SERIOUS HAZARDS OF TRANSFUSION SHOT

Delays in transfusion

BBTS Conference, Sept 2017

Delayed provision of red cells as a result of poor labelling and communication confusion

- An elderly man required an emergency transfusion during massive gastrointestinal haemorrhage (Hb fell from 88 to 47g/L) complicated by a warfarin-related high INR of 11.5
- Group-specific red cells were issued but were unlabelled for the patient and could not be transfused
- The samples were sent by the incorrect route (pneumatic tube rather than hand-delivered), there were communication failures between the clinical area and the laboratory
- The patient arrested and died, and the delay in transfusion may have contributed (3 errors).

More haste less speed – wrong date of birth

- A 66 year old man with a ruptured aortic aneurysm had delayed provision of major haemorrhage packs as the ambulance staff transferring him from one hospital to another gave the wrong date of birth to the emergency department
- This was entered into the Trust information technology (IT) system. In addition, the blood sample was delayed reaching the laboratory and had not been marked as urgent (2 errors)

SHOT Symposium 2018

The Lowry Centre, Salford Quays

Thursday 12th July 2018