ANNUAL SHOT REPORT 2015 SUMMARY

How many reports?

3288 REPORTS IN 2015

1125 ERRORS

7 ABO-incompatible transfusions and 6 more to stem cell transplant patients

MHRA: 97% SAE reports due to HUMAN ERROR

26 deaths
8 preventable
Risk 1:100,000
Risk of death from error 1:320,000
166 patients suffered serious harm

1 in 3 WERE PREVENTABLE

But 288 additional near miss ABO-events

Deaths related to transfusion 2015

TANEC: transfusion-associated necrotising enterocolitis

Cases reviewed in 2015

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTI: Trauma and Tertiary</td>
<td>0</td>
</tr>
<tr>
<td>BCT: Blood component error</td>
<td>0</td>
</tr>
<tr>
<td>Anti-D: Anti-D immunoglobulin</td>
<td>5</td>
</tr>
<tr>
<td>TANEC: Transfusion-associated necrotising enterocolitis</td>
<td>0</td>
</tr>
<tr>
<td>HTR: Haemolytic transfusion reaction</td>
<td>2</td>
</tr>
<tr>
<td>TRALI: Transfusion-related acute lung injury</td>
<td>3</td>
</tr>
<tr>
<td>TACO: Transfusion-associated circulatory overload</td>
<td>0</td>
</tr>
<tr>
<td>HTTR: Haemolytic transfusion reaction</td>
<td>0</td>
</tr>
<tr>
<td>ADU: Avoidable transfusion</td>
<td>0</td>
</tr>
<tr>
<td>ADU: Undertransfusion</td>
<td>0</td>
</tr>
<tr>
<td>ADU: Delayed transfusion</td>
<td>0</td>
</tr>
<tr>
<td>Anti-D: Anti-D immunoglobulin</td>
<td>0</td>
</tr>
<tr>
<td>BCT: Incorrect blood component transfused</td>
<td>0</td>
</tr>
<tr>
<td>IBCT: Incorrect blood component transfused</td>
<td>0</td>
</tr>
<tr>
<td>Anti-D: Anti-D immunoglobulin</td>
<td>0</td>
</tr>
<tr>
<td>BCT: Incorrect blood component transfused</td>
<td>0</td>
</tr>
<tr>
<td>IBCT: Incorrect blood component transfused</td>
<td>0</td>
</tr>
</tbody>
</table>

How many errors?

78% ERRORS

CRITICAL FACTORS IN PATIENT SAFETY

ICE 3

IDENTIFICATION
COMMUNICATION
EDUCATION
Deaths related to transfusion 2010-2015 n=93

Multiple errors in the transfusion process 2012-2015

Pulmonary complications, particularly TACO, and delays are the main causes of death

Laboratory errors have increased

SHOT data 2012-2015 showing 4 year trends indicating the critical points in the laboratory processes where errors occur

SHOT RECOMMENDATIONS 2015

Be WARM:
Work
Accurately and
Reduce
Mistakes

1. Use a TACO checklist
2. Use a bedside checklist

SHOT Office, Manchester Blood Centre, Plymouth Grove, Manchester, M13 9LL
Tel: +44 (0) 161 423 4208   Enquiries: shot@nhsbt.nhs.uk   Website: www.shotuk.org

If ‘yes’ to any of the above
- Review the need for transfusion (do the benefits outweigh the risks)?
- Can the transfusion be safely deferred until the issue can be investigated, treated or resolved?
- Consider body weight dosing for red cells (especially if low body weight)
- Transfuse one unit (red cells) and review symptoms of anaemia
- Measure the fluid balance
- Consider giving a prophylactic diuretic
- Monitor the vital signs closely, including oxygen saturation

CONTACT DETAILS

Human factors in hospital practice
Be safe! Use the bedside checklist

- Positive patient identification - ask the patient to state name and date of birth
- Check identification of component against patient wristband
- Check the prescription - has this component been prescribed?
- Check for specific requirements - does the patient need irradiated components or specially selected units?