

Annual SHOT Report 2018 – Supplementary information

Chapter 8: Incorrect Blood Component Transfused (IBCT)

IT-related IBCT cases n=125

IBCT-WCT n=24

Of the 24 WCT IT-related errors, 17 were in the laboratory area, and 7 in the clinical area.

Of the 24 incorrect blood components transfused related to IT errors, 16 were in HSCT patients and two in solid organ transplant patients. The IT errors related to the laboratory were largely due to the failure of flags, alerts and warnings but also because information about the transplant had not been communicated to the laboratory. In 8 cases there was a flag to denote the ABO requirement of blood components in ABOi HSCT, but these were not heeded and in another 8 the flags were not updated to reflect the change in requirements.

IBCT-SRNM n=101

Of the 101 SRNM IT-related errors, 60 arose in the laboratory and 41 in the clinical area.

A large proportion of errors resulted in the correct phenotype match not being selected (27 cases). Ten of these were due to failure to consult the historical record and 1 due to failure to link or merge records. In 2 cases the information that could have enabled the correct phenotype of red cells was on Sp-ICE. In 12 cases flags were either not heeded (4) or not updated (5) or flags were not used (3).

There were 51 cases where irradiated blood was required but not provided. In 25 cases there was a failure to heed (4) or update (21) the LIMS warning flag and a further 16 where the flag was not used.