

SHOT Report 2012

Errata list

This list is not guaranteed to be complete. Errors such as minor typing errors or missing superscript fonts are not listed. SHOT would be grateful if you would report any further major or serious errors if you discover them.

Page	Item / Location	Error	Notes
20	ABO incompatible transfusions n=13 sub heading	2 Lab cases of ABO incompatible red cell transfusions were not included in the 2012 figure, and the number from 2011 has been amended due to an error in the 2011 data.	Corrected section should read: ABO incompatible transfusions n=15 (red cells n=12, FFP n=3) (10 incompatible red cells transfusions in 2011) There were 15 ABO-incompatible transfusions of which 4 transfusions of incompatible red cells resulted in major morbidity ('never events' ²⁰). Eleven originated from clinical errors: 3 wrong blood samples, 1 error in both collection and administration, and 5 mistakes in administration alone. Two haemopoietic stem cell transplant patients received incompatible red cells because the clinical area had not informed the laboratory about the transplant (these and other transplant issues are discussed in Chapter 29). Four laboratory errors resulted in 2 ABO incompatible red cell transfusions in HSCT patients, and 2 incompatible FFP transfusions.
28	Table 6.3 Annual summary report for all UK serious adverse events 2012 (n=930)	'Human error' total is incorrect. The correct number is 836 not 837.	Corrected table below
28	Table 6.4: Blood Establishment reports 2012 (n=153)	2 'Other' reports in the 'Human error' column were later classified as 'Distribution' but the figures were not properly amended to reflect this change.	Corrected table below

31	Table 6.6: Hospital blood bank reports 2012 (n=777)	'Human error' total is incorrect. The correct number is 761 not 762.	Corrected table below
55	Figure 9.1: Wrong blood incidents 2003-2012 showing ABO incompatible red cell transfusions	Number of red cell ABO incompatible transfusions amended following errors in the 2011 and 2012 data	Corrected figure below

<div><div><div><div><div><div></div><div>All other IBCT cases</div></div><div></div><div>ABO incompatible red cell transfusions</div></div></div><div><div>Number of reports</div><div>350</div><div>300</div><div>250</div><div>200</div><div>150</div><div>100</div><div>50</div><div>0</div></div><div><div>2003</div><div>2004</div><div>2005</div><div>2006</div><div>2007</div><div>2008</div><div>2009</div><div>2010</div><div>2011</div><div>2012</div></div><div><div>226</div><div>243</div><div>242</div><div>190</div><div>152</div><div>252</div><div>268</div><div>196</div><div>237</div><div>240</div></div><div><div>26</div><div>19</div><div>10</div><div>8</div><div>12</div><div>10</div><div>14</div><div>4</div><div>10</div><div>12</div></div><div>Year of report</div></div></div>			
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56	Table 9.1: Summary of incorrect blood component transfused cases	Numbers amended in 'Incorrect ABO/RhD group transfused to haemopoetic stem cell transplant patients (HSCT)' section – 2 of the laboratory cases should have been classified as incompatible ABO red cells.	Corrected table below
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57	ABO incompatible red cell transfusions n=10	Amend number to include the 2 additional laboratory HSCT cases	ABO incompatible red cell transfusions n=12 There were 10 clinical incidents which are summarised in Section 9.1.1, and 2 laboratory cases which are detailed in Chapter 29.
73	Table 10.3: Testing errors resulting in a failure to meet the patient's specific requirements	The headings and associated numbers are incorrect in this table	Corrected table below

Table 6.3: Annual summary report for all UK serious adverse events 2012 (n=930)

SAE deviation	Total number	Product defect	Equipment failure	Human error	Other
Whole blood collection	91	67	0	24	0
Apheresis collection	11	8	0	3	0
Testing of donations	3	0	1	2	0
Processing	14	0	0	14	0
Storage	217	0	8	207	2
Distribution	60	0	0	60	0
Materials	3	1	1	1	0
Other	531	1	5	525	0
Overall Total:	930	77	15	836	2

Table 6.4: Blood Establishment reports 2012 (n=153)

SAE deviation	Total number	Product defect	Equipment failure	Human error	Other
Whole blood collection	91	67	0	24	0
Apheresis collection	11	8	0	3	0
Testing of donations	3	0	1	2	0
Processing	3	0	0	3	0
Storage	3	0	0	3	0
Distribution	20	0	0	20	0
Materials	2	1	0	1	0
Other	20	1	0	19	0
Overall Total:	153	77	1	75	0

Table 6.6: Hospital blood bank reports 2012 (n=777)

SAE deviation	Total number	Product defect	Equipment failure	Human error	Other
Processing	11	0	0	11	0
Storage	214	0	8	204	2
Distribution	40	0	0	40	0
Materials	1	0	1	0	0
Other	511	0	5	506	0
Overall Total:	777	0	14	761	2

Table 9.1: Summary of incorrect blood component transfused cases

Type of event	No. of incompatible ABO red cell cases	No. of incorrect ABO/RhD cases	Total number
Collection and administration of incorrect blood component			32
ABO incompatible red cells	6		
RhD mismatched red cells		1	
ABO non-identical and RhD mismatched red cells		1	
ABO non-identical red cells		4	
ABO identical red cells		10	
Others		10	
'Wrong blood in tube'			6
ABO incompatible red cells	2		
RhD incompatible red cells		1*	
ABO non identical red cells		2	
ABO identical red cells		0	
Other		1	
Laboratory errors			21
ABO incompatible red cells	0		
RhD incompatible red cells		9	
ABO non identical red cells		4	
ABO identical red cells		1	
Other		7**	
Incorrect ABO/RhD group transfused to haemopoietic stem cell transplant patients (HSCT)			14
Clinical	2	2	
Laboratory	2	8	
Clinically based cases of specific requirements not met			106
Laboratory based cases of specific requirements not met			70
Clinical miscellaneous			3
TOTAL	12	61	252

* This also included in addition to red cells, a transfusion of O RhD positive fresh frozen plasma (FFP) to a B RhD negative recipient.

** There were 2 ABO incompatible FFP transfusions in paediatric patients.

Table 10.3: Testing errors resulting in a failure to meet the patient's specific requirements

Testing errors resulting in a failure to meet the patient's specific requirements	24/63
Antibody identification/exclusions not performed following positive antibody screen result	11
Inappropriate use of electronic issue	6
Errors in interpreting antibody identification results	5
Isolated cases: 1 wrong sample, 1 error in manual transcription of antibody screen result	2