Right Blood Right Patient (RBRP) n=216

13

Authors: Diane Sydney and Hema Mistry

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 message

- The key SHOT messages from 2017 remain pertinent: importance of patient identification (PID) and bedside checklist (Bolton-Maggs et al. 2018)

There were 216 cases reported in 2018 (200 in 2017) (Bolton-Maggs et al. 2018). The variation between clinical and laboratory errors are illustrated in Figure 13.1.

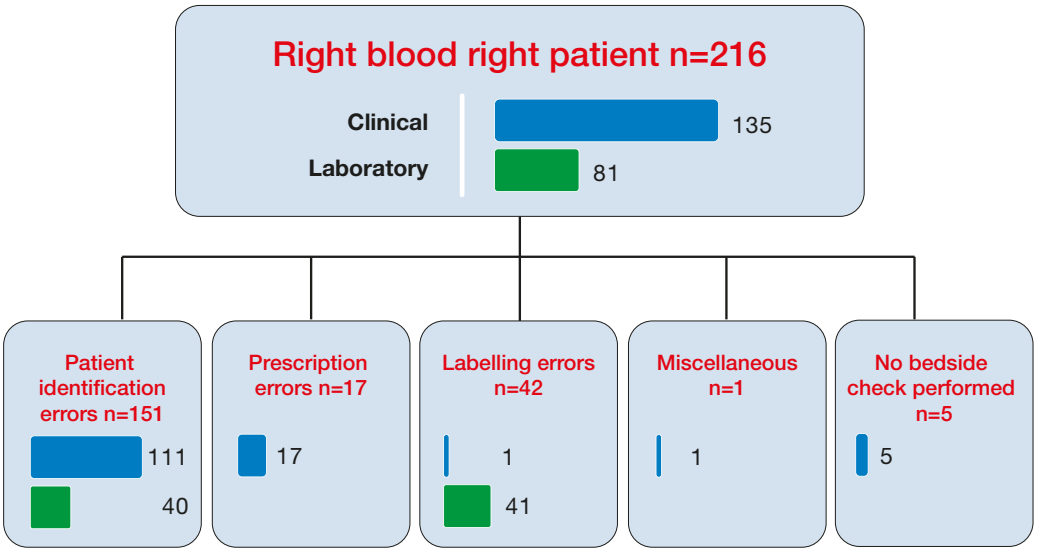

Figure 13.1: Breakdown of 2018 RBRP reports n=216

Of the 216 RBRP incidents, the single miscellaneous case was a student nurse who was asked by the consultant to collect a third shock pack during a major haemorrhage (as no one else was available) but had not been competency-assessed therefore could not gain access to the transfusion laboratory as they were not authorised for entry. They rang the bell, fortunately one of the laboratory staff came and helped on this occasion due to the urgency of the situation. The student nurse felt that they had to help and did not think about the fact that this was a task they were not able/trained to perform. The student nurse admitted they did not understand what a shock pack was. Fortunately, units were given to the patient in a timely manner, but this could have led to a delay in transfusion.

Learning point

- Staff/students can only participate in the transfusion process if they have appropriate training and are deemed competent

Patient identification (PID) n=151

PID errors are listed in Table 13.1. PID errors occurred in both the clinical, 111/151 (73.5%) and laboratory, 40/151 (26.5%) area and accounted for 151/216 (69.9%) of the RBRP reports, an increase of 31.3% from 2017 (n=115), (Bolton-Maggs et al. 2018). The laboratory PID errors have increased by 37.9% in 2018 (n=29 in 2017). There were 114/202 (56.4%) near miss PID errors where 78/114 (68.4%) occurred in the clinical area and 36/114 (31.6%) in the laboratory.

Table 13.1: Patient ID errors in 2018 n=151

Area/location	PID error	Number of reports
Clinical	Incorrect ID in relation to the four key identification datasets*	101
	No wristband/ID band	7
	Incorrect donation number	1
	Incorrect date on sample	1
	No signature on sample	1
Laboratory	Demographic data entry errors in relation to the four key identification datasets*	39
	Incorrect donation number	1
Total		**151**

**First name, last name, date of birth (DOB), unique identifier (Robinson et al. 2017)*

The two cases outlined below include multiple identification errors in the transfusion process which led to RBRP errors.

Case 13.1: Important to check PID against the label attached to the blood component and the wristband

A major haemorrhage protocol (MHP) was activated in the emergency department (ED) for a patient who had no previous historical records. Emergency O D-negative units were requested. The biomedical scientist (BMS) proceeded to issue O D-negative blood however when entering information on the laboratory information management system (LIMS) they linked the patient to a unique identifier belonging to another patient.

The porter collecting the emergency O D-negative blood arrived at the transfusion laboratory without a collection slip. The BMS gave the blood to the porter, who in turn delivered it to the ED. There were no staffing issues or other emergencies identified in the laboratory area at that time, although this patient was declared as a major haemorrhage. The nurse was confused as to why the emergency blood had another patient's details on the tag. However, as it was an emergency the nurse and another member within the team checked the prescription and confirmed the patients name and DOB with the PID band. The patient's unique ID was checked against the prescription but not checked against the label attached to the bag.

There were four subsequent points in the transfusion process where the primary error could have been identified:

- **Primary error - component selection:** When issuing emergency O D-negative units the BMS entering information onto the LIMS linked the patient's unique ID to another patient
- **Component labelling:** The BMS should have performed a check when labelling which could have identified that the unique ID did not belong to the patient the component was intended for. This could have led to a delay

- **Collection:** The porter did not have a collection slip therefore could not check which component needed collecting or be able to cross check the details on the label
- **Prescription and administration:** The nurses failed to undertake a comprehensive bedside check independently as per national requirement (Robinson et al. 2017). It is important to check PID on the wristband and the label attached to the blood component

Case 13.2: Error missed during a two-person bedside check

A foundation year one doctor spelt the surname incorrectly on the transfusion prescription or authorisation record. This form was used as part of the collection process. The healthcare support worker failed to notice the spelling error at collection. Subsequently two nurses undertaking the bedside check, failed to recognise the error.

Increasingly a transfusion record document is being used as part of the prescription or authorisation process, with medical staff predominately undertaking this task. Subsequently this document is being used for collection purposes, administration checks and also traceability. If there is an error on the prescription or transfusion record with core PID, staff undertaking the next step in the transfusion process are not detecting these errors.

These errors can be picked up by bedside verification information technology (IT) systems.

Learning points

- Staff must be vigilant if using the transfusion prescription or authorisation record as part of the collection process to ensure that core patient identification (PID) datasets are correct
- All staff working in transfusion should follow their correct local procedure/policy especially during emergencies and demanding periods as this is when errors are more likely to occur

For further laboratory-related errors and key messages and learning points for laboratory staff please see Chapter 14, Laboratory Errors.

Near miss RBRP cases n=202

There were 202 near miss RBRP incidents, 117/202 (57.9%) where the error originated in the laboratory and 85/202 (42.1%) in clinical area. Near miss errors associated with PID were the biggest group with 114/202 (56.4%), followed by labeling errors 85/202 (42.1%), the remaining 3 were prescription errors.

IT-related RBRP cases n=35

Further details of the IT-related reports can be found in the supplementary information on the SHOT website www.shotuk.org.

Commentary

As with previous years Annual SHOT Reports there has been very little alteration in the overall findings. SHOT continues to highlight that **ALL** staff participating in the transfusion process must adhere to correct PID procedures with attention to detail in all steps in the transfusion process. The administration process is a critical step in the transfusion process and the bedside check should be performed correctly and in full prior to administering the blood component to the patient.

References

BSH Robinson S, Harris A, Atkinson S, et al. (2017) 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 30 May 2019].

Bolton-Maggs PHB (Ed), Poles D et al. (2018) on behalf of the Serious Hazards of Transfusion (SHOT) Steering Group. The 2017 Annual SHOT Report. https://www.shotuk.org/shot-reports/ [accessed 30 May 2019].