Appendix 3 – Staff guidance for use (workshop discussion document only)

‘Red label’ system: guidance for use

Introduction

Serious Hazards of Transfusion (SHOT) data show that ABO incompatibility is the most important and high profile error occurring in blood transfusion, with the greatest number of incidents taking place during the bedside check. Between 1996 and 2004, there have been a total of 193 incidents of ABO incompatible red cells reported to SHOT and in SHOT’s 2004 annual report 491 near miss incidents were reported. These related to patient mis-identification at the blood sampling stage resulting in ‘wrong blood in tube’. Of the 491 near misses, 230 were samples taken from the wrong patient, but labelled with the intended patient’s details and 261 were samples taken from intended patients but labelled as per another patient.1

A joint initiative between the National Blood Transfusion Committee (NBTC), SHOT and the National Patient Safety Agency (NPSA) has set an overall target to reduce the number of significant incidents occurring in blood transfusion by 50% over three to five years from January 2005. This is in accordance to SHOT data. The ‘red label’ system is one of four solutions which aim to help achieve this target.

‘Red label’ system

The ‘red label’ system, already established in some hospitals, is an approach to improving blood safety. The aim is to concentrate the attention on the bedside check between the labelled blood and the patient. The system is designed to be a simple, inexpensive process for use within in, outpatient and community settings. This system does not replace other patient identifier checks and works to improve the safety of blood transfusions.

The system is based on a set of unique numbered ‘red labels’ per patient. Each self adhesive label has the same unique number printed on it. This unique numbered set of labels is assigned to one patient for a single episode of care. This unique number provides a direct link between the blood sample, patient and cross-matched blood, and for patients with unknown identity, provides a further link between blood sample and patient. This aims to prevent mis-transfusions by samples being labelled with another patient’s details or the wrong patient being bled.

How it works

1. With Venepuncture

One set of ‘red labels’ is used for every blood specimen taken for either ‘cross match’ or ‘group and save’. Once the identity of the patient is confirmed, the requested blood is taken and the blood bottle labelled at the bed side, according to hospital policy. The ‘red labels’ are applied as follows:

   1. One ‘red label’ is applied to the blood bottle.

2. A second ‘red label’ is placed inside a new wristband and placed on the patient’s wrist. It is advisable to use a different coloured wristband, so to distinguish this label from the patient’s identification wristband.

**N.B.** If the patient is an outpatient, place the wristband into a sealed envelope with the patient’s name on the front. The patient then brings this with them on admission to hospital. It is recommended the patient is made aware of the importance of this wristband and that failure to bring this with them on the day of admission may delay their treatment. The envelope must also be labelled with this information so relatives and/or carers are also made aware of its importance.

3. A third label is affixed to the transfusion request form.

4. The remaining labels are then stuck by using a fourth ‘red label’ to the back of the request form. The blood and request form are then placed inside a laboratory specimen plastic bag and sent to the Blood Transfusion Laboratory.

**2. In the laboratory**

1. All specimens received in the laboratory must be checked to ensure the sample and form have a ‘red label’ attached to them and the remaining labels are affixed to the back of the request form for laboratory use. If the ‘red labels’ are not attached to the sample bottle or are missing the sample must be discarded and a repeat sample requested.

2. The unique ‘red label’ number may be entered onto the laboratory computer, but for all cross-matched units issued one of the remaining ‘red labels’ must be attached to it before leaving the laboratory.

**3. For the administration of the blood transfusion**

1. The bedside checks must be carried out in accordance to trust policy and NBTC guidance.

2. The extra and final check is to compare the ‘red label’ number adhered to the blood unit with the one on the patient’s wristband. If these are different or the patient is not wearing a ‘red label’ wristband the transfusion must not take place.

**In conclusion**

The simplicity of this system means the administrator of the blood undertakes the final check with the patient ensuring the right patient receives the right blood.
Appendix 4 – Staff leaflet (workshop discussion document only)

Further information
For further information and advice, please contact:

[Insert trust contact details including test blood transfusion procedures and the blood transfusion department.]

Blood transfusion red label system: the process of matching blood sample to patient

National Patient Safety Agency

Blood Transfusion Department [Insert contact numbers]

Blood transfusion is a high-risk procedure involving a complex chain of events. If the system fails at any stage between collecting a sample and administering the transfusion, the consequences can be fatal.

These should be agreed protocols for carrying out the following procedures:
1. Collecting patients’ blood samples
2. Labelling blood samples
3. Checking patients’ identities using the red label system
4. Administering blood transfusions

1 Collecting patients’ blood samples

Samples for group and save, and cross matching should be by a doctor, nurse, midwife or phlebotomist. Other members of staff can only take samples if they have been trained and certified as competent to take blood for pre-transfusion testing.

Identify patients by asking them their name and date of birth, and then check their replies against the request form.

Hospital admissions’ records should also be checked against their identification wristbands. If a patient does not have an identification wristband do not start the transfusion and notify the name in charge of the clinical area.

If a patient is unconscious, or unable to confirm their identity for any other reason, always check the details on the identification wristband.

2 Labelling blood samples

When a sample has been taken, label it with the patient’s checked details.

These details should also be added to the labels on units of cross matched blood.

Samples for blood transfusions taken at patients’ bedside should be labelled by hand immediately. Addressograph labels are not acceptable.

The following information must be on the label:

[Insert trust’s requirements such as:]
- patient’s full name;
- hospital number or casualty number for patients in accident and emergency;
- patient’s date of birth; signature of the person taking the blood;
- red label (see below for details).

3 Checking patients’ identities using the red label system

This is an additional check that can prevent wrong transfusions caused by a sample being labelled with another patient’s details or the wrong patient being bled.

A set of numbered red labels is used each time a patient is bled for transfusion. A unique number creates a direct link between patient, sample and cross matched blood.

Red labels come in strips of 32 identical numbers.

Follow these steps:
1. Attach one label to the sample.
2. Inpatients should have their labels inserted into green wristbands attached to their wrists.
3. Outpatients should be given the label in an envelope ready for admission.
4. Attach the remaining 30 labels to the back of the request form. These will then be added to the unit of blood before administering the blood.

4 Administering blood transfusions

The red label number on the patient’s green wristband must be checked against the red label number on the unit of blood before administering the blood.
Appendix 5 – Risk assessment

[see separate document]