Annual SHOT Report 2014 – Supplementary Information

Chapter 23: Right Blood Right Patient (RBRP)

DATA SUMMARY
Total number of cases: n=169

Implicated components	
Red cells	**136**
Fresh Frozen Plasma	**6**
Platelets	**19**
Cryoprecipitate	**0**
Granulocytes	**0**
Anti-D Ig	**0**
Multiple components	**8**
Unknown	**0**

Mortality/morbidity	
Deaths *definitely* due to transfusion	**0**
Deaths *probably/likely* due to transfusion	**0**
Deaths *possibly* due to transfusion	**0**
Major morbidity	**0**
Potential for major morbidity *(Anti-D or K only)*	**0**

Gender	
Male	**83**
Female	**78**
Not known	**8**

Age	
≥ 18 years	**150**
16 years to <18 years	**1**
1 year to <16 years	**2**
>28 days to <1 year	**1**
Birth to ≤28 days	**5**
Not known	**10**

Emergency vs. routine and core hours vs. out of core hours	
Emergency	**23**
Urgent	**42**
Routine	**93**
Not known	**11**
In core hours	**76**
Out of core hours	**33**
Not known/Not applicable	**60**

Where transfusion took place	
Emergency Department	**16**
Theatre	**17**
ITU/NNU/HDU/Recovery	**26**
Wards	**73**
Delivery Ward	**3**
Postnatal	**1**
Medical Assessment Unit	**15**
Community	**0**
Outpatient/day unit	**4**
Hospice	**1**
Antenatal Clinic	**0**
Other	**12**
Unknown	**1**

(ITU=Intensive therapy unit; NNU=Neonatal unit; HDU=High dependency unit)

Right Blood Right Patient (RBRP) - Previous Recommendations

Year first made	Action	Recommendation
2011	**Hospital Transfusion Teams (HTTs), Trust/hospital/ Health Board Chief Executive Officers (CEOs)**	It is imperative that laboratory staff are extra vigilant when issuing multiple components for the same patient and that a final component/patient ID check is undertaken prior to issue. Hospital transfusion laboratories should consider purchasing label verification software or ensuring that a two-person check of units is undertaken prior to issue - Training and assessment in the laboratory must cover basic manual checking procedures - It is imperative that staff are vigilant at all times in the laboratory and clinical areas when participating in the patient ID process, especially when the patient is admitted - NO wristband (or alternative patient ID) – NO transfusion - Use of a transfusion checklist across the transfusion process will provide and extra level of safety