When your worst fear happens…

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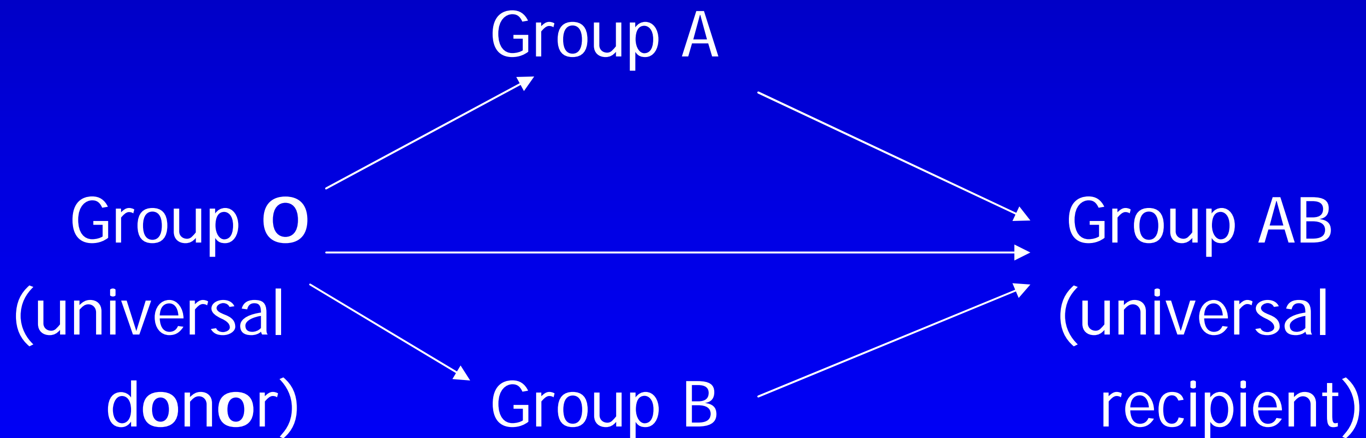
Fast bleeped

- Healthcare assistant, doing '15 mins' observations, recognised patient having a transfusion reaction

- Patient blood group O Rh D pos
- Transfusion group A Rh D neg

Transfusion: Blood groups II

- When considering red cell and organ transfusion across the ABO blood group system, the following diagram is useful:



Medical care

- Fluid resuscitation
- Intravascular haemolysis, haemoglobinuria
- Renal failure
- HDU etc

This talk is mainly about dealing with the incident than medical management

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- Follow Trust serious incident procedures (usually involves informing Medical Director immediately)

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- If you do get called to Coroner’s Inquest, use support from Legal Department, & Media Office

Acknowledging error

- Inform patient and relatives
- Acknowledge feelings of staff

Early Investigation

- Arrange early (<24hrs) investigation of all parties involved – (Blood Service), Lab (BMS and clerical), porters, nurses & HCAs
- Document all facts eg bed state, clinical load, lab workload, staffing etc

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- Chair with "Open mind" to identify all sources of error

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- Can be therapeutic for staff who feel guilty
- Seek all factors – there will be at least 7!

Post meeting

- Write up the report (in anonymous style)
- Plan and implement safety improvements
- Audit whether change has occurred
- Trust Incident / Clinical Governance will need update and final report

Legal issues

- Blame culture - Media
- “no blame” culture
- Negligence – ignore / break rules (SOPs)
- Level of “duty of care”, degree of harm
- Personal / organisational prosecutions
- Blood Safety & Quality Regulations

This case

- Medical outlier on surgical ward
- Staffing issues
  - Nurse ill (A&E) but returned to work
- Busy day with many calls including bed managers
- Unexpected cardiac arrest / relatives
- 2 patients being transfused in same bay

- Initial check (prescription, unit of blood, compatibility slip) at nurses station
- Call interrupted check so second checker left to resume work
- First checker picked up wrong unit of blood and set up transfusion without recheck (patient ID) at bedside

Outcome

- Patient had renal impairment but survived
- Ward managers to be supernumerary
- Blood checks not to be interrupted and always at bedside
- Education of staff (Ward managers & SUET)
- Changes to working of bed management team (interruptions)

- Good format for dealing with other clinical incidents eg Major Haemorrhage and near misses

Questions