Attention to detail is required: Ensure patient identification is right

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Background

A RBRP incident is reported when a patient is transfused the correct blood component despite one or more serious errors in the process that in other circumstances might have led to an incorrect blood component being transfused. Although ensuring patient safety is a principal characteristic of statutory requirements and clinical governance, Right Blood Right Patient (RBRP) incidents still happen.

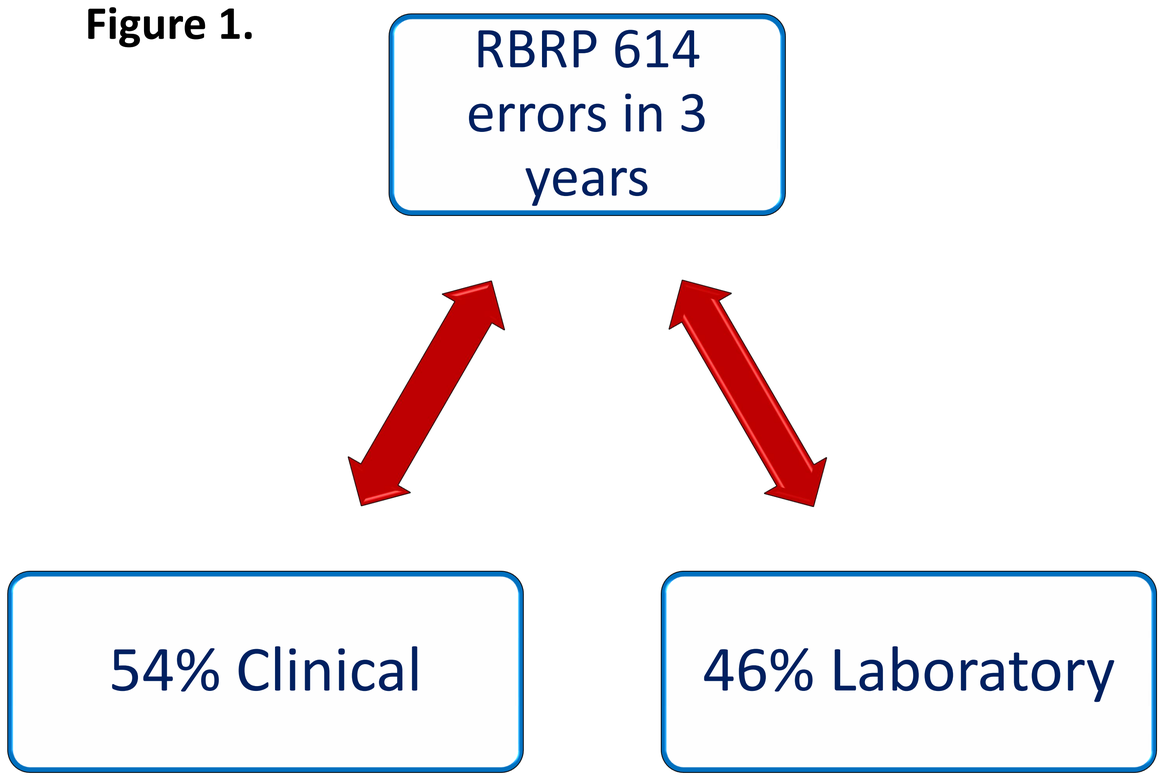
Method

RBRP reports made to SHOT from January 2015 to December 2017 were reviewed to ascertain where errors in patient identification (PID) most frequently originated to establish main areas staff should focus on for improvement and prevention.

Results

In total 614 reports (Figure 1) were reviewed over a 3 year period, 332 (54%) originated in the clinical area while 282 (46%) occurred in the laboratory.

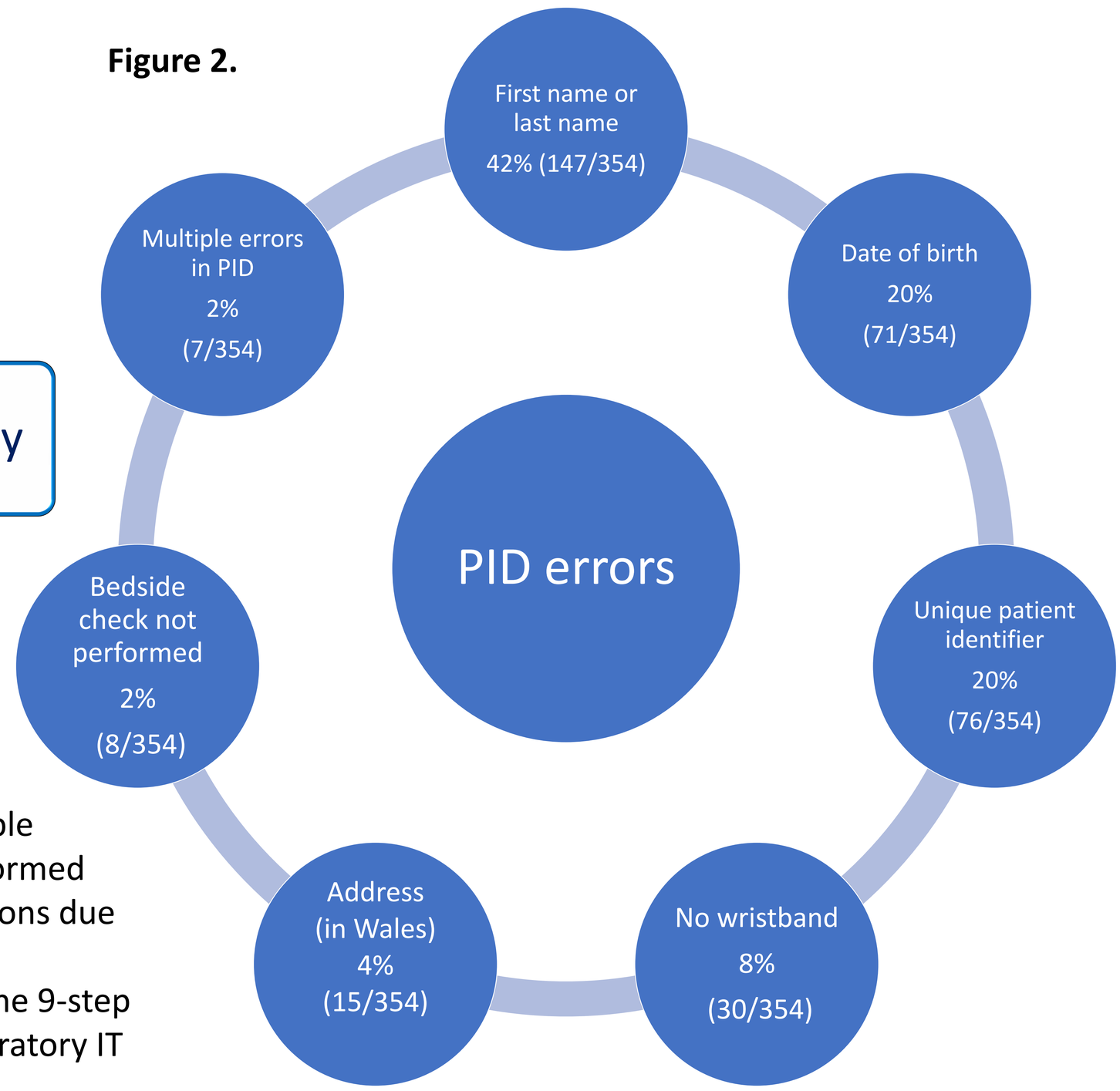
Figure 1.



Errors in PID accounted for 354/614 (58%) incidents where 224/354 (63%) occurred in a clinical setting and 130/354 (37%) in the laboratory. The remaining 260 RBRP incidents were due to errors in component labelling or the prescription.

The most common PID errors were omissions of core patient identifiers:

Figure 2.



ABO incompatible transfusions from PID errors

In the same time period there were 11 ABO-incompatible transfusions reported to SHOT where PID was not performed correctly. Patients received ABO-incompatible transfusions due to errors in PID during sample taking (3 cases) and administration (7 cases). These are key points of ID in the 9-step process of transfusion. The final case was due to a laboratory IT validation error.

Conclusion

RBRP errors do not cause harm but are symptoms of a significant problem which could result in harm or death from wrong transfusion. Most PID errors are clinical: missing or inaccurate information on transfusion request forms, prescriptions and PID bands. Reviewed cases highlight failures of correct bedside checking. This is a critical PID point. The final bedside check is the last defence to prevent an error leading to potentially catastrophic wrong transfusions. It must be correctly completed, and is a national recommendation from SHOT and the Chief Medical Officers.

Correct PID is crucial and must be accurate throughout the transfusion process.

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