NPSA+SHOT+NBTC Initiative: Safer transfusion. Is it achievable?

John Lilleyman
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National Patient Safety Agency
What are the real risks of harm when having a blood transfusion?

- Variant CJD
- HIV
- Hepatitis
- TRALI
- GVHD
- Wrong blood
2628 incidents reported to SHOT 1996-2004
Where do things go wrong?

70% outside the laboratory
When do things go wrong?

During A&E and surgical emergencies
When wards are busy with distractions

When experienced staff are thinly spread
When patients have regular transfusions

When everyone looks the same
And in the middle of the night
National Comparative Audit of BT by RCP Clinical Evaluation and Effectiveness Unit showed:

- Over complexity of systems
- Assumptions made by staff over patient identity
- Assumptions over steps in the procedure
- Peer pressure to take shortcuts
- Too many competing priorities
RCPath Seminar December 2004

- Hosted by NPSA/NBTC/SHOT
- Invited presentations of any initiatives to improve blood tracking outside the laboratory
- 17 submissions
- 5 selected for further consideration of wider uptake in NHS
Eventually 4 initiatives chosen

- Standard specification for IT tracking systems
- ‘Red Label’ system of unique number labelling
- Photo ID cards for regular transfusees
- Continuing education of staff administering transfusions and achieving defined competencies with regular assessment
IT Tracking

- National standard specification for IT tracking system for blood administration
- Reflect experience of current users of IT tracking systems
- Will inform Connecting for Health and commercial companies
Red Label system: present users

- Maidstone and Tunbridge Wells NHS Trust (3 hospitals)
- Oxford Radcliffe NHS Trust
  - JR Hospital
  - Horton Hospital
- South Tyneside Hospital
- Macclesfield DGH
- Leeds G Infirmary
  - (Ad hoc A&E only)
Photo ID for regular transfusees

Assessed at:

North Middlesex*
Barts and the London
Swansea
Freeman Hospital
Dudley Group of Hospitals

*Ms Karen Madgwick
Dr DA Yardumian
Know what you’re doing

• Development of defined competencies
  – obtaining a venous blood sample
  – Collection of blood from blood fridge
  – Administering a transfusion
• Development of competencies in conjunction with Skills for Health
• Need for three yearly competency assessment
Evaluation of effects

• Uptake of Photo ID
• Uptake of Red Label
• Roll out of IT tracking
• Compliance with competencies
• SHOT data over the next 5 years
  – ↓ IBCT frequency
  – ↓ ABO incompatible transfusions
Finally, safer practice by restraint. Transfusions should only be given when essential. Otherwise the risks will always outweigh the benefits. Blood is not a tonic.