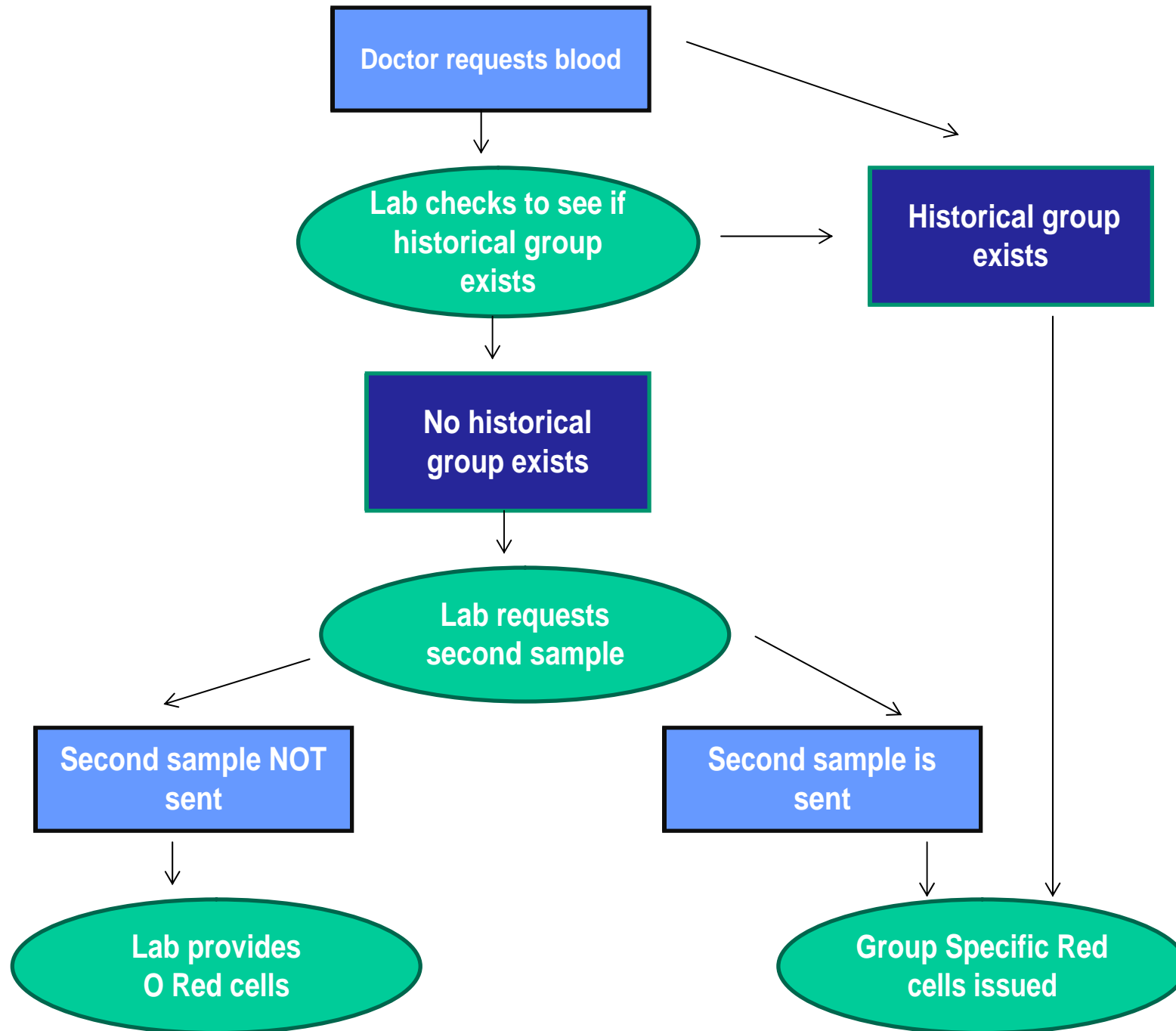
- Serious Hazards of Transfusion (SHOT) reported 643 Wrong Blood in Tube Incidents 2013
- There are 30-40 unacceptable samples per month in blood transfusion lab at WAHT = approximately 7% of samples are labelled incorrectly



British Committee for Standards in Haematology (BCSH)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.





Sample Collection in an Emergency for a Patient with no Historical Group

- **The BMS will inform you that a second sample is required**
- **Samples must be taken as two separate venepunctures!**
- **Ideally by two different members of staff**
- **Sent to the laboratory urgently**



How many patients will this affect in WAHT??

One month audit of transfusion episodes:

- **105 patients transfused red cells**
- **12 patients required a second sample**
- **2 patients required blood “urgently”**
- **1 of these did not use the blood for 6 hours?**

So 1 patient would have required O Negative blood



Summary

“Incorrect labelling is a major concern as it has been found that incorrectly labelled samples have a 40 times higher chance of being WBIT” *Lumadue et al, 1997*

2 sample policy builds a layer of safety against this by corroborating any given result with the second sample

