Learning points

- The pre-transfusion checking procedure must include a check of the expiry date of the component.
- Hospital transfusion teams must collaborate to ensure that procedures are in place for safe transfer of blood between hospitals.

Errors originating at the supplying blood centre

There were 10 errors by 7 blood centres. Errors included;

Failure of screening procedures to detect a strong anti-Fy^{a} in an apheresis platelet donor resulting in passive transfer of antibody sufficient to cause a positive antibody screen.

Failure to detect a high titre haemagglutinin in red cells labelled as suitable for neonatal transfusion resulting in accelerated red cell destruction in a group B infant.

Two instances in which a verbal report by a reference laboratory was inconsistent with the final report. In one case this resulted in failure to select antigen negative red cells; in another anti-D was inappropriately administered to a patient with a weak D.

Provision of RhD positive platelets when RhD negative had been requested for a RhD negative patient - this error was not detected by the hospital laboratory or at the bedside.

An ad hoc delivery of Group O RhD negative blood directly to an A&E department instead of to the transfusion laboratory. A doctor transfused the blood.

Failure to provide CMV negative components.

Errors in anti-D administration

SHOT has not actively encouraged reports of incorrect administration of anti-D Ig, but nevertheless each year reports of such events are received. This year there has been a reduction in the number of anti-D errors reported.

As with other IBCT reports, there are errors at all stages of the process, including patient identification, laboratory errors, incorrect serological reasoning in the laboratory and by clinical staff. The majority of errors are of commission and we receive few reports of errors of omission, which are likely to have more serious clinical consequences.

This year 26 errors were reported in 24 cases, of which 16 related to incorrect or equivocal RhD grouping in laboratories.

Table 5
Anti-D errors

Type of error	Number
Misunderstanding of guidelines by midwife	3
Anti-D given to wrong patient	3
Late administration of anti-D Ig (>72hrs)	2
Patient already sensitised, misinterpreted by laboratory	2
RhD grouping error – cord sample	5 (2 due to reagent problem)
RhD grouping error – maternal sample	5
Weak RhD group (includes 1 reference laboratory)	6

Case 42

The wrong notes accompanied a patient to theatre for a caesarian section. Anti-D Ig was given on basis of historical group in (wrong) notes without sending a confirmatory sample.