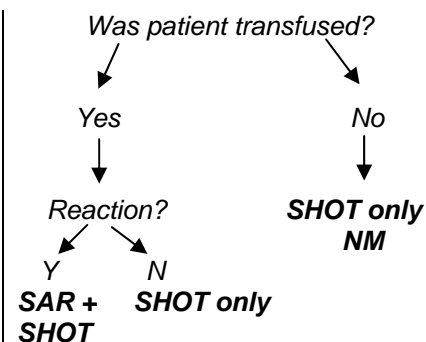


SABRE SCENARIOS & SOLUTIONS

<p>1. Two patients on an oncology ward required transfusion. Patient 1 was Group O, Patient 2 was group A. Both units of blood were collected from the blood bank and checked on the ward away from the bedside. The units were inadvertently transposed by the nurse and transfused to the wrong patients. Patient 1, who was group O, and received group A blood, suffered a severe acute haemolytic transfusion reaction and required admission to ICU. Patient 2, who was group A and received group O blood, was unharmed.</p>	<p>Patient 1 = SAR + SHOT</p> <p>Patient 2 = SHOT only</p>
<p>2. A young woman was admitted through A&E with gastro-intestinal bleeding. An on-call BMS grouped her as D positive when, in fact, she was D negative. She had been grouped previously but because she was allocated an A&E number the previous record was unavailable.</p>	<pre> graph TD Q1[Transfused?] -- N --> A1[SAE + SHOT] Q1 -- Y --> A2[SAE + SHOT NM] Q2[picked up where?] --> A3[Lab] A3 --> A4[SHOT only NM] </pre>
<p>3. A patient with Hodgkins Disease required an elective transfusion. The request form stated "Anaemia due to Hodgkins' Disease", but did not stipulate that irradiated blood was required. The lab supplied non-irradiated red cells, the patient suffered no ill-effects.</p>	<p><i>May vary locally</i> BMS expected to know that Hodgkins requires irradiated components ?</p> <pre> graph TD Q3[May vary locally BMS expected to know that Hodgkins requires irradiated components ?] -- Y --> A5[SAE + SHOT] Q3 -- N --> A6[SHOT only] </pre>
<p>4. Blood was cross-matched for a patient undergoing liver transplantation on Friday 7th October and was placed in a satellite refrigerator in the liver unit. One of the units expired at midnight on Saturday 8th and the ICU had been warned by the lab that it was near expiry and should be used first. This blood was not used peri-operatively, but on Sunday 9th the patient's Hb had fallen to 6.5 g/dl and transfusion was prescribed. The expired unit was collected from the refrigerator and transfused. The patient did not suffer harm.</p>	<p>Who is responsible for stock control?</p> <pre> graph TD Q4[Who is responsible for stock control?] -- LAB --> A7[SAE + SHOT] Q4 -- WARD --> A8[SHOT only] </pre>
<p>5. Same scenario as 4 above but nurse carrying out bedside check notices the expiry date and does not transfuse the blood.</p>	<p>Who is responsible for stock control?</p> <pre> graph TD Q5[Who is responsible for stock control?] -- LAB --> A9[SAE + SHOT NM] Q5 -- WARD --> A10[SHOT NM] </pre>
<p>6. A patient is admitted with a ruptured abdominal aortic aneurysm. A blood sample for crossmatch is sent to the lab. The on-call BMS uses a manual grouping technique and incorrectly groups the patient as AB instead of the correct group, O. He has no group AB blood available, so instead issues 4 units of group A, which are all transfused in theatre. During the operation the patient becomes hypotensive. Massive bleeding is uncontrolled and he dies in the recovery room.</p>	<p>Consider symptoms to decide whether SAR or SAE</p> <p>consider imputability level</p> <p>after full investigation of case review report type and imputability</p> <p>SAR or SAE + SHOT</p>

<p>7. A patient is admitted with a ruptured abdominal aortic aneurysm. A blood sample for crossmatch is sent to the lab. The on-call BMS uses a manual grouping technique and incorrectly groups the patient as AB instead of the correct group, O. He has no group AB blood available, so instead issues 4 units of group A, which are all transfused in theatre. During the operation the patient becomes hypotensive and develops DIC. Massive bleeding is uncontrolled and he dies in the recovery room.</p>	<p style="text-align: center;">SAR + SHOT</p> <p style="text-align: center;"><i>Reaction imputability 3</i></p>
<p>8. A patient is admitted to A&E from a hospice with gastro-intestinal bleeding. He is terminally ill with oesophageal cancer. The SHO requests blood but takes the sample for crossmatch from the wrong patient. After the first 100 mL of blood the patient complains of loin pain, develops a fever and passes dark urine. The transfusion is stopped and on investigation the blood is found to be ABO incompatible. The patient develops renal failure and dies 3 days later – the certified cause of death was metastatic carcinoma.</p>	<p style="text-align: center;">SAR + SHOT</p> <p style="text-align: center;"><i>Reaction imputability 3</i></p>
<p>9. A patient with acute leukaemia is admitted from the clinic for a platelet transfusion. During the transfusion she becomes acutely dyspnoeic and a chest X-ray shows a complete white-out. She is admitted to ICU and ventilated for 48 hours. She makes a complete recovery.</p>	<p style="text-align: center;">SAR + blood service + SHOT</p> <p style="text-align: center;"><i>Do not send confirmation until investigations complete and agreed with SHOT. Review imputability before submitting confirmation.</i></p>
<p>10. Request made for 4 units of FFP for a patient prior to liver biopsy. Immediately after the second unit has been given the patient suffers acute respiratory distress. The transfusion is stopped and the initial report to the lab is query TRALI.</p>	<p style="text-align: center;">SAR + blood service + SHOT</p> <p style="text-align: center;"><i>Do not send confirmation until investigations complete and agreed with SHOT. Review imputability before submitting confirmation.</i></p>
<p>11. Request made for 2 units of red cells for a patient on Fludarabine. The request is made for the units to be irradiated. The lab computer has marked against this patient the need for irradiated components. Two units issued but not irradiated. The patient received the 2 units with no apparent ill effect. Six weeks later the patient develops TA-GvHD confirmed by skin biopsy.</p>	<p style="text-align: center;">SAE + SHOT</p> <p style="text-align: center;"><i>When notified of TA-GvHD report as</i> SAR + SHOT</p>
<p>12. Two units requested for patient with NHL who is on oral fludarabine. Information on request form = anaemia. No request for irradiated components, patient not known to LIMS. Two units issued, transfused no ill effect. Two days post transfusion the consultant informed lab the patient should have received irradiated components. Marked for future on LIMS.</p>	<p style="text-align: center;">SHOT only</p>
<p>13. A group received on a 28 year old female who is 26 weeks pregnant and admitted with APH. Lab groups the sample as group O D negative, no irregular antibodies – 500 iu anti-D issued. The following day a repeat group received and grouped as O, D positive. A further sample was requested and confirmed as O positive. The original sample had been taken from the wrong patient.</p>	<p style="text-align: center;">SHOT only</p> <p style="text-align: center;"><i>anti-D</i></p>

14. Sample received from patient who had previously grouped as O positive. The current sample groups as A positive. On questioning the MO who had taken the sample he realised he had bled the wrong patient.



15. Patient undergoing THR, postop significant blood loss and unstable. Two units of blood requested and stored in theatre. One given in recovery, the 2nd unit of blood up and running. When checked on handover – patient details found to be incorrect. Blood groups compatible. Patient wrongly identified from addressograph label.

SHOT only
BUT SHOT would need further detail before deciding whether this is IBCT or right blood to right patient.

16. Patient admitted for CABG, orthopaedic op 2 years previously and received transfusion elsewhere. Antibody screen negative. No historical transfusion records. Two G+S samples Antibody neg. Blood issued by E.issue. No immediate problems. Ten days post-op patient haemolysing with Hb 7 g/dL. Ab screen now positive.

SAR + SHOT

17. Two units of blood requested for Ann Jones, dob 14/12/52. Lab used sample labelled Annie Jones, 14/12/02. The sample used was group A positive, the patient was O positive and received 2 units A positive with no apparent adverse outcome.

SAE + SHOT

18. Unit of platelets required for prophylactic management in oncology patient thrombocytopenia. Platelets given, immediate fever, hypotension and shock. Blood and platelets cultured and were positive for *Staphylococcus aureus*.

SAR + blood service + SHOT