

## Annual SHOT Report 2018 – Supplementary information

### Chapter 7: Adverse Events Related to Anti-D Immunoglobulin (Ig)

#### IT-related Anti-D Ig cases n=12

There were 12 cases where IT errors played a part in incorrect anti-D Ig administration.

#### Anti-D Ig given unnecessarily n=6

In 3 cases the women had an anomalous D group, which should have been managed as D-positive. In the first case the D-group had already been resolved but there was insufficient patient ID to merge two Specialist Services electronic reporting using Sunquest's Integrated Clinical Environment (Sp-ICE) records. In a 2<sup>nd</sup> case the Blood Service reference laboratory result was available but was not accessed so the wrong advice was given. In a 3<sup>rd</sup> case, pending the results of the investigation, the D-group defaulted to D-negative. The resolved D-group was not uploaded and acted on in a timely way. The corrective action for this error was to create a laboratory information management system (LIMS) orderset to identify a pending result and prompt quicker and more timely follow-up.

In 1 case the result of a cffDNA predicted fetus to be D-negative but the alert which stated 'Note: the fetus is rhesus negative. Are you sure anti-D is needed?' was ignored.

#### Case 7.11: Wrong calculation of FMH using the LIMS

*A D-negative woman was given four times the required dose of anti-D Ig because of a miscalculation of the fetomaternal haemorrhage post delivery. The LIMS is able to calculate the volume of fetal red cells from the Kleihauer result but the results of the cell count had to be entered manually. A member of staff returning from prolonged leave had not done the competency for this procedure and the standard operating procedure (SOP) was unclear. 3000IU anti-D Ig was given when 500IU would have been sufficient.*

#### Case 7.12: Negative antibody screen misread as D-negative

*A woman attended for routine 28-week antenatal appointment and had samples taken for group and screen. The midwife looked up the blood group from the booking appointment to see if anti-D Ig was required and misread 'antibody screen: negative' as 'D-negative' and gave an injection of anti-D Ig. This error was identified when the paperwork was reviewed and the blood group was D-positive.*

#### Delayed anti-D Ig administration n=2

In 1 case the act of booking in a group and screen to the LIMS overrode the request for a Kleihauer so anti-D Ig was issued late for a PSE. Another delay occurred because the D-group in the maternity electronic record was incorrect due to a manual transcription error.

#### Right product, right patient n=4

Manual transcription of anti-D Ig batch numbers onto the LIMS was subject to an error in 2 cases. The wrong record was selected on the LIMS in another case, and the LIMS allowed issue of anti-D without a current group in the final case.