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A case of transfusion error in a trauma patient with subsequent root cause analysis leading to institutional change.

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https://psnet.ahrq.gov/issue/case-transfusion-error-trauma-patient-subsequent-root-cause-analysis-leading-institutional

Transfusion errors can have serious consequences. This case analysis discusses a wrong-patient transfusion error in a hospital's emergency room and reviews findings of the subsequent root cause analysis, which determined training weaknesses, time pressures, and distractions within the team due to the chaotic nature of trauma care.