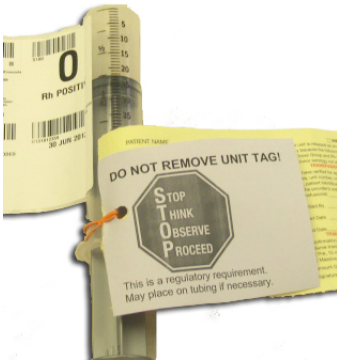
Children's Hospitals and Clinics of Minnesota

Practice Update

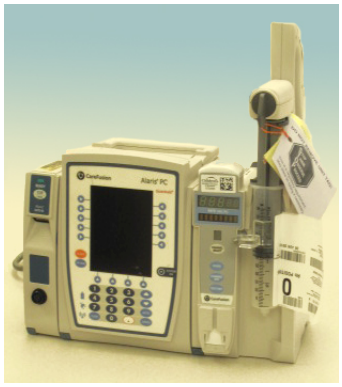
The Center for Professional Development & Practice

June 26, 2013

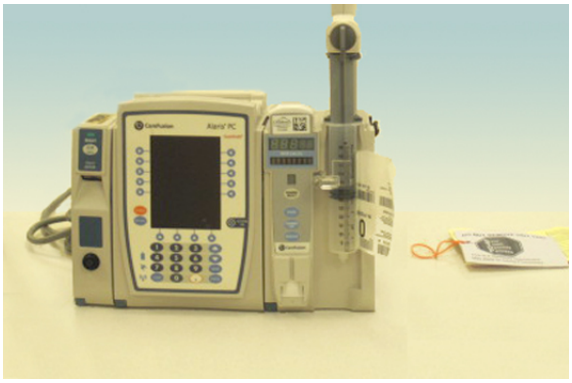
Blood Administration Tags: DO NOT REMOVE!



Unit tag.



Correct use of tag.



Improper removal of tag.

More than 30 million blood or blood component transfusions are administered each year in the United States, saving thousands of lives. Clerical error is the largest contributor to the small number of adverse events or deaths that result from transfusions. To make blood transfusions as safe as possible, rigid national standards were put into place to make sure that the blood delivered to the patient is the blood intended for the patient. Most of these processes occur in laboratories and blood banks prior to release of the syringe or bag containing the blood components.

Once a nurse receives the blood from the blood bank, he/she becomes solely responsible for ensuring the remaining national standards are met, ensuring the right patient receives that right blood component.

National standards dictate that the bag or syringe containing the blood or blood component includes patient and other identification information. We are currently meeting these standards by attaching a yellow unit tag which contains this required information. Some nurses remove the tag in order to write on it or to provide better visualization of the tubing or pump and forget to reattach the tag to the bag or syringe. All hospitals have agreed to the national standard that a dispensed blood product must be labeled/tagged with identifying patient information at all times. When we remove the tag, we are in violation of these standards.

Children's received two deficiencies in two consecutive inspections by the American Association of Blood Banks (AABB)/College of American Pathology (CAP) because they observed that nursing staff had removed the unit tag containing the patient identification information before starting the transfusion. **Another deficiency of this standard could result in automatic Joint Commission/CMS investigations and censures.** AABB/CAP inspections will again occur sometime between June 29th and September 29th and they will be observing to see if we are meeting this standard.

The blood bank has added a "Do Not Remove" tag on top of the yellow unit tags on blood products to serve as a reminder that they **cannot** be removed from the blood product until the transfusion is complete.

The Blood Bank and Administrative Representatives will be conducting random audits. If your patient is receiving a blood component with no label, you will be asked to replace the tag immediately and follow up with unit leadership.

If you have questions, please ask your patient care manager, patient care supervisor, and/or clinical educator.