

Patient identification errors in transfusion continue to compromise patient safety

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Background

SHOT is the UK's independent, professionally-led haemovigilance scheme affiliated to the Royal College of Pathologists. Evidence based recommendations are made to improve patient safety in relation to the blood transfusion

SHOT collects and analyses anonymised information on adverse events and reactions related to transfusion of blood components

Transfusion is a complex multistep process involving members of several different professional groups, nurses, doctors, laboratory scientists as well as the donors and recipients

Patient misidentification at any step can have potentially fatal consequences for the recipient

Method

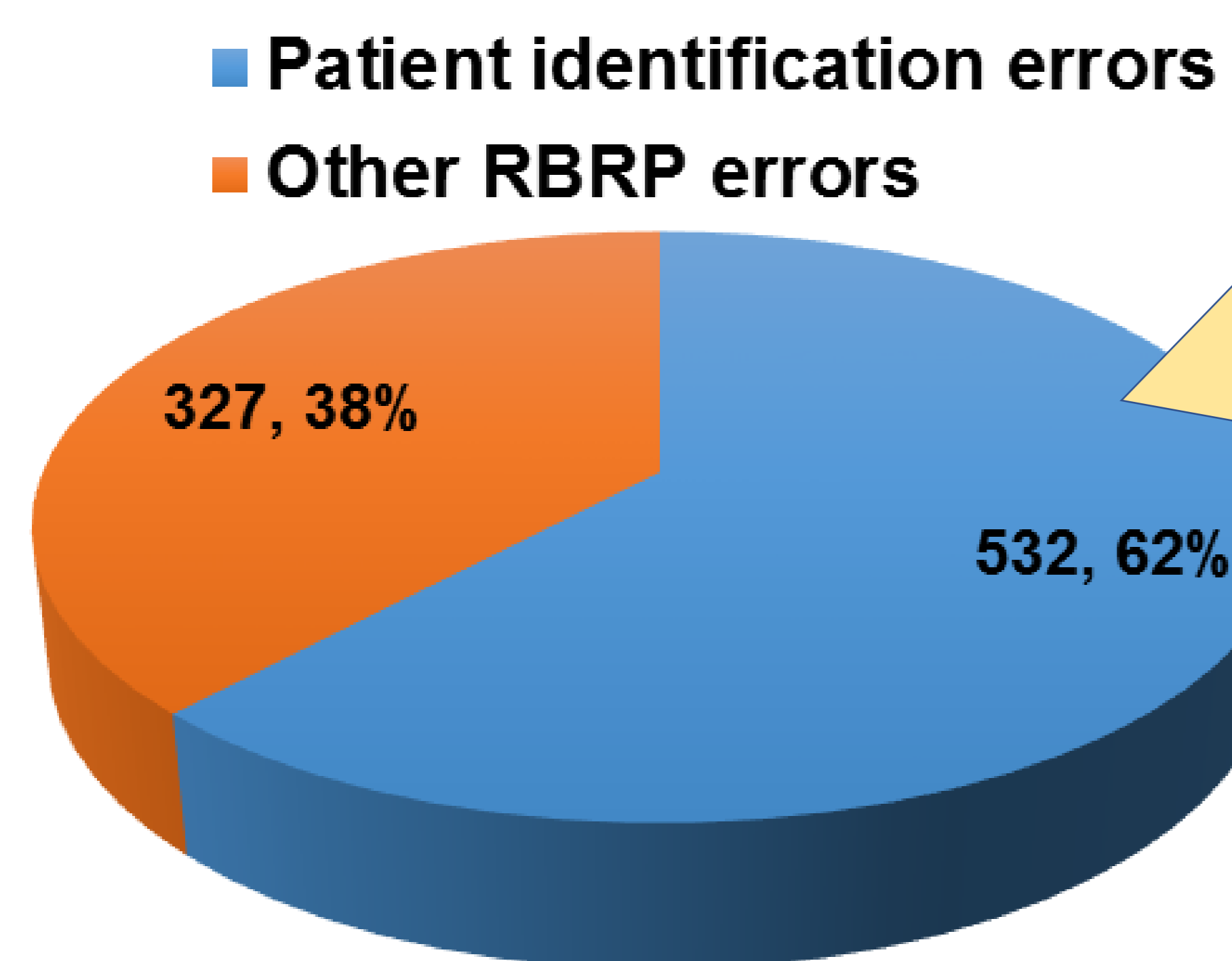
Right Blood Right Patient (RBRP) are incidents where a patient was transfused correctly despite one or more serious errors that in other circumstances might have led to an incorrect blood component transfused (IBCT)

A retrospective analysis was performed of all RBRP cases reported to SHOT between January 2016 to December 2019 to identify the frequency of patient identification errors and areas for improvement

Results

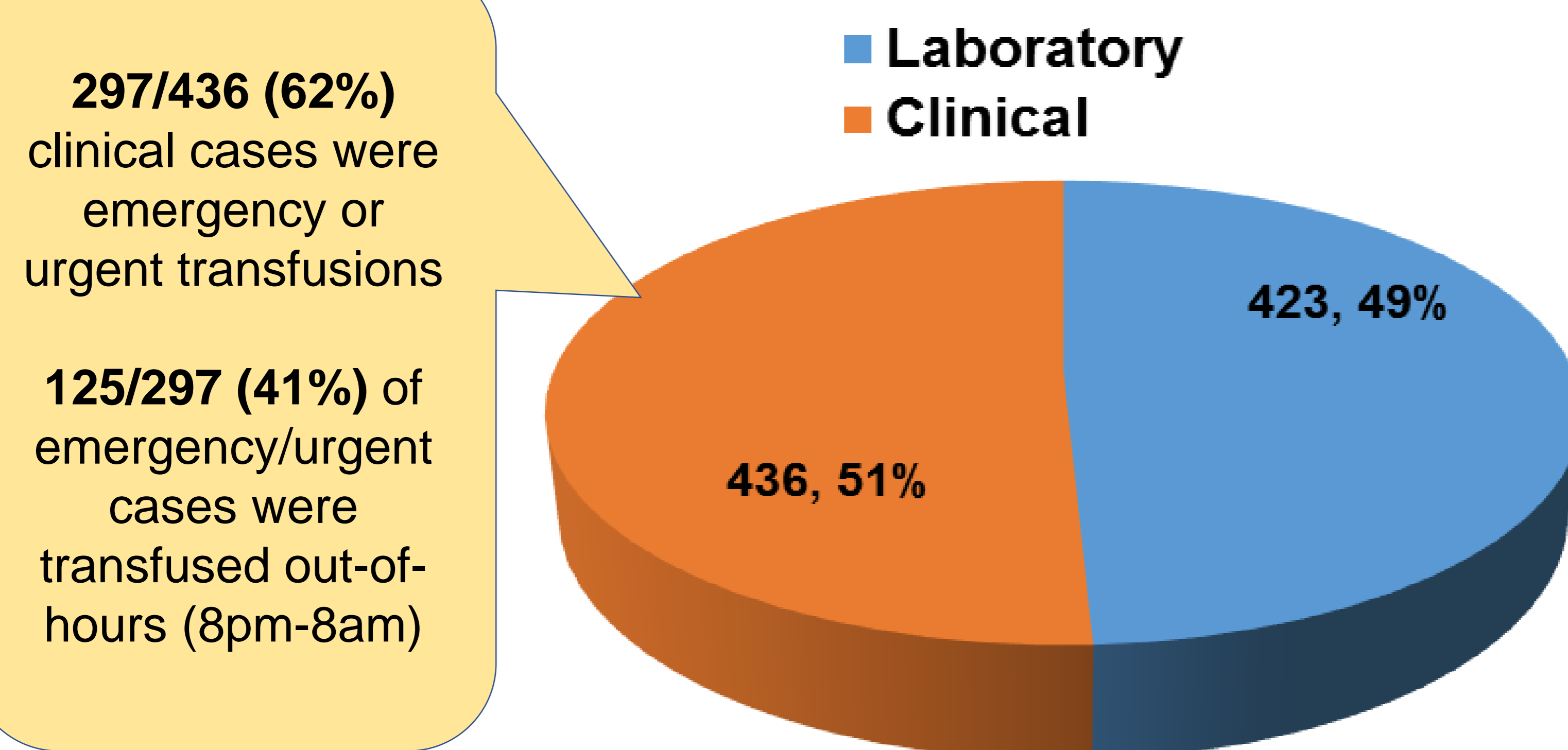
Total RBRP errors comprised **6%** of all SHOT reports received during this period **n=859/13,895**

The majority (**62%**) of RBRP were patient identification (PID) errors **n=532/859**



Nearly half of PID reports (**48%**) related to erroneous patient name on the pre-transfusion blood sample **n=260/532**

In **18%** of PID errors, these were transfused in the emergency department **n=97/532**

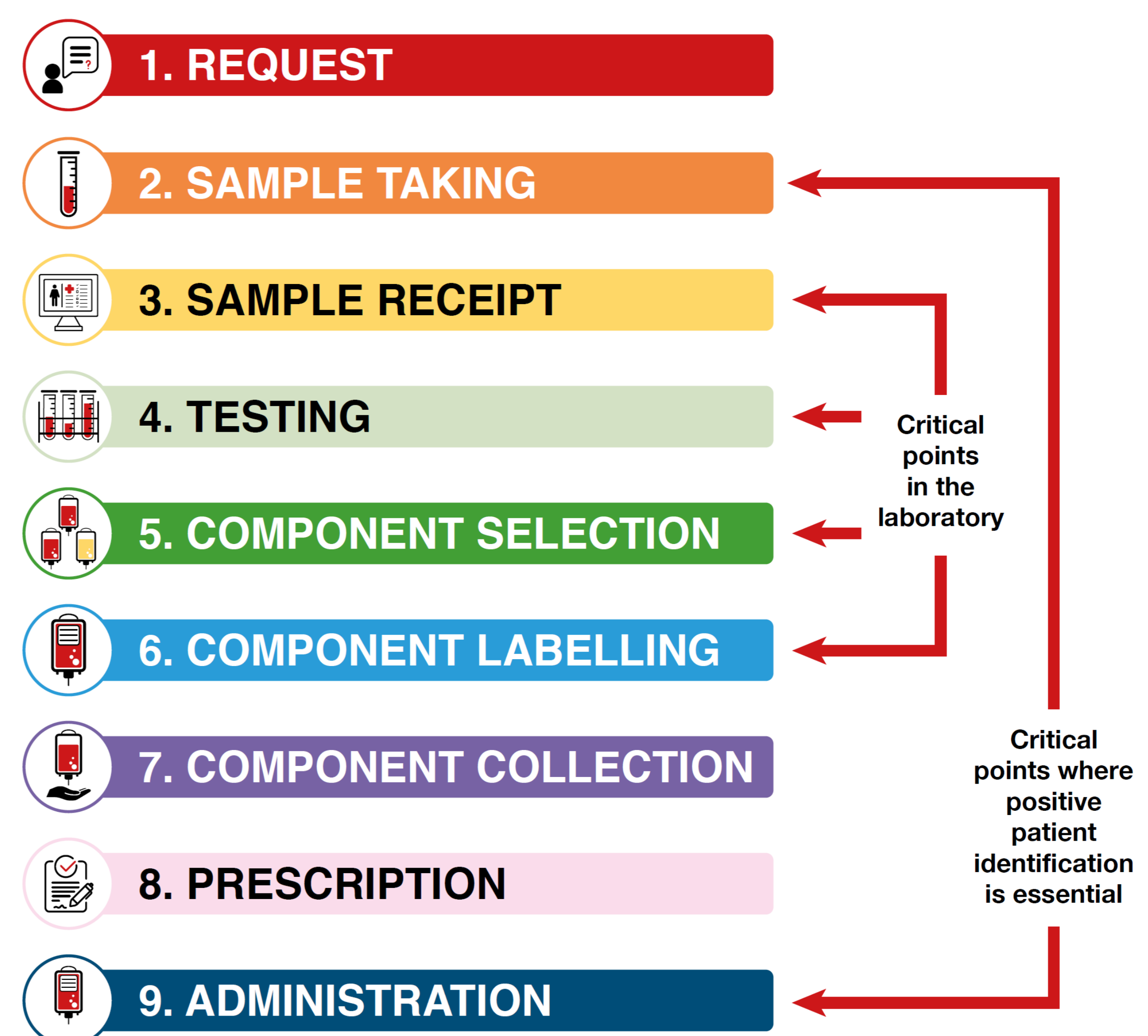


297/436 (62%) clinical cases were emergency or urgent transfusions

125/297 (41%) of emergency/urgent cases were transfused out-of-hours (8pm-8am)



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Note: Once a decision to transfuse is made, the authorisation or prescription may be written at variable times during this sequence, but **must be checked at the final stage.**

Conclusion and Recommendations

Patient identification errors continue to occur and can result in fatalities in patients due to the wrong component being transfused

The use of a bedside checklist may reduce the number of identification errors. It is imperative (where possible) that the patient is involved at the sampling and administration stage of the process

The use of electronic patient identification (EPI) systems has been shown to result in a lower incidence of PID

All staff involved in the transfusion process must be aware of policies for correct patient identification and follow them

There is a need for increased vigilance in both the clinical and laboratory settings

It is very important to review and learn from these incidents to prevent future occurrences