



## Mistaken Identity of a Voluntary Plateletpheresis Donor; Reiterating the Importance of Positive Identification in the Blood Transfusion Chain

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Sir,

An important limiting factor for use of apheresis platelets is the availability of plateletpheresis donors.<sup>1</sup> At our regional blood transfusion center approximately 80% of our whole blood (WB) collection is contributed by voluntary donor base. The need for apheresis platelets is ever increasing especially in hematology and transplant centers and we are trying to build-up a panel of plateletpheresis donors from the existing pool of WB donors by continuous motivation and awareness about the need for apheresis platelets. Hence, every deferral of a plateletpheresis donor needs to be critically evaluated.

We report an unusual cause of deferral in a plateletpheresis donor that surfaced when a plateletpheresis donor presented with a 'blood group card' (BGC) bearing his name and blood group as O Rh (D) negative. The BGC is provided to all our voluntary blood donors who donate blood in various outdoor blood donation camps which carries the following information as mentioned by the donor in the 'donor registration card' prior to donation: (i) donor registration number, which is unique to the donor and the corresponding blood unit, (ii) date of donation, (iii) donor's name, address and contact number and (iv) the blood group (ABO and Rh D) as determined by our testing. These BGC are collectively despatched from our center after checking the individual donor details to the organizer of that particular blood donation camp along with the 'camp blood group list'. These BGC are further distributed by the organizer to individual donors in accordance with the enclosed list.

As per the standard operating procedure for plateletpheresis, the donor's blood samples were collected for blood grouping, hemoglobin, platelet count and transfusion transmissible infection testing. To our utmost surprise the blood group of the donor was typed as B Rh (D) positive. A discrepancy between the blood group documented on the BGC and the blood group testing became apparent and repeat blood grouping from a fresh sample confirmed the results. The donor registration card, camp blood group list and blood grouping records of fully automated immunohematology analyzer (Qwalys 3, Diagast, France) reported the group as O Rh (D) negative. The master donor record register was checked and it also provided concordant information; it verified that the blood unit was cross matched and issued to a patient with O Rh (D) negative group and transfused without any adverse reaction.

The donor was questioned as to whether this group card was his own and he confirmed that he had donated blood on that particular date and venue at a blood donation camp, and this corroborated with our blood donation camp records. However, during further interaction with the blood donor; he mentioned that the address printed on the group card was incorrect. Subsequently, we again checked the blood donor registration card and the camp blood group list, and they matched in totality; but differed from that printed on the group card. On further cross checking the details with father's name, address and telephone number on the blood donor registration card were not matching with the information being provided by the present donor. This led us to think that could there be two blood donors in that camp with same names; and to our relief there were indeed two donors with same name. The blood donor registration card of the second donor from the same blood donation camp was retrieved and it matched on all accounts with the details of the present donor; thus, confirming that this donor was indeed B Rh (D) positive (surname was not entered by both the donors on the registration card filled by the donors). On further questioning, the donor informed that he was contacted by the camp organizer to come and donate for a patient and this BGC was also given to the donor for the platelet donation at that time only and he did not check the details in

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a hurry, due to urgency for platelet donation. This cleared all the prevailing confusion and it proved that he was handed over the group card of the other donor having same name. The entire episode made us realize the very basic taught to every transfusion medicine trainee that positive confirmation of identity is of utmost importance. Whether it is blood sample taken inward from transfusion recipient and sent to blood bank for blood grouping, cross matching or any special immunohematology test or the prospective blood donor before donating blood, thus correct identification is a must during the entire 'vein to vein' transfusion chain; and must also be maintained during the entire documentation involved within the blood transfusion services and in correspondence with blood donors including the distribution of reports like group cards. This episode reiterates that information provided by the donor is of vital importance and the staff in transfusion services should be sensitized to this fact in order to avoid errors in the vein to vein transfusion chain, which is a very important recommendation issued in the serious hazards of transfusion (SHOT) 2011 annual report and summary chapter eight; incorrect blood component transfusion under the action category of everyone.<sup>2</sup>

## REFERENCES

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