VERIFICATION OF CORRECT DATA ENTRY POLICY FOR ELECTRONIC CROSSMATCH

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PURPOSE

To define a procedure to verify correct computer data entry before issuing blood or blood components when a serologic crossmatch is not performed. This applies to any RBCs that are electronically crossmatched by the computer.

BACKGROUND

To ensure patient safety, it is vital that correct computer data entry be reviewed and verified prior to issuing blood. The computer must alert the user of any discrepancies in order to ensure patient safety. This includes review of donor unit labeling, blood group confirmatory test interpretation, and the existence of any ABO incompatibility.

RELATED DOCUMENTS

M-W-TS-0310 Issue of Blood Components for Transfusion

POLICY

SafeTrace Tx is the LIS program for the following CHI-FH hospitals: SAH, SCH, SEH, SFH, SJMC, HMCB, and HMCS. It has a unique feature which verifies both the patient data – and – the blood component data for units assigned to the selected patient.

The Product ID Tag (P-tag) is one of the mechanisms that is used to verify that the patient and the product are correctly matched before transfusion. The P-Tag contains critical patient information necessary to identify the patient and relevant product information to identify the product and confirm compatibility to the patient.

The P-tag is automatically printed when the crossmatch is completed. It is placed on the reverse side of the blood unit. Its function is to link that patient information and the unit information to verify that the correct blood is being given to the correct patient.

Other Safeguards Include:

1. Blood units are barcode-scanned (all four quadrants) into the LIS when they are received from the supplier.

2. Proper clerical checks of patient and unit information are completed at the beginning of the blood issue process with the assistance of the transporter who has come to pick up the blood.

3. There is a field in the blood issue screen where the P-tag barcode must be scanned in.

4. Once the computer verifies that this is the correct P-Tag code – matching both patient and unit information – and all clerical checks have been performed – the tech will click on the “Accept” button, thus moving the unit ~~it~~ into a grid of product(s) that are ready to issue. These checks – especially the P-Tag code – ensure the right blood product for the right patient.

5. When attempting to issue blood - if the P-tag code does not match the patient/unit it is impossible to finish the issuing process and an investigation must be done. When this occurs, the only action the computer allows is to close the issuing screen without completing the transaction. The blood is not issued.

6. The computer can also alert the user to any discrepancies by **factors** which display in a pop-up window on the computer screen. All factors MUST be reviewed; and if required, SafeTrace Tx will prompt for action taken to be documented in the system.
    - A factor appears in any situation that keeps a patient, a test, or a product from being safe for transfusion.
    - A warning appears on the computer screen
    - When this occurs, there may be mitigating circumstances that require the user to continue with the process.
        - In this situation the user, and possibly another approver involved with the continued action must document their approval.

7. **The introductory factor is: Factors exist. Would you like to review?** - Always respond "Yes" to this factor. Click on the **detail** button for further information.

    Factors include:

    - Appropriate crossmatch test not performed
    - Biohazardous indicator prohibits release
    - Abnormal blood condition in remote location
    - Component blood attribute not confirmed
    - Component blood type not confirmed
    - Component expired
    - Component label not verified
    - Component does not meet patient special need
    - Derivative lot expired (This means RhIG)
    - Derivative lot recalled
    - Component emergency issue is not compatible with the patient
    - Intended use prohibits release
    - No current patient visit
    - Ordered modification not complete
    - Other product donation type available
    - Patient auto-compatibility failure
    - Patient merged
    - Patient medical record number changed
    - Patient name changed
    - Patient transfusion reaction unresolved
    - Product auto-compatibility failure
    - Product not compatible with patient
    - Required antibody identification test not complete
    - Required patient blood attribute unknown
    - Required product blood attribute unknown
    - Required test not complete
    - Specimen expired
    - Specimen rejected
    - Test history mismatch
    - Visual inspection not okay
    - Crossmatch interpretation not compatible
    - Crossmatch not valid for patient specimen

8. Factors are autogenerated by the computer and display as needed for patient safety. They come in various colors.
    - ***Red factors are not to be overridden by anyone***.
    - They are serious and must be investigated.

- Once the situation causing the red factor has been resolved, a comment may be entered into the patient record if required by SafeTrace Tx.

9. Remote site staff should not override red or yellow factors without approval or under the direction of SJMC staff.

10. The identity of the person performing the data review and verification can be determined in two ways.
    - The ID of the tech who issues the blood can be found in the electronic record
    - The tech who issues the blood records initials, date/time on the pickup slip as an indicator that the data has been reviewed and verified.
        - These forms will be kept for 5 days in the blood bank in case there should be a question regarding the blood component.

REFERENCES

AABB Standards for Blood Banks and Transfusion Services, current edition

AABB Technical Manual, current edition