Right Blood Right Patient (RBRP) n=187

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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 (IBCT) being transfused.

Key SHOT message

- Hospitals using electronic storage solutions or bedside checking systems should ensure that staff are trained and assessed as competent in their use in accordance with British Committee for Standards in Haematology (BCSH) guideline (BCSH Jones et al. 2014)

This category continues to be linked with patient identification (ID) and labelling errors, for example:

- Administration with erroneous or partial/omitted patient details on the label
- Labels being transposed between multiple units that are intended for the same patient
- Not using a patient ID wristband
- Administering transfusions for the intended patient that have not been authorised/prescribed

Reporters are encouraged to submit incidents where the right patient was transfused with the right blood, despite the observation that many of the errors could have led to rejection of the unit or limited evidence of documentation being available for the transfusion episode. Although these errors do not fit the IBCT definition as the intended patient received the blood component that was planned for them, they have been included to inform practice. There were 187 cases analysed in 2015, a slight increase from 169 cases in 2014.

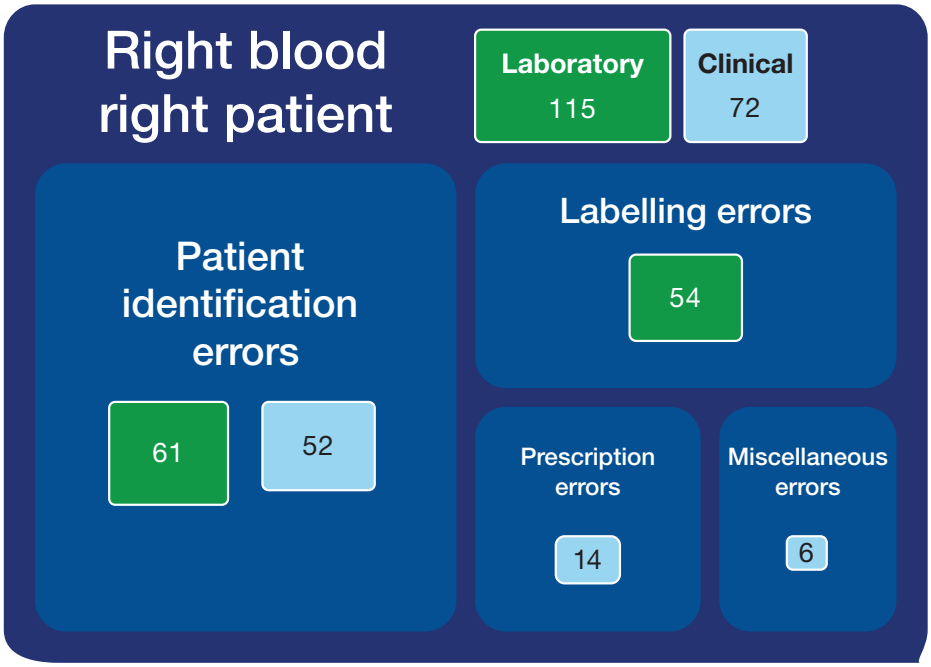

Figure 19.1: Overview and primary source of error

Table 19.1: Classification of errors

Type of error	2013	2014	2015
Patient identification errors	**118**	**116**	**113**
Name alone or with other elements	*51*	*45*	*51*
Date of birth (DOB) alone or with other elements	*28*	*32*	*26*
Wristband* missing/wrong wristband in place at final bedside checking procedure	*14*	*11*	*7*
Hospital or National Health Service (NHS) number or with other element	*21*	*27*	*24*
Address alone or with other elements	*3*	*1*	*5*
Patient ID details missing on sample tube/request form	*1*	*0*	*0*
Labelling errors	**52**	**34**	**54**
Transposed labels	*38*	*24*	*26*
Other labelling errors	*14*	*10*	*28*
Prescription error	**9**	**14**	**14**
Miscellaneous errors	**5**	**5**	**6**
No final patient ID check undertaken prior to administration of component	*1*	*2***	*1***
Other errors	*4*	*3*	*5*
Total	**184**	**169**	**187**

'Wristband' refers to identification wristband (or risk-assessed equivalent) as defined in the BCSH Guideline on the Administration of Blood Components (2009)

***BloodTrack electronic bedside checking and tracking used inappropriately resulting in RBRP checks not performed. This occurred with 164 units issued from a BloodTrack refrigerator with no final bedside check undertaken (same error as in 2014, 273 components). Users used the system designed to issue O D-negative blood in an emergency when removing components from the refrigerator*

Case 19.1: Patient identification error

Using the BloodTrack electronic system a nurse checked the patient's ID band against the compatibility tag on the unit of red cells. The system alerted the nurse to a wristband compatibility mismatch. There was a difference in spelling of the surname. This was the right blood for the right patient and the nurse proceeded with the transfusion ignoring the alert. The transfusion was stopped because the blood transfusion laboratory staff noticed the alert on BloodTrack and contacted the ward to instruct them not to proceed.

Case 19.2: Labelling error

Two units of red cells were issued to a patient where the blood tags were transposed. The first unit was collected and transfused. It was not noted that the bag and the label details did not fully match. The error was identified on checking the second unit prior to transfusion, when the staff realised that the blood tag and blood unit did not correspond. The staff notified the transfusion laboratory staff of the incident and the unit was returned, the error was corrected, and the unit was reissued and transfused.

Information technology (IT)-related RBRP error reports n=31

The 2014 Annual SHOT Report noted the need for hospitals and manufacturers to ensure that effective systems were put in place to negate staff bypassing the inbuilt checks when collecting blood. Unfortunately this continues to happen as detailed in the case study below.

Case 19.3: Bedside override of electronic system results in several units not being checked properly at the bedside

These incidents (discussed also in Chapter 10, Information Technology (IT) Incidents) are related to a previous 2014 SHOT report in which the BloodTrack electronic bedside checking and tracking was set up and used inappropriately resulting in RBRP checks not being performed. Despite identification of the problem a further 164 units were transfused in this way over a 13 month period, from November 2014–November 2015.

Remedial actions taken after the first occurrence noted last year have not had the expected impact required. This should be reviewed and resulting action plans implemented and assessed on a regular basis to ensure compliance.

Near miss RBRP cases n=130

Point in the process	Type of error made	Number of cases	Percentage of cases
Sample receipt	Sample labelling error not rejected	23	33.8%
	Wrong identifiers entered in LIMS	21	
Component labelling	Transposition of labels for same patient	52	66.2%
	Incorrect patient information on label	34	
Total		**130**	**100%**

**LIMS=laboratory information management system*

Table 19.2: Near misses that could have led to RBRP n=130

COMMENTARY

There has been little change in the overall findings. All staff must adhere to correct identification practice in all aspects of transfusion.

References

BCSH Harris AM, Atterbury CL, et al. (2009) **Guidelines on the administration of blood components**. http://www.bcshguidelines.com/documents/Admin_blood_components_bcsh_05012010.pdf [accessed 20 January 2016]

BCSH Jones J, P Ashford, et al. (2014) **Guidelines for the specification, implementation and management of information technology (IT) systems in hospital transfusion laboratories**. http://www.bcshguidelines.com/4_haematology_guidelines.html?dtype=Transfusion&dpage=0&sspage=0&ipage=0#gl [accessed 20/01/2016]

Bolton-Maggs PHB, Poles D et al. (2014) **The 2014 Annual SHOT Report**. www.shotuk.org [accessed 20 January 2016]