



Knowledge, Attitude and Practice about Pre-Analytic Errors of Blood Transfusion among Interns

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Aim: The aim of this study is to evaluate knowledge, attitude and practice about pre-analytic errors among interns. This elicits the efficiency of interns on the basis of knowledge, attitude and practice in blood transfusion and to analyse about the pre-analytic errors in blood transfusion.

Study Design: A cross sectional study

Place and Duration of Study: Department of Transfusion Medicine, Saveetha Medical College Sriperumbudur, between January 2020 to August 2020.

Methodology: The prospective study will be done by distributing online questionnaire. From the questionnaire the interpretation of pre-analytical errors will be analysed statistically.

Results: A total of 150 interns in a Tertiary care teaching hospital were given the online questionnaire in which 136 interns responded and 14 were not responded and the results showed lower frequency of incidents in pre-analytic errors.

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Conclusion: Though the pre analytic errors were less, the lack of knowledge among the medical staff in transfusion is obvious. Therefore, we must have the possibility of organizing regular training and follow-up activities to improve the knowledge of interns in transfusion.

Keywords: Blood transfusion; pre-analytic errors; prevalence.

1. INTRODUCTION

Blood transfusion is the process of transferring of blood or blood products from one individual (donor) into another individual's bloodstream [1]. This life saving procedure can replace one's blood loss following a surgery or injury. Before transfusing the blood, pre-analytic tests called ABO compatibility and Rh compatibility are done between the donor and the recipient [2-6]. Transfusion transmitted infections screening is also done for the donor's blood sample. Improper screening may lead to incompatible blood transfusion causing severe hemolytic disease which at times leads to fatal consequences and infectious blood transfusion causing diseases [7,8].

Blood transfusion errors occurs due to infusing incorrect blood due to misidentification of patients [9], wrong labeling of blood bags can cause adverse reactions [9], errors in compatibility testing can cause hemolytic reactions, antibodies present in donor blood against recipient antigens causing antigen antibody reactions, transfusing blood due to improper screening may contains infectious agents like HIV, hepatitis B and C [10], infusion of large amount of blood can cause iron overload, storage of blood at incorrect temperatures can cause adverse reactions [11,12].

Policies and guidelines related to blood transfusion have been established by increasing safety procedures in transfusing blood and preventing the side effects triggered by incompatible blood transfusion [13,14]. Much attention must be paid to safety of blood products prior to transfusion rather than the actual blood transfusion process [15].

2. METHODOLOGY

The prospective study on the pre-analytical errors of actual transfusion of blood components was conducted by distributing online questionnaire among the interns of tertiary care teaching hospital during January to August 2020. The data, collected from the responses, was analyzed statistically.

3. RESULTS

A total of 150 interns in a Tertiary care teaching hospital were given the questionnaire in which 136 interns responded. The significant findings of the pre-analytical errors of blood transfusion are: 105 [77.8%] interns were aware of the blood transfusion guidelines and remaining 31 [22.2%] were unaware of it. 116 [85.9%] interns stated that the blood components have to be transfused within 30 minutes from the time of Issue and remaining 29 [14.1%] stated that blood has to be transfused within 1 hour. 122 [90.3%] interns stated that transfusion should be completed within 4 hours for packed RBC and 14 [9.7%] interns stated that transfusion should be completed within 6 hours. 109 [80.1%] interns stated that the request generation was granted by resident doctor for blood transfusion and remaining 27 [19.9%] from faculty.

Around 103 [76%] interns stated that labeling should be done at bedside for collected blood sample, 26 [19.5%] interns stated that labeling should be done at nursing counter and then sample should be collected at bedside, 7 [4.5%] interns stated that sample should be collected first and then labeling should be done at nursing counter. 24 [18.4%] interns stated that blood sample should be collected in EDTA and remaining 110 [81.6%] stated as Plain and EDTA.

132 [97.1%] interns were aware of checking compatibility report of blood bag but remaining 4 [2.9%] wasn't aware of checking compatibility report.

Regarding test tube labeling 99 [73.5%] interns stated that both name and hospital registration number of the patient is necessary and 37[26.5%] opted for only hospital number.

126[92.8%] interns stated that comparing the patients identification with patients hospital armband and compatibility report along with blood group is necessary before transfusion but 10[7.2%] opted only for blood group and name.

135[99.3%] interns were aware of signs of acute transfusion reaction and only 1[0.7%] was unaware of signs of acute transfusion reaction.

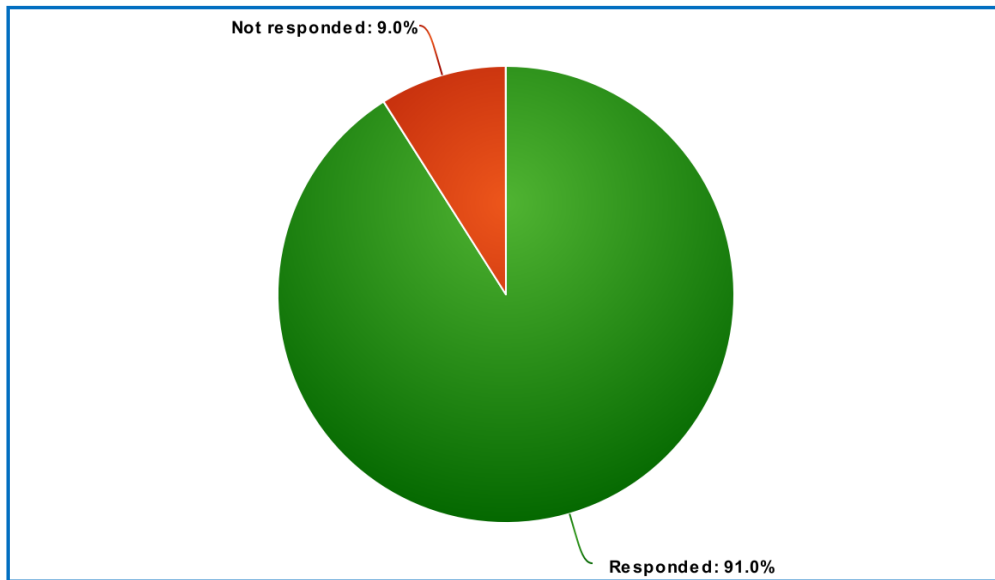


Fig. 1. Survey Respondents

4. DISCUSSION

The role of blood transfusion is significantly effective but at the same time it could be a life-threatening risk [16-18]. This study was conducted to know about the awareness of knowledge, attitude and practice of the blood transfusion procedures among the interns. The results showed lower frequency of incidents in pre-analytic errors (mistakes in bedside transfusion and verification of blood) which was similar to the results of Masaki et al., 2020 [9]. Generation of request by the resident doctors showed similar results of Kabinda et al., 2014 [10] and results related to labeling the test tube by both name and hospital registration number is similar to the results obtained by Khetan et al., 2018 [19]. Results revealed in the compatibility error was similar as compared to the results of Linden et al., 1994 [20] and Mc Clelland et al., 1994 [7].

5. CONCLUSION

In this study, low prevalence of pre-analytical errors was observed in all the stages. These errors occur during patient identification and sample collection are preventable. Blood bank should record all the errors being committed and provide education and training with appropriate transfusion procedures to prevent those errors and ensure safe of blood transfusion.

CONSENT

Online consent form obtained from participants.

ETHICAL APPROVAL

Ethical approval obtained and preserved by authors.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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