The Group-Check Policy
Current state of play in the UK

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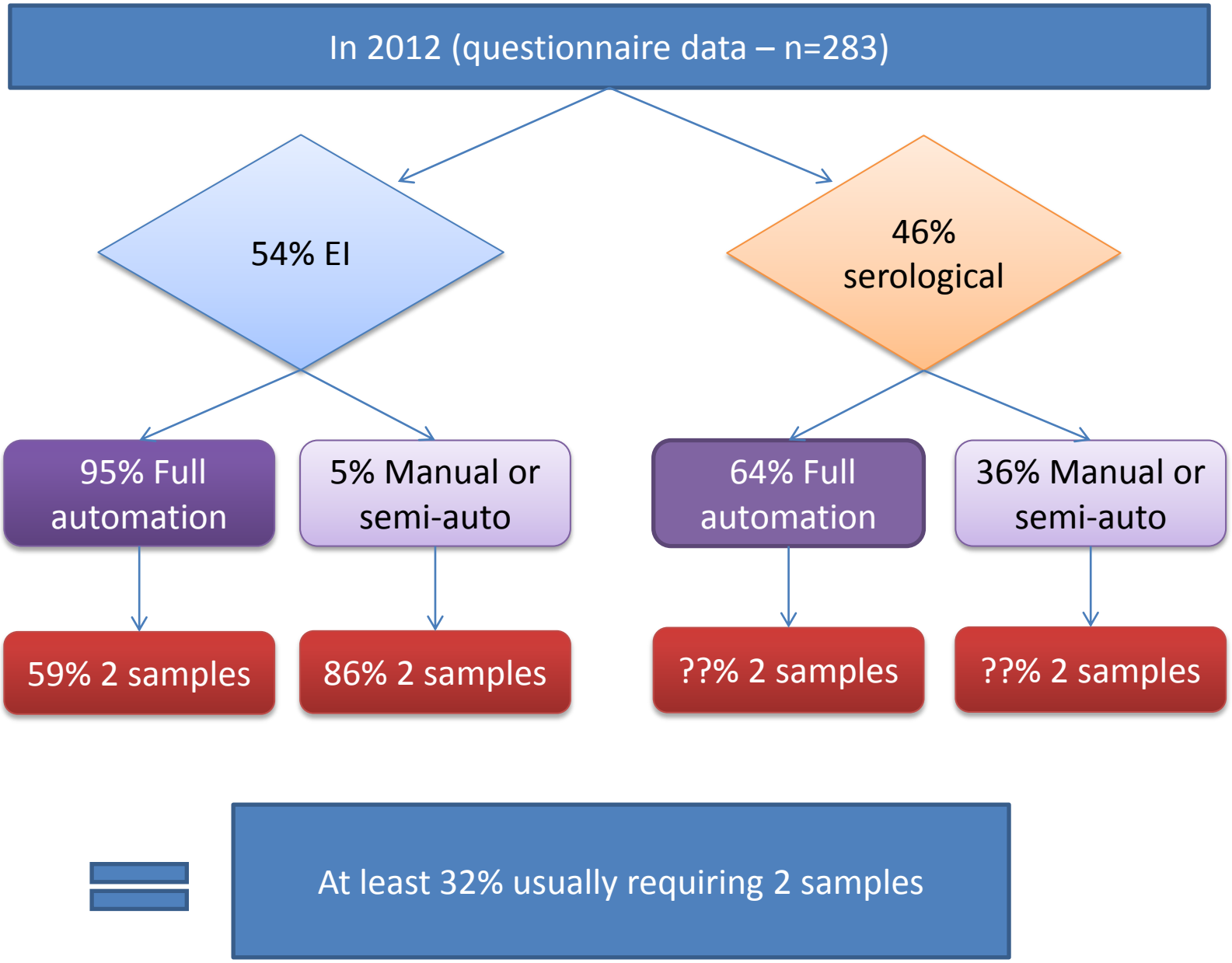
2006: The IT guidelines said…

- That to use electronic issue:
  - group the same sample twice (with full automation)
  - group two separate samples (if manual)

What's the point in grouping the same sample twice when using full secure automation?

If the sample is from the wrong patient, it doesn't matter how many times you group it or whether you do a serological crossmatch or EI!


In 2012 (questionnaire data – n=283)
54% EI
46% serological
95% Full automation
5% Manual or semi-auto
64% Full automation
36% Manual or semi-auto
59% 2 samples
86% 2 samples
??% 2 samples
??% 2 samples
=
At least 32% usually requiring 2 samples

To reduce the risk of ABO incompatible transfusion due to Wrong Blood In Tube, 2012 UK BCSH guidelines made a key recommendation:

Unless secure electronic patient identification systems are in place, a second sample should be requested for confirmation of the ABO group (regardless of how compatibility is established), where this does not impede an urgent transfusion.

≡ The group-check policy

Concerns raised

- Potential impact on:
  - use of O D negative red cells
  - workload
- Potential delays to urgent transfusions, because a second sample is not forthcoming.

The benefits of introducing a new policy must outweigh any additional risks

- Paediatric patients
- Assuring 2nd sample is really a 2nd sample

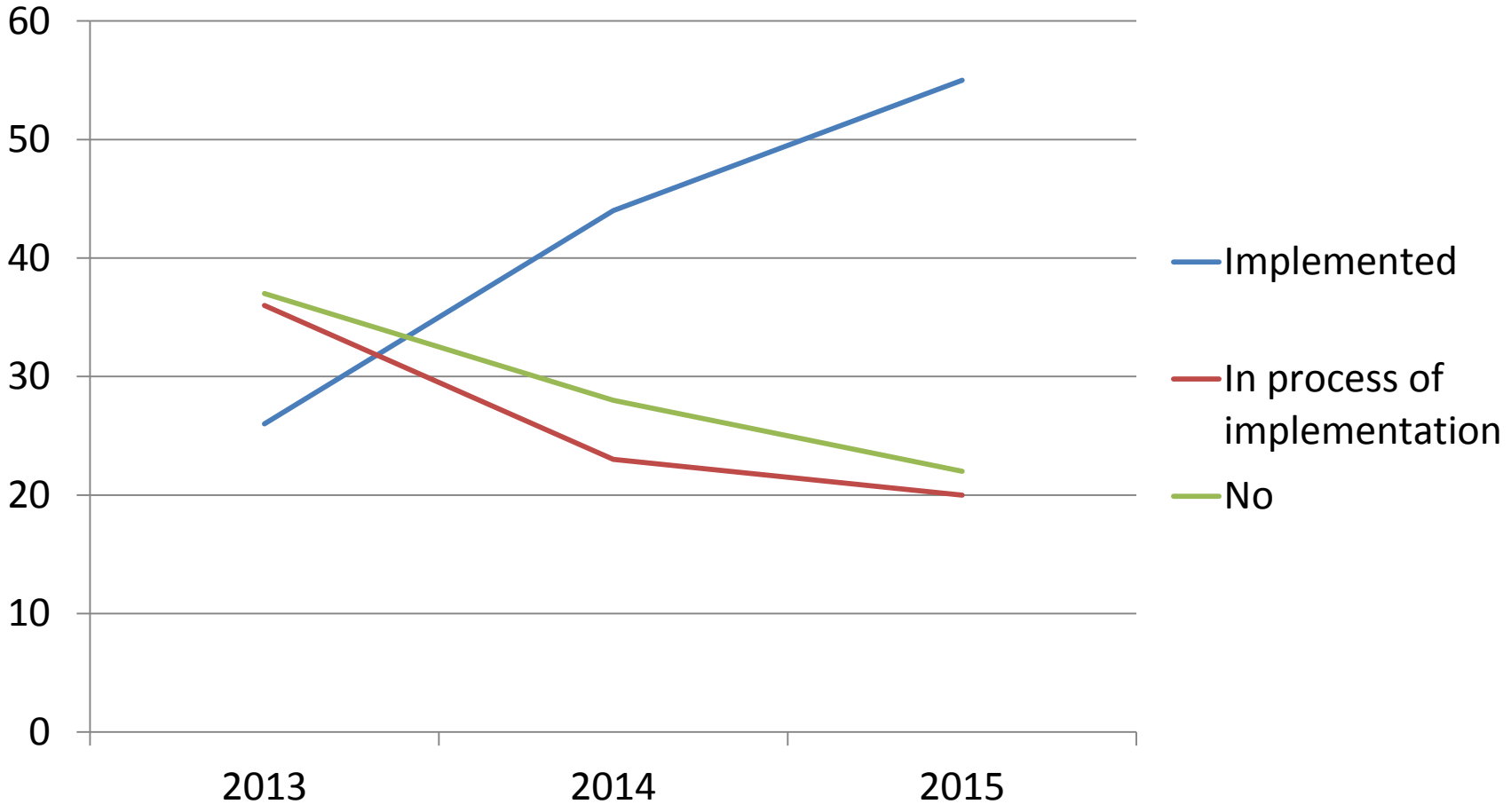
Keeping a track…
Annual Questionnaires

- Basic data

- Areas of concern

2015 data (return rate 77%)

Implementation of a group-check policy in the UK (and Ireland) –



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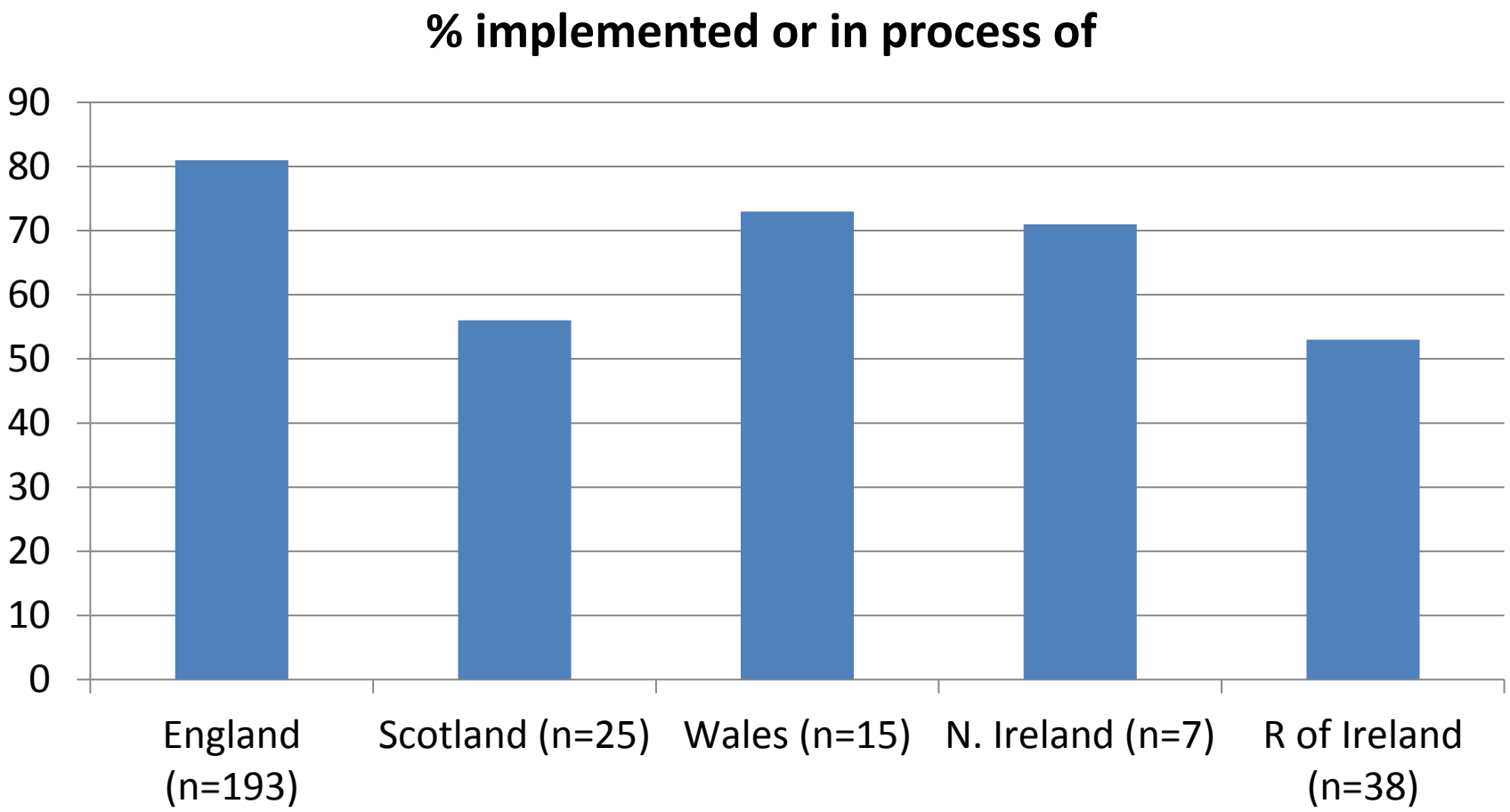
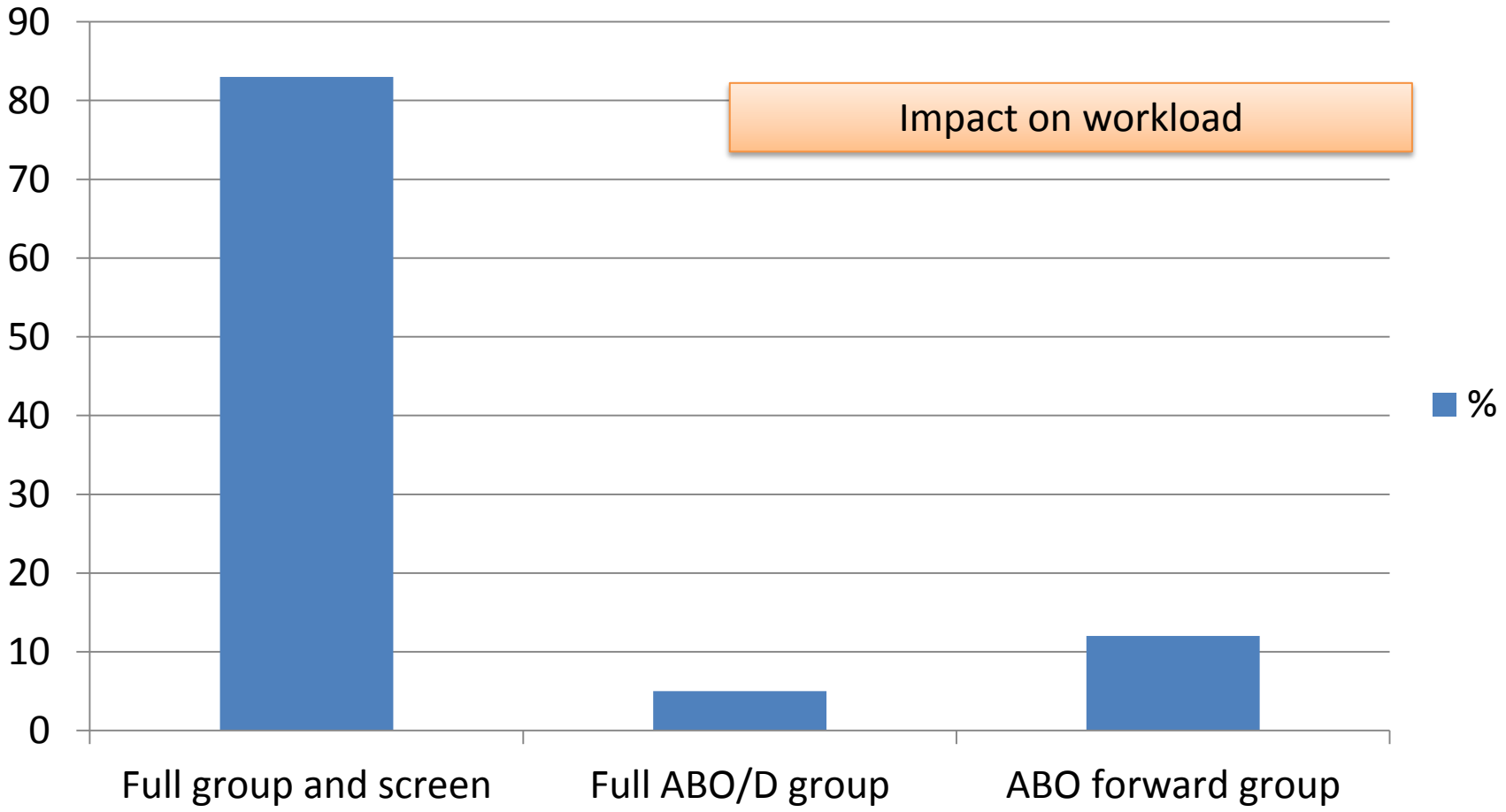
2015 by country



Tests undertaken on 2nd sample



sure 2 independently n samples

Picture courtesy of Yvonne Scott, Newcastle upon Tyne Hospitals NHS Foundation trust

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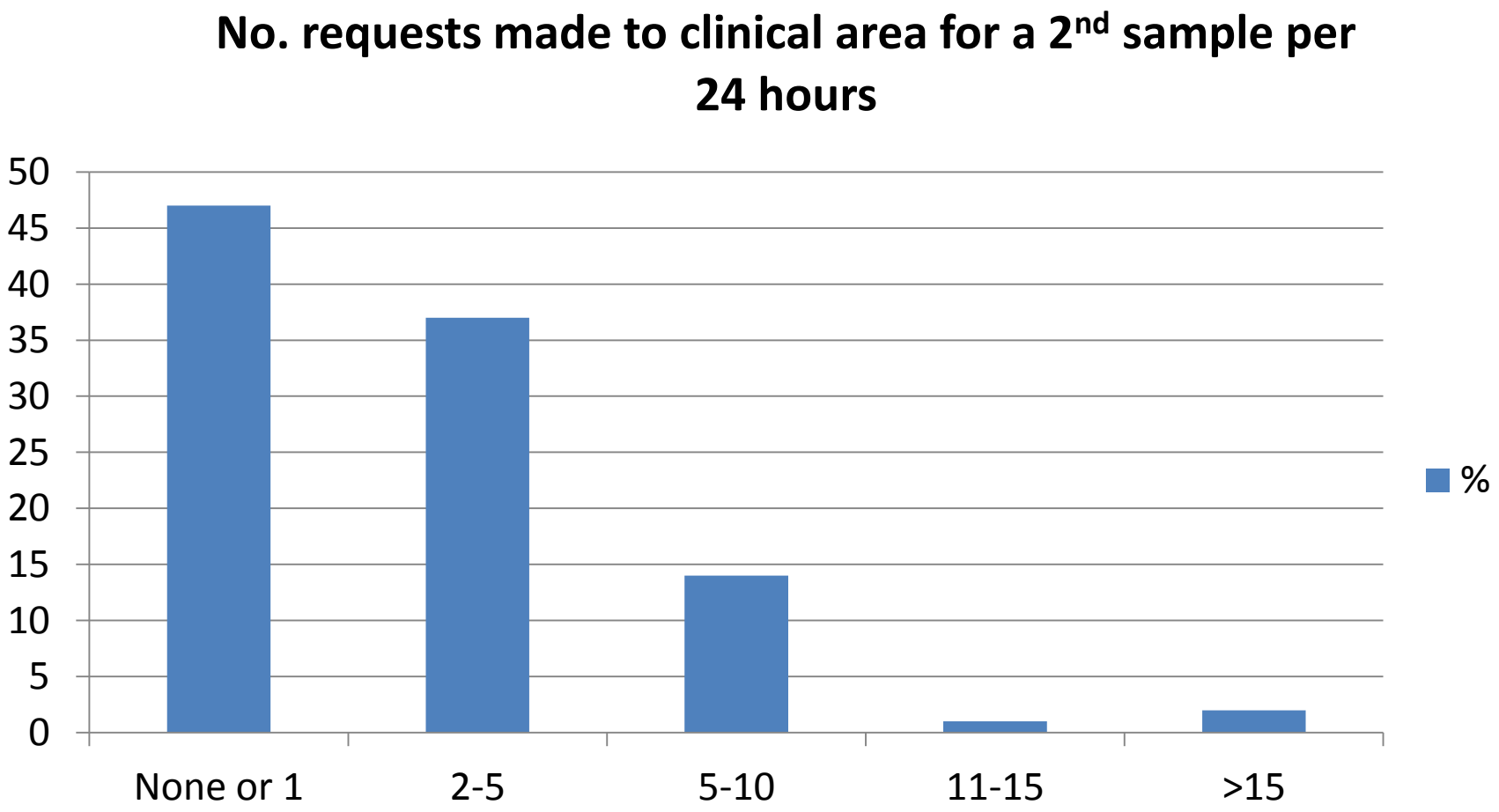
Urgent blood required and no group-check sample available (n=149)

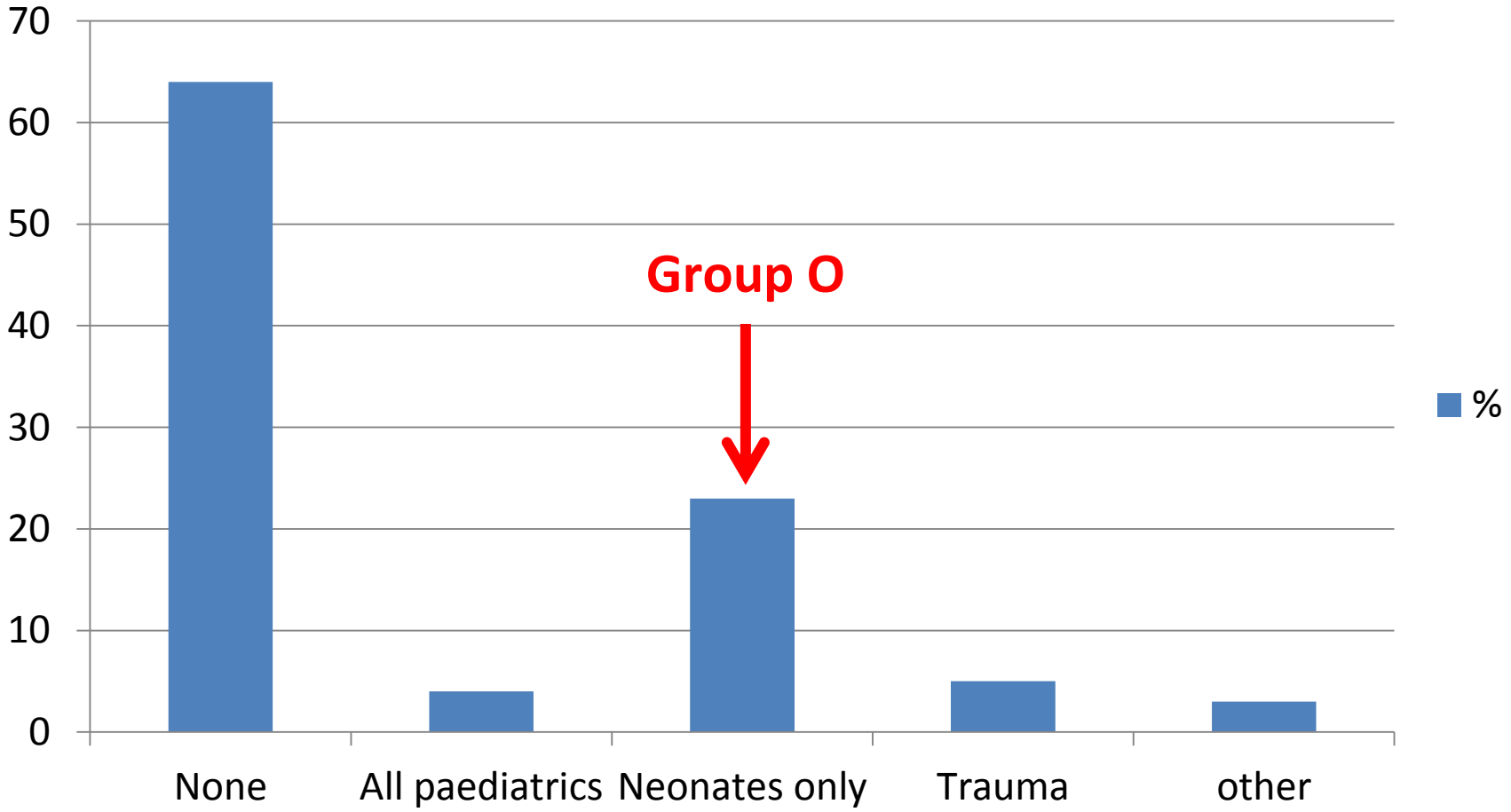
Policy	Number (%)
Give group O	112 (75%)
Give group compatible	35 (23%)
No policy	2 (1%)

Impact on use of group O and potential to cause delays to transfusion

Impact on workload



Exemptions


70
60
50
40
30
20
10
0
Group O
None
All paediatrics
Neonates only
Trauma
other
%

Delays to transfusion and impact on use of O D neg red cells

Delays?	No. (%)		Increased use of O D neg red cells?	No. (%)
No	120 (82%)		No	119 (81%)
Yes, but rarely	25 (17%)		Minimal	27 (18%)
A few times	1 (1%) *		Significant	1 (1%) **

*Give group O in absence of group-check sample

**Laboratory not based in hospital –
reported a minimal impact on workload

Alternative strategies

Secure electronic patient ID systems in place

39 in total

6 cited as alternative strategy

? Systems in limited use

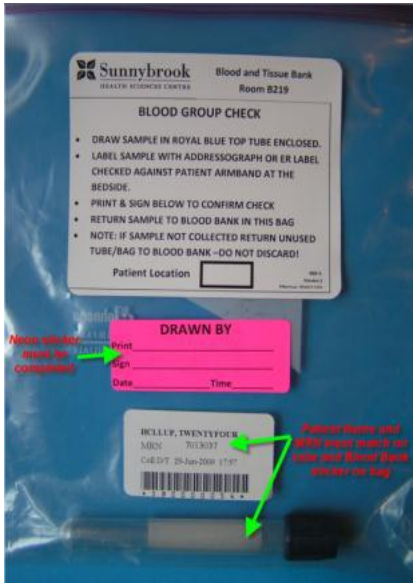
Typenex or similar (additional number on wristband, sample and blood bag) (n=3)

Request form with a declaration box signed by person taking sample that sample was checked and labelled at the bedside (n=1)

Risk assessment not to implement (n=2)

Summary

- Implementation continues to rise
- Some variation between countries
- Some have implemented with exceptions rather than not at all
- Limited number of alternative strategies
- No evidence of widespread significant impact
  - On use of group O
  - Workload
  - Transfusion delays



Above pictures from Jeannie Callum, Sunnybrook