Workshop Case Studies

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Case Study 1
Incorrectly Transfused Blood

- **Midwife A asked the housekeeper to collect a unit red blood cells for a patient JK.**
- **Patient 1- JK 24 year old, Date of Birth 24/08/1990, Room 2,needing red cell transfusion**.

  2.5L blood loss, starting haemoglobin 115 g/L. Post delivery haemoglobin 75g/L, symptoms includes breathlessness, saturation 94% on oxygen blood pressure 90/50. Blood group O RhD Positive, 3 units red cells prescribed
- **Patient 2- JK 36 year old 24/08/1975, Room 8, needing red cell transfusion.**

  –1L blood loss, starting haemoglobin 120g/L. Post delivery haemoglobin 90g/L. Asymptomatic of anaemia. Blood group A Rh D Positive. No red cells prescribed.
- **At the issue fridge, there were red cell units for both patients. Draw system of alphabetical by surname**

Case study 1 continued

- **Housekeeper took JK in room 8 transfusion chart to the issue fridge.**
- **Signed for and removed the red cell unit, returned to clinical area, giving said unit to midwife B. Midwife B is caring for Room 2.**
- **At the point of administration Midwife B asks student midwife A to second check said unit.**

- **Both Midwife B and student nurse checked unit at the bedside.**
- **Pre transfusion observations documented at 13.35**
- **Unit start time 14.00**
- **Room 8 patient rang call bell at 14.18 complaining of itching and feeling cold.**
- **Unit was stopped and inspected by student midwife A. On realising the patient details did not correspond with what patient initially told her and midwife B.**

Which staff are allowed to collect blood from the issue fridge?

A. Competent, trained staff

B. Anyone available at the time

C. The receptionist

D. The housekeeper

What are the main identifiers when administrating any blood product to a patient?

A. Address, Gender, Post code

B. Full name, Date of Birth, Hospital or NHS Number

C. Sexual orientation, Religious beliefs

D. Dietary intake

In this scenario what should be best practice to prevent this error from occurring?

A.Only staff trained in the blood collection process should do so?

B.As the patient was symptomatic, any one readily available should do so?

C.Blame the housekeeper for collecting the wrong blood?

D.This patient was not appropriate for transfusion

What were the shortcomings in this scenario?

A.Patient was not appropriately transfused?

B.All check point guidelines were not adhered to as with local and national guidelines.

C.All staff involved cared for the patient appropriately

D.The staff involved did not have a tea break

What would be the best next steps in this scenario

A.Stop the blood, Check the unit against the patient identification band, Call for help

B.Go for a tea break

C.Inform Transfusion staff of transfusion error

D.Blame the housekeeper

Case study 2
Wrong Blood In Tube

- Patient A requiring antenatal booking bloods.
- Maternity support worker (MSW) given request form
- Patient informed MSW of change of surname due to marriage.
- MSW bled patient and left filled unlabelled sample tube at the workstation
- Midwife A on seeing the left tube, started to label tube with request form that was at on the workstation (not patient's A form)

- Patient A who is Blood Group A Rh D Negative needing Anti D as known from her previous pregnancies.
- Core identifiers written on sample tube were for patient B, who is Blood Group B Rh D Positive

What are the main patient identifiers for safe blood group/ cross matching?

A.Gender, Postcode, Telephone

B.Full name, Date of Birth, Hospital Number,Gender

C.Religious belief, Social class, Diet

D. Skill set, education background, income

What would be the next best step for the midwife involved

A.Panic

B.Recall both patients for repeat blood test

C.Tell off the MSW

D.Ignore the situation

Who reports this incident?

A. Transfusion lab staff

B. MSW

C. Midwife in charge of the patient

D. The patient

Is this incident reportable to Serious Hazards of Transfusion (SHOT)

A.Yes

B.Maybe

C.NO

D.Depends on what the Transfusion Practitioner says!