

Annual SHOT Report 2018 – Supplementary information

Chapter 9: Handling and Storage Errors (HSE)

IT-related HSE cases n=23

Of the 23 cases, 12 related to cold chain management, 2 were due to expired blood components, 3 due to sample validity and 2 due to duration of the transfusion. There were 2 labelling errors and 2 miscellaneous handling and storage errors.

Case 9.4: Transfusion started despite the two blood-tracking alerts

A unit of blood was removed from the issue refrigerator just after midnight. An alert appeared on the kiosk explaining the unit had expired and to contact the laboratory. The on call BMS incorrectly assumed the alert was related to an earlier network failure and allowed the unit to be taken to the ward. A second alert occurred on the PDA again explaining the unit had expired and not to continue. But the transfusion went ahead. Within a few minutes the on call BMS looked into the alerts further and realised the error, recommending the transfusion be stopped and the blood returned to the laboratory.

Case 9.5: Malfunctioning infusion pump results in slow transfusion

A haematology patient was prescribed a routine red cell transfusion over 2 hours. And the infusion device was set at 150mL/hour. When the staff member returned, the rate of transfusion had changed to 75 mL/hour. The machine displayed a warning symbol next to the rate. However, the rate had not been changed by a staff member. This event was attributed to an infusion device malfunction, which is still under investigation by the hospital and the manufacturer.