Annual SHOT Report 2018 – Supplementary information

Chapter 13: Right Blood Right Patient (RBRP)

IT-related RBRP cases n=35

There were 35 cases where there were IT errors that led to blood transfusion of the right blood to the right patients but with an error in the patient's ID. For 18 of these the error was the wrong name, 5 the wrong date of birth and 5 the wrong unique patient number. In 2 cases multiple details were wrong.

Historical or duplicate records n=4

In 1 case the historical record had not been identified or consulted and in 3 cases the wrong record had been selected on the LIMS or patient administration system (PAS).

Manual transcription n=26

There were 10 RBRP errors due to incorrect data being entered or accessed manually on the LIMS, in 11 cases there was a discrepancy between the LIMS and the PAS. In 5 cases blood was issued against the wrong patient ID manually entered from the sample or request form.

Problems with electronic blood management systems n=3

In 1 case with a major haemorrhage patient was not wearing a wristband so it could not be scanned with a bedside tracking system – but the blood was given anyway. In another case blood was collected from a remote electronic issue refrigerator despite there being an error in the date of birth.

Case 13.3: Expired mandatory training blocks access to electronic blood management system

As is intended, staff members who do not keep up-to-date with mandatory transfusion education can be blocked from using electronic blood management systems. When staff members had their access revoked they continued to transfuse patients without any electronic bedside checks.

Case 13.4: Nurse followed incorrect process and did not print a label for remote electronic issue

A remote electronic issue system was in operation on a site with a haematology/oncology day ward. A nurse who had been trained to use the system obtained blood for an elective day-case transfusion by using the emergency button to access the refrigerator then, using a blood group and antibody screen result, selected a unit of blood of the same blood group as the patient and transfused it without printing out any compatibility labels.

Warning not heeded n=1

In this case a PDA alerted the nursing staff to a discrepancy with the patients' name, which had the first and last names transposed. This alert was ignored and the blood transfused anyway.

Printing error n=1

A transfusion record sheet contained a label where only the patient name was legible, with the other patient identifiers not being printed clearly. The transfusion took place without proper positive patient identification.