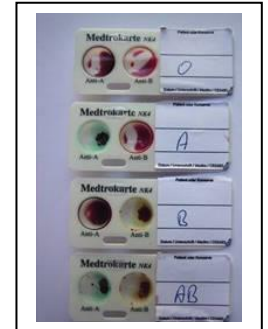


2022 Communication - Blood transfusion

Permission to print:	Yes
Category	Communication
Incident type	Good Catch Near Miss
Duration of incident:	seconds
Description:	<p>Prior to CPB in a neonatal case a RBC-transfusion was deemed necessary to add to the prime. The PRBC in question was checked by the anaesthesiologist, signed and checked for compatibility by Metro-Karte antibody test. (Metro-Karte is a bedside A-B-0 antibody identity test required to be done prior to any transfusion to confirm compatibility to the recipient. Blood is taken from the patient and compared to the packed blood. [Picture attached]). A transfusion set was then connected and prior to adding the calculated amount of RBC to the reservoir with a last look at the label saw the highlighted phrase: "Not for paediatric use". We have now had this occur twice in two months. This time was very close as the transfusion filter was primed and literally at the last millimetres before the blood was at the stopcock.</p> <p>According to our Dept for Transfusion the labelling reason was likely due to specific medication taken by the donor. However, we could not find out what substance exactly as that PRBC was labelled by the exterior blood bank / Donor Service. [the precise details are still being investigated]. The PRBC was otherwise compatible re ABO-blood-type, Rhesus factor, kell-system. The PRBC was then discarded and a new pack ordered from the transfusion dept. Checking in the OR usually occurs by two to three people, first the anaesthesiology nurse / technician) when the blood is deposited in the OR-refrigerator, then by the anaesthesiologist prior to the transfusion. In our cardiac OR the Perfusionist should also check the packed blood and laboratory documentation.</p>



GOOD CATCH - what went well	The wrong pack of RBCs was not transfused. Yet in this case by sheer luck (last look onto the PRBC, before filling the syringe)
What could we do better	Take the time to thoroughly check the PRBC, as the highlighted sentence stood in the usually blank space and was not part of the regular check of blood type, Rhesus-factor and pack-number.
Preventive actions	Institutional: yet to be determined. Personally: extra time to check the PRBC
Type of incident:	Management
Hospital incident filed:	Yes
Ext Authority Advised	No
Discussed with team:	Yes
Rule issue	Yes
Skill issue	No
Knowledge issue	No
Protocol issue	Yes
Supplies Issue	Yes
Patient outcome varianc	Nil
Commentary	<p>This report identifies a good catch of essentially a communication near-miss with unexpected positioning of an advisory on a blood transfusion label. Had the transfusion proceeded unnoticed it would have fallen into the category of where a patient was transfused with a blood component where the patient's specific requirements were not met known as an SRNM error. This and other aspects of transfusion error are elegantly explained in a paper by Bolton-Maggs and Watt https://onlinelibrary.wiley.com/doi/10.1111/bjh.16256 that may be of interest particularly to students. PIRS2 Ed</p>