ABO incompatible transfusion

How a “never event” happened!

Background

- Patient A received unit of blood that had been prescribed and issued for Patient B
- 2 nurses checked blood away from the patients bedside using prescription (Patient B's) and compatibility form
- 1 nurse went to Patient A, did not check patients ID and commenced transfusion.
- Error only noticed when nurse came to write in notes – prescription had been put back in correct folder (Patient B)
- Patient had no reaction during transfusion and only mild reaction post transfusion
- Both nurses assessed as competent and up to date with training

Contributing factors

- Transfusion took place at night
- Historical way of working is to perform a check away from the bedside – this is not what our policy says!!
- Separate unnecessary accompanying paperwork helps reinforce the above
- Two person check, but not done independently

Action plan to prevent reoccurrence

- Change to blood bag label – removal of compatibility form from checking process.
  - Hopefully forces check at the bedside
- Change from 2 person check to 1 person check
  - Risk assessment shows no greater risk
  - Again forces check at bedside
- Consider introduction of electronic bedside tracking