Positive patient identification and pretransfusion checking procedure audit report

2025 (revised December 2025)

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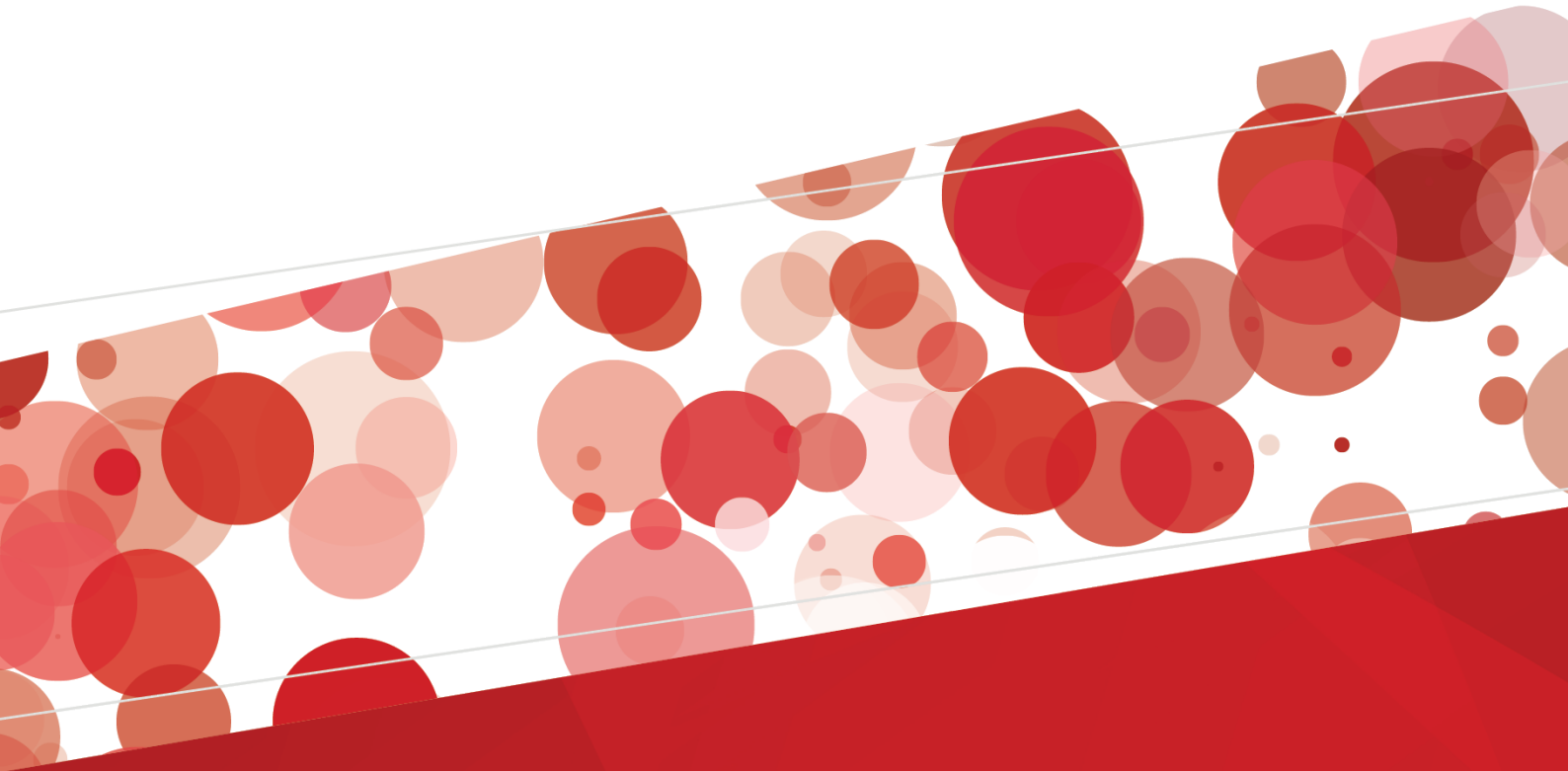

VICTORIA State Government

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Blood Matters

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2025

Revised Report December 2025:

Data anomalies were identified for steps in the pretransfusion checking procedure where ‘not applicable’ was an available response, requiring revisions to Tables 5, 7 and 8. Figures and percentages have been adjusted accordingly throughout the report.

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Acknowledgements

Blood Matters thanks the health services and transfusion laboratories across all participating jurisdictions that contributed to the audit.

Abbreviations, acronyms and definitions

Term	Definition
ANZSBT	Australian and New Zealand Society of Blood Transfusion
Blood product	In this report, references to “blood products” are consistent with the ANZSBT Guidelines for the Administration of Blood Products (2024), and encompass both fresh blood components and manufactured blood products
Blood component	Red blood cells, Platelets, clinical Fresh frozen plasma, Cryoprecipitate
CMV	Cytomegalovirus
DOB	Date of birth
Double independent checking	Clinicians individually and without requiring direct involvement of each other, check the prescription, patient and blood product identification, and blood product characteristics (including expiry, compatibility and special requirements (if any)). This process must ensure that each clinician is individually satisfied that, and responsible for, the correct product is transfused in the correct way to the correct patient. (ANZSBT Guidelines for the administration of blood products, 3rd edition, revised 2024)
EMR	Electronic medical record
FFP	Fresh frozen plasma
Lifeblood	Australian Red Cross Lifeblood
MHP	Major haemorrhage protocol
MRN	Medical record number
NZBS	New Zealand Blood Service
RBC	Red blood cells
STIR	Serious Transfusion Incident Reporting system

Executive summary

Thank you to all health services that participated in this audit and contributed data.

The pretransfusion checking procedure, which includes positive patient identification, is the last chance to ensure the right blood component is transfused to the right patient at the right time.

Health services were requested to audit their blood administration policy and pretransfusion checking procedure, and to conduct observational audits of staff performing the pretransfusion check. The aim was to measure whether policy and practice aligned with the Australian and New Zealand Society of Blood Transfusion (ANZSBT) Guidelines.

Historically a shared pretransfusion checking procedure has been undertaken where one person reads information aloud from one source and a second person checks that information against another source. Shared checking can lead to confirmation bias and errors in the pretransfusion checking procedure and is not aligned with current guidelines and best practice. ,

The ANZSBT Guidelines for the administration of blood products 3rd edition (revised 2024)[1] outline the requirements for positive patient identification, double independent checking and the pretransfusion checking procedure. These requirements help to prevent errors that may occur anywhere from specimen collection to blood component issue.

Blood Matters recommends that health services review the report, together with their individual and comparative data, as supplied by Blood Matters. Health services should use this data to determine if there is a need for policy changes, education and training of clinical staff or other patient safety measures related to positive patient identification and pretransfusion double independent checking.

[1] <https://anzsbt.org.au/guidelines/guidelines-for-the-administration-of-blood-products/>

Background

The Blood Matters Program works with health services to ensure blood products are used appropriately and safely.

The ANZSBT Guidelines for the administration of blood products 3rd edition (revised 2024) provide guidance on the clinical transfusion process, including safe administration of blood components. The guidelines were developed for use as a best practice reference to inform jurisdictional and health service policy, procedural documents and practice.

The third edition of the ANZSBT Guidelines for the administration of blood products was released in 2018 and the changes included, but were not limited to, Section 6: Administration of blood products.

Of note, section 6.9.2.1 staff responsibility for the pre-administration identity check of patient and blood product states “each staff member must complete all the checks independently (a process referred to as ‘double independent checking’)”. This represented a change from the second edition of the guidelines (2011) that stated, “although commonly performed co-operatively, consideration should be given to independent checking”.

The patient identification requirements are unchanged: staff members must ask the patient (if conscious and competent) to:

- state and spell their family name and given name in full, and
- state their date of birth (DOB).

Additionally, there is a requirement to ensure the blood product:

- is the correct blood product type
- is compatible with the patient
- is compliant with special requirements
- has a valid crossmatch
- is not expired
- the pack integrity is intact (section 6.9.2.3).

Aims and objectives

The audit aimed to identify if health service blood administration policies and practices are consistent with the ANZSBT Guidelines for the administration of blood products 3rd edition (revised 2024).

The objectives of the audit were to:

- determine if health services have pretransfusion checking procedures and protocols, incorporating positive patient identification and double independent checking in alignment with the ANZSBT Guidelines for the administration of blood products 3rd edition (revised 2024)
- observe clinical staff performing pretransfusion checks to determine if positive patient identification and double independent checking as defined by ANZSBT guidelines is undertaken prior to blood component administration.

Limitations

Auditors received audit tool instructions and were able to seek clarification from Blood Matters staff on data collection, however, did not receive formal training. This may have resulted in variance in interpretation of some questions.

Method

Blood Matters invited all public and private health services in four jurisdictions (Victoria n = 91, Northern Territory n = 6, Australian Capital Territory n = 3 and Tasmania n = 9) to participate in an audit of positive patient identification and the pretransfusion checking procedure prior to transfusion.

Data was collected and managed using REDCap electronic data capture tools and analysed within Access database.

The audit consisted of two parts:

Part A: Policy

Audit of health service blood administration policy, specifically pretransfusion checking procedure, to determine alignment with the ANZSBT Guidelines for the administration of blood products (revised 2024).

Part B: Observational audit

Observation of up to 20 transfusions between 1 March 2025 and 30 April 2025. The audit observed each step required for the pretransfusion patient identification and blood component check prior to administration.

To support validation, each participating health service received a preliminary report detailing their individual data, and overall data from all participating jurisdictions. To ensure data consistency and accuracy auditors were asked to review the preliminary report against data entered and to contact Blood Matters if there was any variation.

Inclusions: Any transfusion that was not part of an active massive haemorrhage protocol (MHP) or critical bleeding event.

Exclusions: Transfusions occurring during an activated MHP or critical bleeding event.

Each observational audit occurred without comment from the auditor unless patient safety was compromised. The auditor was instructed to intervene under the following circumstances:

- **Lack of double independent checking** at the completion of the pretransfusion check
- **Pretransfusion check not conducted at the patient's bedside**
- **Attempted premature spiking** of the blood component prior to completion of the full pretransfusion check
- **Omission of any step** within the pretransfusion verification process
- **Failure to restart the check** from the beginning following an interruption.

When intervention was required, the auditor was advised to educate staff on the importance of completing each step of the pretransfusion check and the principles of double independent checking. Audits were not repeated following intervention.

Results

Audit response rates

Eighty-two (75 per cent) of the 109 health services invited from four jurisdictions responded to part A of the audit, with 75 (69 per cent) responding to part B.

Part A: Policy

All 82 responding health services had a policy covering the pretransfusion checking procedure. Date of last policy review ranged from March 2019 through to May 2025, all following the release of the third edition of the ANZSBT Guidelines for the administration of blood products in 2018 and the inclusion of double independent checking.

Table 1: Policy content and response

Policy question	Yes response number (%) (denominator, n = 82)
Is there a policy statement that identification bands must be attached to all patients during transfusion	79 (96)
Is there a policy statement that requires the following to be included on the identification band: • FAMILY NAME and GIVEN NAME • MRN (medical record number) or equivalent • DOB (date of birth, written as DD/MM/YYYY)	78 (95)
Is there a policy statement that the patient's identity must always be confirmed before transfusion	82 (100)
Is there a policy statement on who can take responsibility for pretransfusion patient identity verification	78 (95)
Does the policy state that two staff members must be involved	82 (100)
Does the policy state that the check must occur at the bedside	79 (96)
Does the policy state each staff member must complete all the checks independently ('double independent check')	58 (71)
Does the policy state the person spiking the blood component must be one of the staff members who undertook the component and patient identity check	72 (88)
Does the policy state the blood component must be spiked and transfusion started immediately after the check has been completed	58 (71)
Does the policy contain the following for conscious and competent patients? • ask the patient to state and spell given names • ask the patient to state and spell family name	59 (72)

Policy question	Yes response number (%) (denominator, n = 82)
Does the policy contain the following for conscious and competent patients? • ask the patient to state DOB	76 (93)
Does the policy contain the following for unconscious patients? • Check the patient's identification band for family name and given name • Check the patient's identification band for DOB and MRN	69 (84)
Is there a policy statement that outlines the pretransfusion checking procedure	81 (99)

Table 2: Pretransfusion checking procedure

Does the pretransfusion checking procedure include that the:	Yes response number (%) (denominator, n = 82)
• patient's family name and given name, DOB and MRN on the ID band must be identical to those on the compatibility label attached to the blood component and the blood prescription	81 (99)
• blood component type is the same on the prescription, the component (Lifeblood component label) and the laboratory compatibility label	82 (100)
• blood component is checked for compliance with any special requirements on the prescription (e.g. irradiated or CMV seronegative)	76 (93)
• blood group and the donation number on the compatibility label are identical to that information on the Lifeblood label on the component	80 (98)
• blood group on the blood component is compatible with the blood group of the patient as indicated on the compatibility label attached to the bag; if the blood group of the blood component and the patient are not identical, the transfusion service provider must make a specific comment to indicate that it is compatible (or is the most suitable available)	73 (89)
• blood component has not passed its crossmatch expiry or component expiry date and time	80 (98)
• integrity of the blood component is confirmed	78 (95)

The audit asked if the health service policy required the staff member to ask conscious and competent patients:

- to state and spell given names
- to state and spell family name

For clarity, these two questions should have asked if the policy required patients:

- to state given name and family name
- to spell given name and family name

Consequentially some health services responded “yes” if they only required names to be stated, while other health services responded “no” with similar policies. Blood Matters contacted all health services to provide the additional information, seventy-three (89 per cent) responded (Table 3). Three health services reported that their policy did not require staff to ask patients to state nor spell their name.

Table 3: Additional policy questions

Policy question	Yes response number (%) (denominator, n = 73)
Does the policy contain the following for conscious and competent patients: ask the patient to STATE their name?	69 (95)
Does the policy contain the following for conscious and competent patients: ask the patient to SPELL their name?	29 (40)

Part B: Observational audit

Between 1 March and 30 April 2025, 778 transfusion episodes were audited by 71 health services across four jurisdictions. An additional four health services reported having no appropriate transfusions to audit during the reporting period.

Ninety-one per cent (n = 710) of patients were conscious and competent. Of the 68 patients not conscious and/or competent, 29 were paediatric patients (aged under 18 years).

Red blood cells (RBC) were the most audited blood component at 87 per cent, followed by platelets (11 per cent), fresh frozen plasma (FFP) (1 per cent), and cryoprecipitate (1 per cent).

Staff responsibility (ANZSBT guideline 6.9.2.1)

Two members of staff must undertake the identity check of the patient and blood product at the patient’s side immediately before administration.

Ninety-six percent (n=743) of patient identity checks commenced at the bedside.

Confirmation of patient identity and matching patients to their care (ANZSBT guideline 6.9.2.2)

The double independent bedside check establishes the identity of the patient by each staff member asking the patient to state and spell their full name, to state their date of birth and checking this response against the identification band, prior to commencing the transfusion.

In the following tables “double independent check” requires that each staff member independently and separately completed the step. “Partial/shared check” refers to either only one staff member completed the step independently or the two staff members completed the step as a team. “No check” refers to the step not being completed by either staff member. The “n/a” columns refer to questions that may not be applicable to a transfusion episode, such as when the patient is not conscious or competent, or the crossmatch expiry which is only applicable to RBC.

Patients receiving a transfusion were wearing an identification band in 99 per cent (n = 767) of episodes. Four patients with no identification band were paediatric patients, the remaining seven patients were considered conscious and competent.

Table 4: Patient identity checks

Identity check	Double independent check occurred number (%)	Partial / shared check occurred number (%)	No check occurred number (%)	Patient unable to participate
State full name	275 (39)	402 (57)	33 (5) *	68
Spell full name	156 (22)	152 (21)	402 (57)	68
State DOB	273 (38)	393 (55)	44 (6)	68
Checked against ID band	336 (43)	421 (54)	21 (3)	-
Checked against prescription	372 (48)	388 (50)	18 (2)	-
All patient identity checks, as above (adjusted for patients unable to participate)	167 (21)	611 (79)	0 (0)	-

*Percentages may not add due to rounding.

Blood product checklist (ANZSBT guideline 6.9.2.3)

Table 5: Blood component checks

Blood component check	Double independent check occurred number (%)	Partial / shared check occurred number (%)	No check occurred number (%)	n/a
Patient identity checked against compatibility label attached to blood component	376 (48)	392 (50)	10 (1)	-
Donation number on compatibility label checked and the donation number on the Lifeblood compatibility label on blood component and are identical	397 (51)	371 (48)	10 (1)	-
Compatibility label on blood component checked for compliance with any special requirements on the prescription	212 (51) *	173 (41) *	34 (8) *	359

Blood component check	Double independent check occurred number (%)	Partial / shared check occurred number (%)	No check occurred number (%)	n/a
Blood product blood group is check against the patient blood group on the compatibility label on product and is compatible.	392 (50)	378 (49)	8 (1)	-
If the product and the patient blood group are not identical, checked comments to indicate that is compatible (or the most suitable available)	64 (43) *	68 (46) *	17 (11) *	629
Crossmatch expiry checked	302 (44) *	283 (42) *	94 (14) *	99
Component expiry date and time checked	397 (51)	374 (48)	7 (1)	-
Integrity of the component checked	377 (48)	315 (40)	86 (11)	-
All component identity checks, as above (adjusted for 'not applicable')	282 (36)	496 (64)	0 (0)	

* Percentage calculation does not include data in 'n/a' column

There was a discrepancy between the patient blood group and the component blood group with no comment documented regarding compatibility in 53 (7 per cent) transfusions audited. As shown in Table 6, action was taken by most staff to ensure the blood component was compatible; however, 6 were continued with no reported acknowledgement of the discrepancy.

Table 6: Action taken when discrepancy between the patient blood group and the component blood group with no comment documented

Action taken	Number (%) denominator = 53
Discussed by checking staff (both aware the component was compatible)	42 (79)
Check stopped by staff member	3 (6)
Clarified by transfusion laboratory	7 (13)
Discussed with medical staff	1 (2)
Discussed with nurse in charge	3 (6)
Continued check with no discussion or acknowledgement of discrepancy	6 (11)

Note: multiple responses allowed

Compliance with all pretransfusion checks

Table 7: Overall compliance with double independent pretransfusion check

Pretransfusion check steps	Double independent check occurred number (%)	Partial / shared check occurred number (%)	No checks occurred across all variables number (%)
Patient identity check*	167 (21)	611 (79)	0 (0)
Blood component check**	282 (36)	496 (64)	0 (0)
All pretransfusion checks (ID and blood component)	**137 (18)**	**641 (82)**	**0 (0)**

* Staff member asked patient to state and spell name, state DOB (where patient conscious and competent), checked against identification band, and checked against prescription.

** Component check included patient ID check against compatibility label attached to blood component, donation number, blood group checked against compatibility label (and if the blood component and the patient blood group are not identical, checked comments to indicate it is compatible, or the most suitable available), special requirement, cross match expiry, component expiry, integrity of pack.

Table 8: All pretransfusion check procedures met according to guidelines

Pretransfusion check requirements	Guidelines met number (%)
Commenced at bedside	743 (96)
Double independent pretransfusion check completed (patient ID and component)	137 (18)
No attempted spiking prior to completion of checks	761 (98)
Gold standard: Double independent pretransfusion check completed (ID and component checks at bedside, no early spiking) as per guidelines	**135 (17)**

Analysis of the data for each step in the pretransfusion check process resulted in 17 per cent of individual transfusion episodes audited meeting guidelines.

Ninety-six per cent (n=743) of pretransfusion checks commenced at the bedside in alignment with the ANZSBT guidelines.

Additional questions were asked regarding the safety of the pretransfusion checking process and whether the auditors needed to intervene (Table 9). Interventions were restricted to events that could cause patient harm. If intervention was required, the staff members were to re-commence the pretransfusion check from the beginning but were not re-audited. Other omissions may have been observed; however, auditors were not required to intervene. Staff members identified discrepancies in patient identification details and stopped the checks in 13 (2 per cent) audits.

Table 9: Interventions and other safety considerations

Safety consideration	Number (%)
Staff member attempted to spike blood product prior to the completion of checks	17 (2)
Staff members interrupted during the checking process	58 (7)
Pretransfusion check stopped by the auditor due to failure in process/actions: check does not commence at patient bedside, blood product spiked attempted prior to completed checks, following an interruption staff did not recommence check from beginning	123 (16)

Discussion

Policy

Ninety-five per cent of health service policies required that the patient be asked to state their given and family name, with only 40 per cent requiring the patient to spell their name. This was reflected in the observational audits where 57 per cent recorded that staff did not ask the patient to spell their name. Anecdotally, one auditor commented patients complained about having to spell their name every time, as this occurred not only for blood component administration, but also for medications and specimen collection. Education regarding patient identification should include explanation to patients of the importance of these safety routines.

The patient identification process for patients that are incapable of participating was detailed in 84 per cent of policies. It is important to have a clearly defined process for staff when the usual process cannot be followed.

While 100 per cent of policies required two staff to perform the pretransfusion checks, only 96 per cent included the need to perform these checks at the patient side. Errors are more likely to occur if any part of the pretransfusion check is undertaken away from the patient's side underscored by the Serious Transfusion Incident Reporting (STIR) system receiving reports of incidents associated with checks occurring away from the patient.

Double independent checking, which was first included in the ANZSBT guidelines in 2018, was reported as a policy requirement by fifty-eight (71 per cent) of the responding health services. All health services reported that their policy had been updated between 2019 and 2025. It was therefore anticipated that double independent checking would be included in all health service blood administration policies.

Seventy-one per cent of policies specified that blood components must be spiked and transfusion commenced immediately following the pretransfusion check. When blood components are not spiked and commenced immediately after the check there is a risk that either the patient and/or product could be moved and if not rechecked could result in an incorrect and potentially incompatible transfusion.

Practice

Seventy-four per cent of the transfusions audited (n=577) were undertaken at health services with a policy that included the requirement for double independent checking, however only 18 per cent of the observational pretransfusion check audits performed double independent checking for the entire checking process. There were steps in the process that were performed individually, but unless both staff perform all checks independently, they are not following the double independent checking process as outlined in the ANZSBT guidelines.

The inclusion of the double independent check in the ANZSBT guidelines in 2018 represented a change in practice for many staff from a shared checking procedure. Despite this inclusion occurring several years ago, it is clear further efforts are required to help embed this into practice. Consideration should be given to train the trainer type programs with clinical staff to educate and promote best practice. BloodSafe eLearning Australia[2] has courses, videos and tools available to

[2] https://bloodsafelearning.org.au/

assist educators and staff in their understanding of the process and demonstrate how to undertake double independent checking.

A message that may be helpful is for staff to think of the check as if they and they alone are responsible for ensuring that the correct patient is receiving the correct blood component.

The 2024 SHOT report (UK) states that pretransfusion checklists, when used appropriately, have prevented many transfusion errors and potential harm. This audit did not include the use of pretransfusion checklists, but they should be considered to assist staff with completion of all steps in the pretransfusion check. The Blood Matters Double independent pretransfusion check poster [3] could be used as a checklist for staff to follow.

It was observed in seventeen (2 per cent) of the transfusions audited staff members attempted to spike the bag before the checking procedure was completed. If the checks are then completed following this error, it is unlikely the patient will receive an incorrect blood component. However, blood wastage has been reported to STIR when the bag was spiked prior to the completion of pre transfusion checks and then found the component was wrong or was for a different patient.

In 53 audited transfusions, patient and component blood groups differed without documented comments on checking compatibility and appropriateness to transfuse. Only on four occasions staff performing the checks spoke to other clinical staff (medical, nursing) to confirm that the unit was compatible with the patient blood group. Incidents reported to STIR indicate that not all clinical staff have sufficient knowledge of blood group compatibility and recommend any blood group discrepancies are referred to the issuing laboratory for clarification and confirmation of transfusion compatibility.

[3] https://www.health.vic.gov.au/sites/default/files/2025-02/double-independent-pretransfusion-check.pdf

Conclusion

The results of this audit will assist health services to identify any gaps in policy and understand the current staff adherence to pretransfusion checking procedures.

Findings from the observational audits highlighted that there is much room for improvement with only 17 per cent completing all elements of the pretransfusion check, including correct positive patient identification procedures and double independent checking.

Correct patient identification, asking patient to state and spell both given and family names and state their date of birth, is not unique to blood transfusion and is a safety routine required in many aspects of patient care.

The concept of double independent checking needs to be better understood and embedded in practice to improve patient safety and align with guidelines.

Practice improvement requires health service policy and procedures to reflect current guidelines and clearly explain and detail what is required of staff. They need to include how to undertake patient identification and each element of the pretransfusion check.

It would be useful for health services to re-audit and regularly undertake observational audits of the pretransfusion check after implementing the recommendations to ensure practice improvement.

Recommendations

Blood Matters will:

- disseminate data to key stakeholders including:
  - Victorian health services/transfusion laboratories
  - Victorian Blood User Group
  - National Blood Transfusion Committee
  - Australian Red Cross Lifeblood
  - National Blood Authority
- assist individual health services/transfusion laboratories to align with guidelines as needed
- provide audit tools for health services/transfusion laboratories for re-auditing.

Health services should:

- review policy and procedures against the ANZSBT Guidelines for the administration of blood products 3rd edition (revised 2024) to include:
  - patient identification for pretransfusion check and the requirement for patient to state and spell both given and family names
  - a definition and description of double independent checking
  - all aspects of the pretransfusion check
  - one of the two staff members spiking the blood component should do so immediately after the pretransfusion check
- discuss the results within their transfusion committees or similar to formulate a practice improvement plan to align practice with health service policy and ANZSBT guidelines

- utilise tools and videos to educate and demonstrate how to undertake patient identification and perform the pretransfusion check incorporating double independent checking
- consider a 'train the trainer program' for blood champions, educators and senior staff to increase education and understanding of patient identification and double independent pretransfusion checking for all staff involved in transfusion
- consider using a checklist that outlines each step of the pretransfusion check to assist staff with adherence to guidelines
- undertake observational re-auditing following review of policy and implementation of improvement actions.

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Appendix 1: Patient identification

Table 9: Patient identity checks performed by the two staff members

Identity check	Double independent check occurred number (%)	Single independent check occurred number (%)	Shared check occurred number (%)	No check (ambiguous) occurred number (%)	No check occurred number (%)	Patient unable to participate
State full name	275 (39)	18 (3)	384 (54)	6 (1)	27 (4)	68
Spell full name	156 (22)	21 (3)	132 (19)	45 (6)	356 (50)	68
State DOB	273 (38)	15 (2)	378 (53)	7 (1)	37 (5)	68
Checked against ID band	336 (43)	6 (1)	415 (53)	2 (0)	19 (2)	-
Checked against prescription	372 (48)	2 (0)	386 (50)	0 (0)	18 (2)	-

Appendix 2: Blood component check

Table 10: Blood component checks performed by the two staff members

Blood component check	Double independent check occurred number (%)	Single independent check occurred number (%)	Shared check occurred number (%)	No check (ambiguous) occurred number (%)	No check occurred number (%)	n/a
Patient identity checked against compatibility label attached to product	376 (48)	8 (1)	384 (49)	3 (0)	7 (1)	-
Donation number on compatibility label checked against the donation number on the compatibility label on product and are identical	397 (51)	2 (0)	369 (47)	1 (0)	9 (1)	-
Compatibility label on blood component checked for compliance with any special requirements on the prescription	212 (51)	2 (0)	171 (41)	1 (0)	33 (8)	359
Blood component blood group is checked against the patient blood group on the compatibility label on product and is compatible.	392 (50)	5 (1)	373 (48)	0 (0)	8 (1)	-
If the blood component and the patient blood group are not identical, checked comments to indicate that is compatible (or the most suitable available)	64 (43)	0 (0)	68 (46)	3 (2)	14 (9)	629
Crossmatch expiry checked	302 (44)	7 (1)	276 (41)	2 (0)	92 (14)	99

Blood component check	Double independent check occurred number (%)	Single independent check occurred number (%)	Shared check occurred number (%)	No check (ambiguous) occurred number (%)	No check occurred number (%)	n/a
Blood component expiry date and time checked	397 (51)	4 (1)	370 (48)	0 (0)	7 (1)	-
Integrity of the blood component checked	377 (48)	18 (2)	297 (38)	2 (0)	84 (11)	-