

# Transfusion errors on the wards

## What can be done to prevent them?

Presented by

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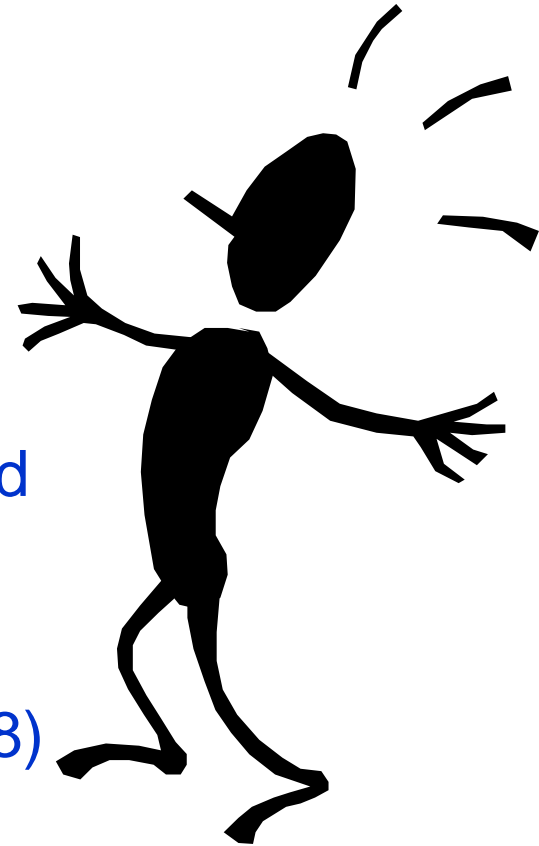
# Transfusion errors on the wards

- What is the scale of the problem?
- Why is there a problem?
- How can transfusion incidents be prevented?

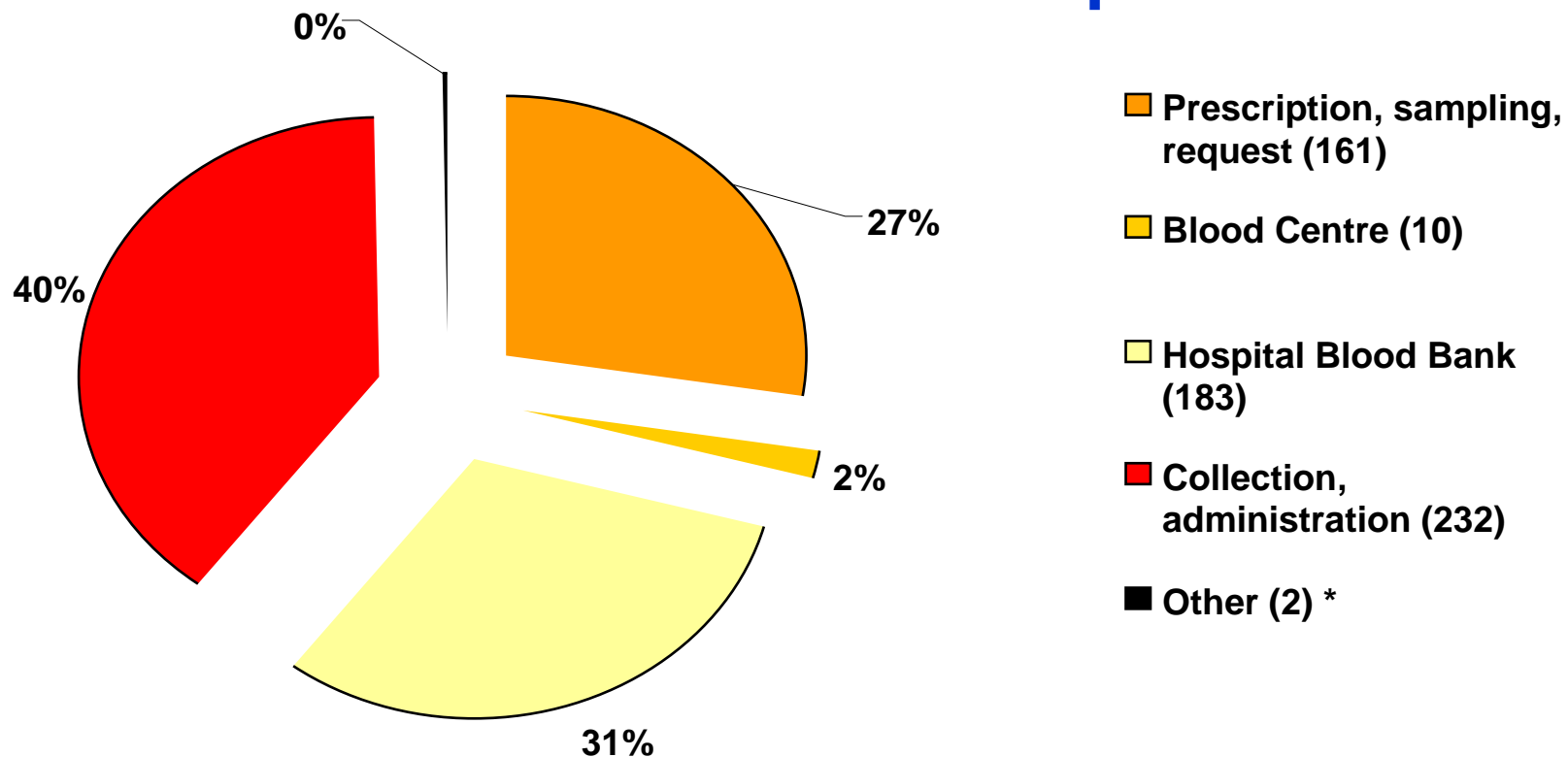


# What is the scale of the problem?

- IBCT continues to be the largest category
- 25% increase in the number of IBCT reports this year
- IBCT makes up 75% of all reports received
- 70% of errors occur in clinical areas
- most common site of failure continues to be failure of the bedside check (156/588)



# Distribution of errors according to the main reporting categories in IBCT: 588 errors from 348 reports



\* Other = errors in software made by IT department

# Errors in prescription, requesting of blood components and patient sampling

- 161 errors in these areas
  - in 44% cases primary error occurred here
  - half the cases related to failure to indicate special transfusion requirements
  - majority of these involved a patient at risk of TA-GVHD

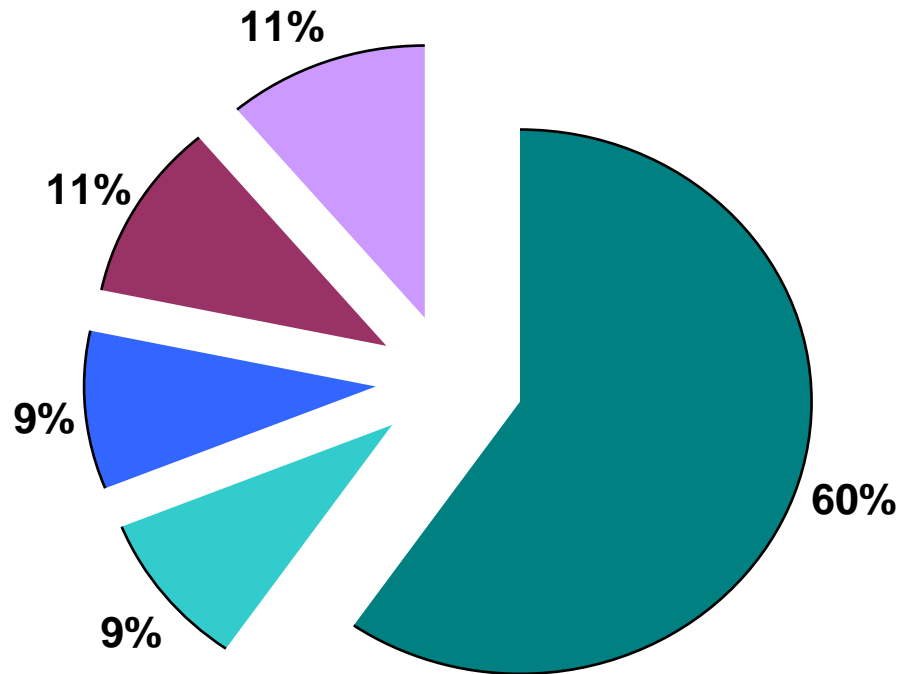
# Errors in collection and administration

- 232 errors in 187 cases
  - in 36% of reported cases the primary error occurred at this stage
  - 37% (65/176 cases with the time recorded) took place between 8pm and 8am, 33 started between MN and 8am of which 16 were said to be routine
  - 156 cases of failure of the bedside check
  - in 21 cases this was the primary error resulting in wrong transfusions being given

# Errors in collection and administration

- in 45 cases the wrong blood component was collected from the fridge and the error not detected at the bedside. 10 of these cases related to acutely bleeding patients undergoing urgent or massive transfusions in critical care situations
- in 135 cases the bedside check failed to detect an error earlier in the transfusion chain, in 24 of these cases an expired unit was transfused

# Categories and proportions of 'near miss' events



- Sample errors (542)
- Request errors (81)
- Laboratory sample handling &/or testing errors (86)
- Laboratory component selection, handling, storage & issue errors (97)
- Component collection, transportation, ward handling & administration errors (100)

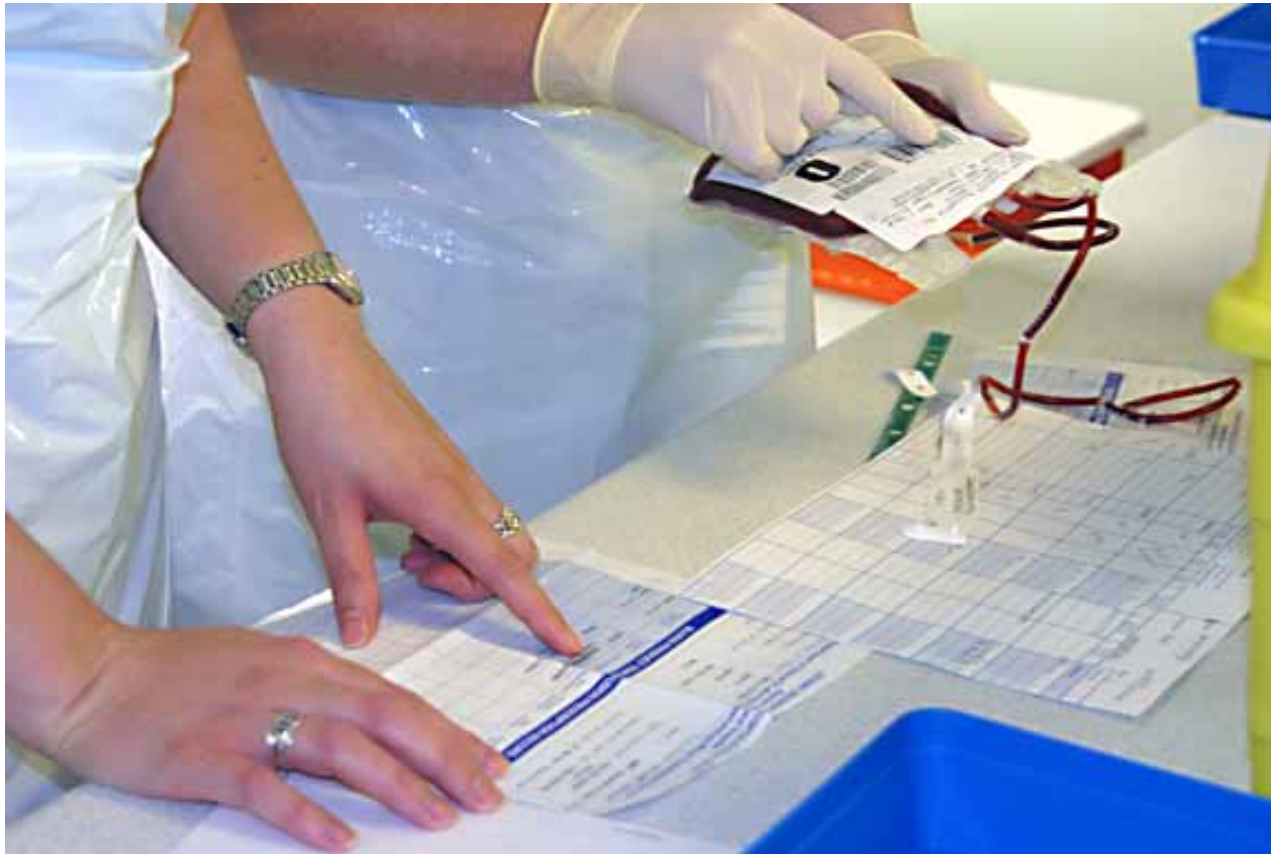
# Right blood to right patient

- 29 cases where the patient receives entirely appropriate blood which was intended for them but which, nevertheless, had some element in the process which was wrong and which could, under different circumstances, have led to a serious transfusion error

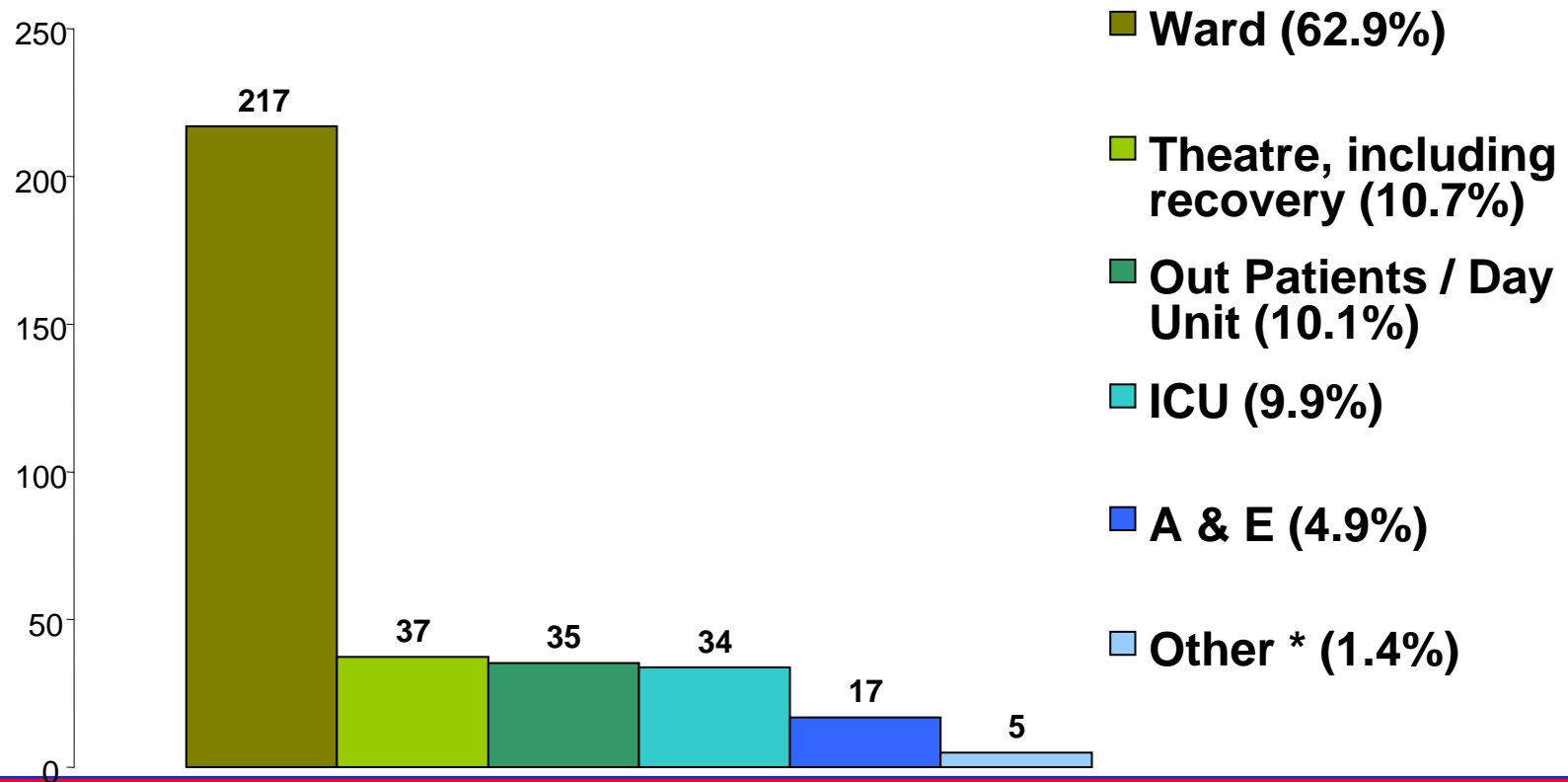
# Why is there a problem?

- Blood transfusion is a complex multi-stage process
- False sense of security?
- Guidelines not always practical and may differ from tradition
- Lack of understanding that blood should be treated like a drug
- Record keeping is poor

# Why is there a problem?



# Site of transfusion where error occurred in a clinical area



# Ward issues

- Nursing shortages and staffing issues
- Dependency of patients
- Pressure on beds - transfusions at night
- High stress levels - mistakes made
- Areas where high nurse:patient ratios not exempt from error - problems confirming patient identity

'Ridiculous' new rules are confusing surgeons and putting lives at risk, say critics

# Chaos on wards as hospitals remove patients' names over data protection fears

HOSPITALS are removing patients' names and medical records from their beds because of fears they might be breaking the Data Protection Act.

NHS managers - frantic to ensure they stick to confusing confidentiality laws - have replaced the names with letters identifying different beds and removed medical notes.

But last night critics claimed the new working practices are confusing doctors, placing an extra burden on nursing staff and could put patients at risk of receiving the wrong treatment.

Joyce Robinson, of health watchdog Patient Concern, said:

**'Patients could get the wrong drugs'**

Survivor stories of NHS staff being unable to find the right patient were now common.

"One surgeon said he often couldn't find patients because they no longer had names above their beds and were treated as such," she said.

"It's just ridiculous - it can be very confusing and people could receive the wrong drug or treatment. I would say a certain amount of beds is confidentially marked but it's all got out of hand."

It's against the safety of patients and not exactly welcoming of nurses or the public in the

By Matt Nixon and Ross Slater

next bed doesn't know who the patient is.

Last night officials at the Department of Health denied banning patients' names from wards, saying the decision was up to individual NHS trusts.

But confusion over data protection legislation, blamed for allowing Section 17B killer Ian Huntley to evade justice for so long, is causing chaos in some hospitals, which claim they are following national guidance.

Nurse staff at Kettering General complain the turnover of patients is so frequent that ward nurses have little time to get to know their individual charges.

One nurse said: "Not using the name boards makes the job harder because you can't have that easy contact with patients by instantly seeing their names."

At Kettering, the nurses are on the ward by the nurses' station but you have to memorise the names and bed position in order to address the patients by name.

"Now, instead of Mrs Jones next to Mrs Smith, it is "A" bed next to "B" bed which is somewhat impersonal. But Kettering is no exception. This is becoming common practice now."

Incidents like in the Northamptonshire hospital mean some wards still use the traditional name boards.

One patient, recovering from a knee operation, told The Mail on Sunday: "It's only a small thing,

but when they keep on moving your bed around it's nice to know who you are next to and call them by their name."

Liberal Democrat health spokesman Paul Hurst said: "We seem to have a cottage industry in this country around data protection."

"It is getting in the way of good service and being able to respond quickly to people's needs."

"This example sounds like the classic jobsworth - that is 'I'm not putting a name above a bed because it's more than my job's worth.'"

Kettering Hospital's director of nursing and midwifery Denise White insisted that the change was in line with Department of

**'It has made our job much harder'**

Health guidance. She said: "For security and confidentiality reasons we generally do not feel it is appropriate to display patient names in this way."

"This is in line with national guidance and legislation concerning patient confidentiality. Before any treatment or medication, patients are identified by their wrist band and, where appropriate, verbally."

But a Department of Health spokeswoman said: "The decision on names above beds is not something we would discuss, that is down to individual trusts."



**IDENTITY CRISIS:** Nurses need to double-check every patient

Will this make the situation better or worse?!

# How can transfusion incidents be prevented?

- National Initiatives:
  - Participation in SHOT must be active
    - in every hospital every serious transfusion adverse event must be identified, fully investigated and reported
    - requires involvement of all hospital staff to be aware of the risks and their responsibilities
    - identify and report weak links

# 'Blame free' culture

- 'An Organisation with a memory' 2000: Learning from adverse events in the NHS
- should encourage reporting in an open, learning and improving environment
- events to be fully analysed to determine root cause analysis



# Root Cause Analysis (RCA)

- RCA is a structured investigation that aims to identify the true cause (s) of a problem, and the actions necessary to eliminate it (Anderson and Fagerhaug 2000)
- RCA takes a systems view of incidents – moving away from blaming individuals
- Look at what, how and why it happened

# Resources

- Resources must be made available to ensure that appropriate and effective remedial action is taken following transfusion errors
  - financial
  - IT
  - audit
  - administrative support

# Appropriate Use

- HSC 2002/09  
Better Blood  
Transfusion 2  
  
– BBT2 Toolkit

**Health Service Circular**

**DH** Department of Health

Series Number: HSC 2002/009  
Issue Date: 04 July 2002  
Review Date: 04 July 2005  
Category: Public Health  
Status: Action

sets out a specific action on the part of the recipient with a deadline where appropriate

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**Better Blood Transfusion**

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*Appropriate Use of Blood*

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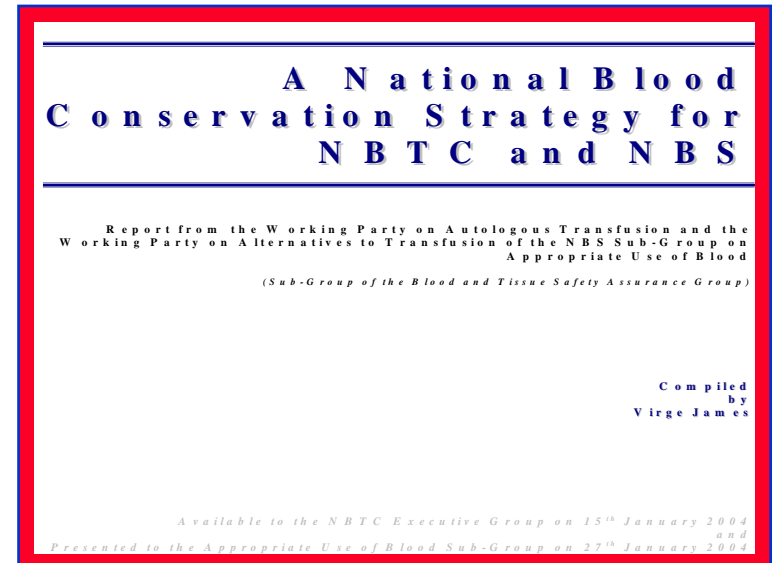
For action by:

- Health Authorities (England) - Chief Executive
- Health Authorities (England) - Directors of Public Health
- NHS Trusts - Chief Executives
- Primary Care Trusts - Chief Executives and Main Contacts

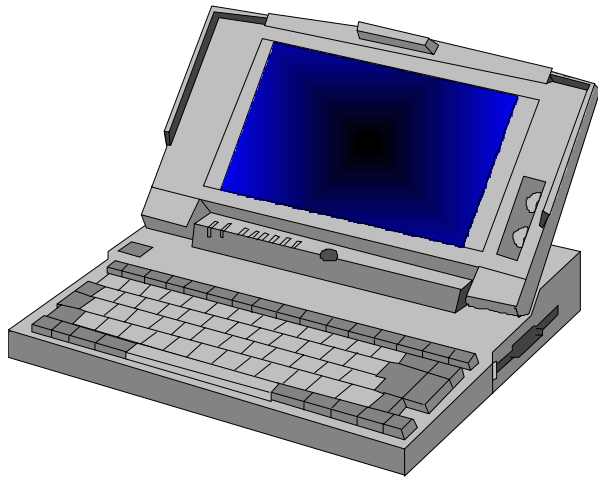


# Appropriate Use

- National Blood Conservation Strategy - 4 key initiatives
  - Education
  - Preparing patients for surgery
  - IoCS
  - Audit



# National and Local Initiatives



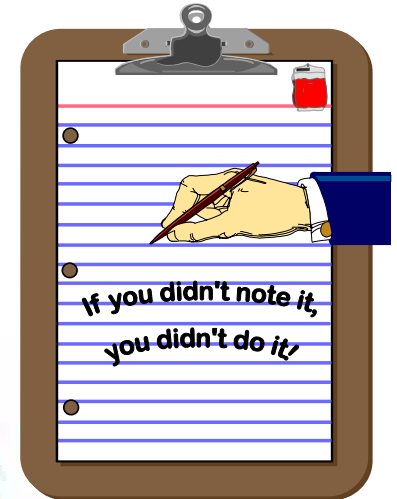
- Electronic aids to transfusion safety should be assessed and developed at national level
  - DoH 'Information for Health' IT strategy
  - National standards and specifications
  - Positive patient identification

# Clinical Audit

- Audit - monitor and improve practice
  - local audit
  - regional audit - organised by RTC's
  - national audit e.g. National Comparative Audit
    - Audit of hospital policy on red cell transfusion
    - Audit of hospital transfusion practice

# National Comparative Audit

- Action Plan:
  - regional seminars
  - blood awareness campaign with posters
  - re-audit practice
  - audit appropriate use of
  - blood



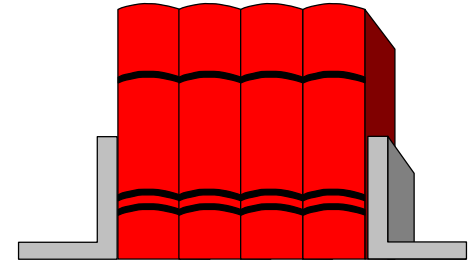
# Hospital Transfusion Teams

- HTT's must be established and supported
  - HSC 2002/09 BBT2
  - Consultant Haematologist, TP and BBM
  - SHOT a regular item on HTT and HTC agenda's
  - networking/support - SPOT, User Groups and NBS Hospital Liaison Teams



# Procedures and policies

- based on national guidelines
- simple and practical
- regularly reviewed
- readily available to clinical staff
- encourage ward staff to look at the clinical picture not just the ‘numbers’



# Education and training

- Education and training to implement policies and procedures into practice
  - nurses, HCA's, phlebotomists
  - BMS's and Doctors at every level
  - tailored for specialist areas
  - Transfusion Practitioner's
  - patients



# Communication

- Communication at all levels e.g.re special requirements and between hospitals when patient care is shared
  - appropriate
  - timely
  - effective



# Promoting SHOT in hospitals

- Increase nurse involvement with SHOT
- Raise awareness - more educational sessions on SHOT in Trusts, at HTC's, in the North
- Make SHOT PowerPoint presentations available to all hospitals to use in training
- Have a SHOT poster available to hospitals for awareness days

# Supporting SHOT

- Questionnaire survey to Transfusion Practitioners
- 'Introduction to SHOT' pack
- Regional Newsletter with SHOT articles
- Articles in general nursing journals as well as in more specialised publications such as 'Blood Matters'

# Case 37

- An ABO incompatible transfusion was given to a patient in ICU which resulted in major morbidity
  - elective transfusion done ‘out-of-hours’
  - porter had no documentation
  - wrong unit collected and not correctly logged out
  - 2 nurses checked unit but not at the bedside
  - blood held at room temperature for over 30 minutes
  - observations not done and an acute reaction was not recognised until almost whole unit transfused

# Thank You

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