

Anti-D

.....at the sharp end

Presented by

Tony Davies - Transfusion Liaison Practitioner

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Anti-D now a separate chapter, instead of part of IBCT

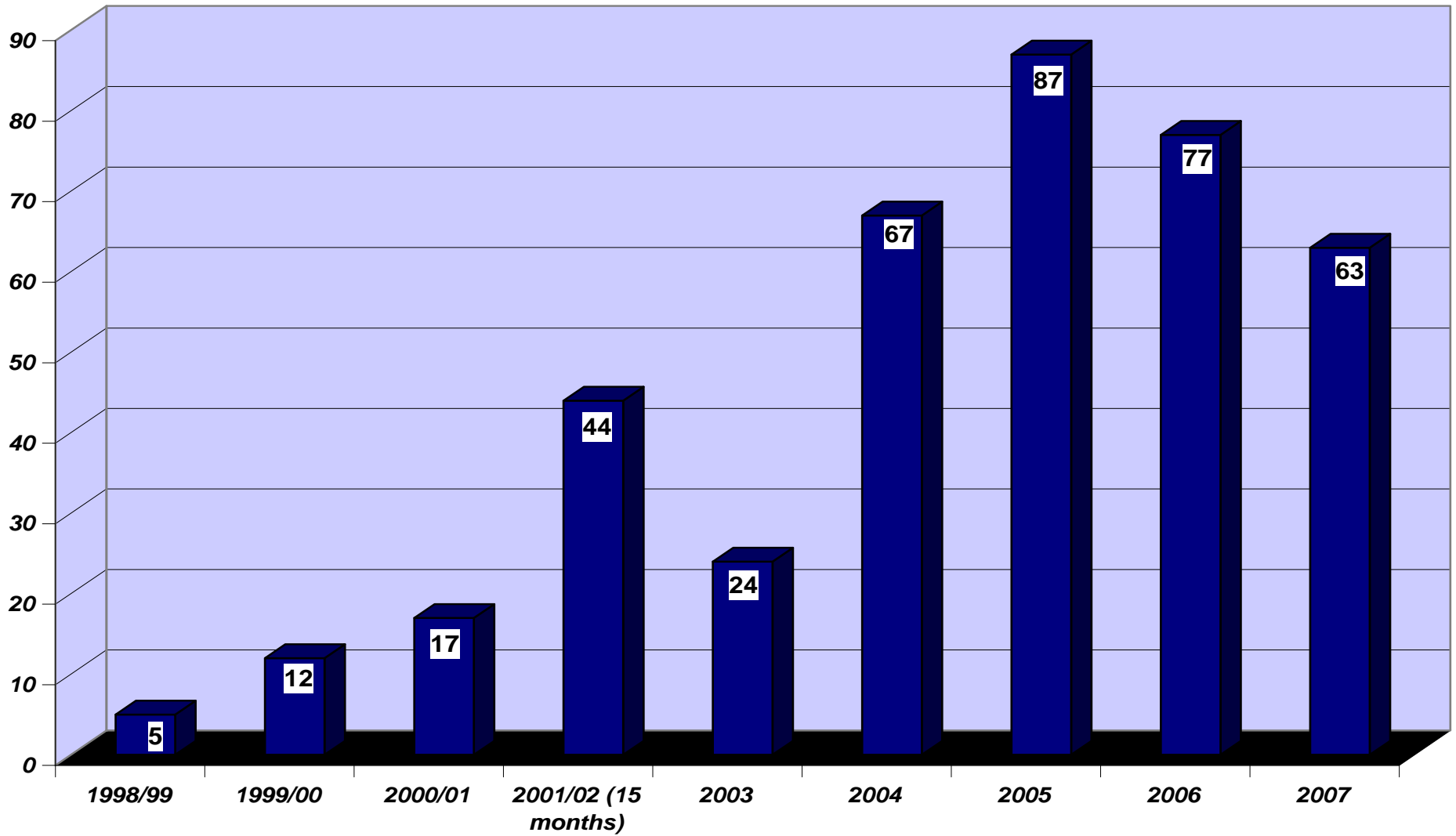
- “Any reaction due to anti-D when administered, or any serious adverse event relating to the prescription or administration of anti-D which has the potential to cause harm to the mother or foetus immediately or in the future.”



Reporting Categories

- Omission or late administration of anti-D immunoglobulin.
- Inappropriate administration of anti-D immunoglobulin to;
 - a D positive patient.
 - a patient who already has immune anti-D.
 - a mother of a D negative infant.
 - a different patient from the patient it was issued for.
- An incorrect dose of anti-D immunoglobulin according to local policy.
- Administration of expired, or otherwise out of temperature control, anti-D immunoglobulin





Type of event	Number of-			
	Cases	Primary (All) Errors		
		Midwife / Nurse	Laboratory	Doctor
Omission or late administration of anti-D Ig	24	22 (24)	2	-
Anti-D Ig given to D positive patient	17	3 (5)	11	3
Anti-D Ig given to patient with immune anti-D <i>(In 4 reported cases, there was no actual error involved)</i>	6	(1)	2	-
Anti-D Ig given to mother of D negative infant	6	-	6	-
Anti-D given to wrong patient	6	5 (5)	-	1
Wrong dose of anti-D given	2	(2)	2	-
Anti-D Ig expired or out of temperature control	1	(1)	1	-
Other <i>(anti-D Ig administered instead of anti-Tetanus globulin)</i>	1	-	-	1
Total cases	63	30 (38)	24	5
Total errors; Primary / (All)		59 (67)		

Laboratory errors accounted for 24 (36%) of the reported errors in this section.

- Two errors, where anti-D was issued to mothers of D negative babies, were by laboratory staff who did not regularly work in transfusion.
- In 6 cases, historical results or hazard flags in the LIMS should have prevented the issue of anti-D, but these were ignored or overridden by the BMS on duty at the time of request.
- There were 3 cases where the wrong dose, according to local policy, or an expired vial of anti-D was issued, and these were compounded by failure to detect the error at the bedside prior to administration



Case 10

- *Mother and cord samples were correctly tested, both as D negative. The BMS then incorrectly transcribed the maternal result onto the request card as D positive.*
- *When the ward telephoned the laboratory to ask for the results, a second BMS assumed that the D positive result belonged to the cord, and issued anti-D on that basis.*



Case 4

- *28 week sample had detectable anti-D*
- *Erroneously reported as 'post-injection' of anti-D where there was **no record** of previous anti-D administration*
- *Further anti-D administered later in the pregnancy*



Case 22

- *BMS misread manual cord test as D Pos*
- *Failed to follow laboratory SOP to carry out confirmatory testing*
- *Issued anti-D to mother of D negative baby*



Case 26

- *M&C request received from a patient with known anti-C+D, but did not specify this on the form*
- *BMS ignored antibody hazard flag on laboratory IT system and issued anti-D*



Many of the cases involve failure to follow basic clinical and laboratory protocols and highlight the need for education to all staff groups around a subject where there is evidently variation in practice and lack of understanding

An Anti-D Working Group with multidisciplinary representation has been formed to take this forward

