# 13 Right Blood Right Patient (RBRP) n=216

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## Definition:

**Incidents where a patient was transfused correctly despite one or more serious errors that in other circumstances might have led to an incorrect blood component transfused (IBCT).**

## Key SHOT messages

- To minimise right blood right patient (RBRP) errors the emphasis must be to ensure that there is accurate patient identification throughout the transfusion process
- Staff should continue to utilise the bedside checklist as part of the administration process
- SHOT laboratory message (2018) remains pertinent: All laboratory staff must complete annual good manufacturing practice (GMP) training (European Commission 2015)

## Abbreviations used in this chapter

| | | | |
|---|---|---|---|
| **DOB** | Date of birth | **LIMS** | Laboratory information management system |
| **GMP** | Good manufacturing practice | **PID** | Patient identification |
| **IBCT** | Incorrect blood component transfused | **RBRP** | Right blood right patient |
| **ID** | Identification | | |

## Introduction

There were 216 cases reported in 2019 with no increase in the overall error rate from the 2018 report (Narayan et al. 2019). Clinical errors accounted for 153/216 (70.8%) with laboratory errors 62/216 (28.7%) and 1/216 (0.5%) where the location of the primary error could not be determined with the information that was received. The variation between clinical and laboratory errors is illustrated in Figure 13.1.

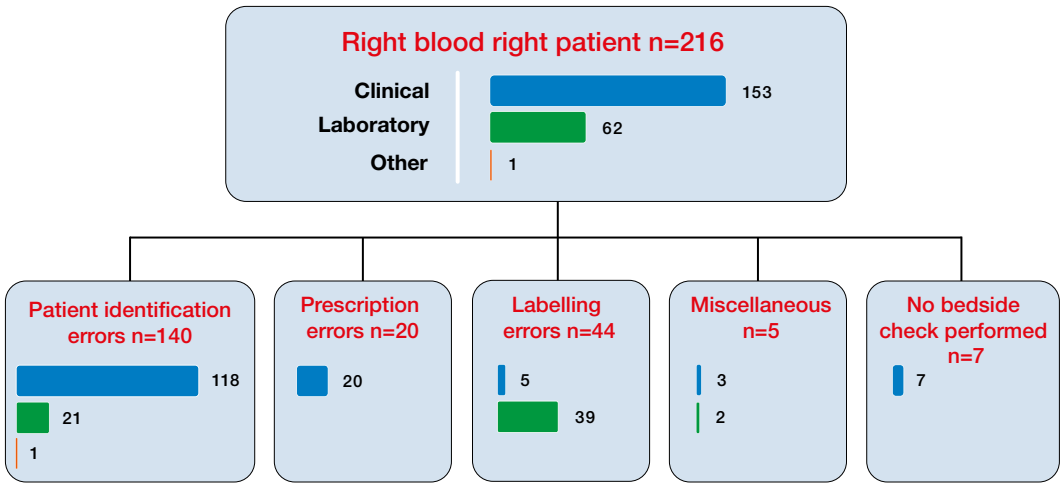


**Figure 13.1: Breakdown of 2019 RBRP reports n=216**

## Patient identification (PID) errors

PID errors accounted for 140/216 (64.8%) and remain the main cause of errors in RBRP as shown in Table 13.1. These PID errors continue to occur in all parts of the transfusion process. This includes clinical staff incorrectly writing patients details, omitting key demographics during the completion of the request form and sample labelling and these errors subsequently not being detected by the laboratory. In the laboratory this includes staff not transcribing and entering data correctly into the laboratory information management system (LIMS) during booking in of a sample.

**Table 13.1: Patient ID errors in 2019 n=140**

| Area/location | PID error | Number of reports |
|---|---|---|
| Clinical n=118 | Incorrect ID in relation to 4 key identification data points* | 96 |
| | No wristband/ID band | 6 |
| | Wrong details on wristband/ID band | 15 |
| | Incorrect address | 1 |
| Laboratory n=21 | Demographic data entry errors in relation to 4 key identification data points* | 20 |
| | Incorrect unidentified patient protocol followed | 1 |
| Other n=1 | Demographic data entry errors in relation to 4 key identification data points* | 1 |
| **Total** | | **140** |

**First name, last name, date of birth (DOB), unique identifier (BSH Robinson et al. 2018)*

### Case 13.1: Patient with dementia has multiple names

*A request for two units was received by the laboratory, at the sample receipt and registration stage the form and sample details matched correctly. The laboratory issued two units of crossmatched blood into the issue refrigerator. The first unit was transfused to the patient, however when collecting the second unit the nurse realised that the surname was the incorrect spelling for the patient. The nurse informed the laboratory and a further new sample and request form was sent to the laboratory. On further investigation it was identified that the patient's name had been changed multiple times on the electronic patient record system and it was only when the patient's relatives were contacted that the correct spelling was identified. The patient had dementia and was unable to confirm the correct details.*

This case outlined a failure to ascertain the correct patient details leading to multiple records for the patient. Whilst this was only a single report, with an ageing population this type of error may become more prevalent in future years.

## Use of checklists at administration

Despite previous SHOT recommendations and the resulting central alerting system (CAS) alert: 'Safe Transfusion Practice: Use a bedside checklist' (Department of Health 2017), the pre-administration bedside checklist is still not universally implemented. On review of the 2018 and 2019 data it would appear that the use of bedside checklists has increased, but the alert is not being adhered to by all. The number of reports stating that no checklist was available decreased from 43/216 (19.9%) in 2018 to 10/216 (4.6%) of reports in 2019. However, the number of reports (216) has remained the same for both reporting years. Checklists should continue to be used as this will aid the administration process and prevent errors.

### Learning points

- Ensure that staff verify patient details for patients who are incapacitated
- All staff must use a bedside checklist at administration

## Near miss RBRP cases n=162

There were 162 near miss RBRP incidents, 87/162 (53.7%) where the error originated in the laboratory and 75/162 (46.3%) in the clinical area. Near miss errors associated with PID were the biggest group with 94/162 (58.0%), followed by labelling errors 67/162 (41.4%), the remaining 1 case was a prescription error. The number of near miss RBRP events has decreased from 2018 when there were 202 errors.

## IT-related RBRP cases n=42

Further details of the IT-related reports can be found in the supplementary information on the SHOT website (https://www.shotuk.org/shot-reports/report-summary-and-supplement-2019/).

## Conclusion

RBRP errors do not cause harm but are indicators of a prevalent problem which could result in harm or death to a patient. It is essential that these incidents are captured and reviewed as they contain valuable learning opportunities, which may enable a systemic issue to be identified and appropriate action implemented, prior to patient harm. To minimise errors the emphasis must be to ensure that there is accurate patient identification throughout the transfusion process from sampling to the final bedside check by all staff groups. Regardless of the number of initiatives which have been developed with the aim of mitigating errors, the reviewed cases highlight a failure of correct bedside checking and attention to detail when entering patient information onto the LIMS. These are critical steps in the process to prevent the patient being transfused with incorrect blood.

## References

BSH Robinson S, Harris A, Atkinson S, et al. (2018) The administration of blood components: a British Society for Haematology Guideline. *Transfus Med* 2018;**28(1)**:3-21. http://onlinelibrary.wiley.com/doi/10.1111/tme.12481/full [accessed 08 June 2020].

Department of Health (2017). Safe transfusion practice: use a bedside checklist (CAS) CEM/CMO/2017/005 (2017). https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102663 [accessed 08 June 2020].

European Commission (2015) Guidelines for Good Manufacturing Practice (GMP) for Medicinal Products for Human and Veterinary Use. https://ec.europa.eu/health/sites/health/files/files/eudralex/vol-4/2015-10_annex15.pdf [accessed 09 June 2020].

Narayan S (Ed), Poles D, et al. (2019) on behalf of the Serious Hazards of Transfusion (SHOT) Steering Group. The 2018 Annual SHOT Report. https://www.shotuk.org/shot-reports/ [accessed 08 June 2020].