SERIOUS HAZARDS OF TRANSFUSION SHOT

SHOT

Serious Hazards 0f Transfusion

Adverse Event Reporting What and How?

WASPS User Day 13th June 2005

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SERIOUS HAZARDS OF TRANSFUSION SHOT

SHOT Presentation

- TLN secondment role
- SHOT toolkit
- Survey to Transfusion Practitioners
- Incident reporting and the EU directive
- What incidents should be reported to SHOT?
- Scenarios
- Importance of incident reporting
- Any questions?

TLN secondment role

- National link for TLN team
- SWG member
- Secondment
  - 1 day per week for 1 year
  - TP workshops, newsletters, journal articles, presentations, TP survey, ‘Introduction to SHOT’ toolkit, PowerPoint slides, RCA work

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‘Introduction to SHOT’ Toolkit

- Introduction to SHOT
- Definitions of SHOT categories
- Handy tips for completing the forms
- Tool to measure compliance with the main SHOT recommendations
- Flow charts to help identify SHOT incidents
- Copies of PowerPoint presentations available
- Future challenges and changes for SHOT

Survey to Transfusion Practitioners

- **Why?**
  - The SHOT team wanted to know what hospitals think about the SHOT reporting system
  - To find out who reports SHOT incidents
  - To establish how many incidents are being reported compared to the number seen
  - To gain a better understanding of how SHOT can help hospitals

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Main Conclusions

- Hospitals with a TP are more likely to report incidents than those without a TP
- Main reason for under-reporting is lack of time
- Some TPs have difficulty categorising incidents
- Near misses are less well reported
- It is usually the TP or BBM who completes the forms

Main Recommendations

- SHOT categories and definitions to be reviewed
- SHOT questionnaires to be made shorter
- More education/training/heightened awareness of transfusion incidents and SHOT required at all levels in hospitals
- Need for more regular/up-to-date feedback
- Need to investigate application of on-line reporting

Incident reporting and the EU Directive

- MHRA is the Competent Authority
- Ongoing talks between OIG, MHRA, SHOT, Blood Services, NPSA etc
- Single point of reporting
- Reporting will be mandatory

Incident reporting and the EU Directive

- ‘**serious adverse events’** means any untoward occurrence associated with the collection, testing, processing, storage and distribution of blood or blood components that might lead to death or life-threatening, disabling or incapacitating conditions for patients, or which results in, or prolongs, hospitalisation or morbidity’

Incident reporting and the EU Directive

• **'serious adverse reactions'** means an unintended response in a donor or in a patient associated with the collection or transfusion of blood or blood components that is fatal, life-threatening, disabling or incapacitating, or which results in,or prolongs, hospitalisation or morbidity

Incident reporting and the EU Directive

- There should be a named contact person at each hospital
- Risk managers to be involved in the reporting process
- Time scales for reporting have yet to be agreed but may well be about 5 – 7 days
- Reports to SHOT must be sent in on ‘real time’ and not saved up and sent in batches
- An effective system is to be in place by Nov 2005

Questions?

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We asked you ...

What should I be reporting to SHOT ?

Reporting "Near miss" incidents

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What should I be reporting?

- ✓ IBCT
- ✓ IMMUNE COMPS.
- ✓ INFECTION
- ✓ ANTI-D
- ✓ AUTOLOGOUS
- ✓ NEAR MISS
- ✓ RIGHT BLOOD to RIGHT PATIENT
- X CLIN. DECISION
- X ALLOANTIBODIES
- X FEBRILE
- X FRACT. PRODUCTS

What exactly IS a near miss ?

Definition :

Any error, which if undetected, could result in the determination of a wrong blood group, or issue, collection, or administration of an incorrect, inappropriate or unsuitable component but which was recognised before transfusion took place.

What exactly IS a near miss ?

Rule No. 1 Was any volume of the component transfused ?

Rule No. 2 If the error had not been discovered in time is there any possibility that the component would have been transfused ?

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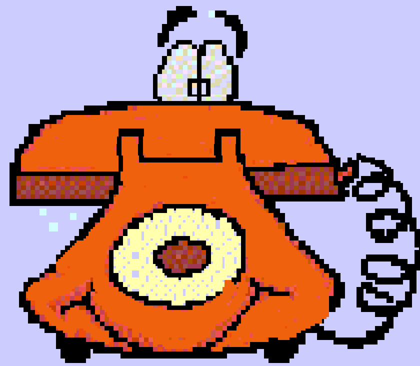
Call us

Anytime



Always happy to help

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Scenario number 1

Sally Cooper is a 42 year old woman coming into hospital for treatment of anaemia following a severe episode of menorrhagia. She is admitted to Willow Ward on 01.09.04 where she had been a patient 3 years ago for treatment of the same problem. Her hospital number is GM42839. Samples are taken for G&S and FBC. Addressograph labels from her notes are used to label the tubes. These labels have been placed in Sally's notes by mistake. They are for another patient of the same name and DOB whose hospital number is GM74613. FBC results show Sally's Hb to be 76g/L and a tx of 2 units of RBC is prescribed. Bedside checks fail to pick up the discrepancy between the 2 hospital numbers.

Scenario number 2

Phil Read is admitted via A&E having suffered multiple trauma in a RTA. He is bleeding profusely and needs emergency surgery. Samples are taken in theatre for grouping but he needs blood urgently before a group can be performed. The surgeon asks a qualified ODA to collect a unit of emergency O neg from the theatre fridge. A second unit is then needed and on taking the first bag down it is noticed that the transfused unit was O neg crossmatched for another patient. Phil is given a further unit of emergency O neg before blood arrives crossmatched for him. His group is also O neg and he makes a full recovery from his injuries.

Scenario number 3

Emily Archer is recovering on the ward following surgery the previous day for THR. She has been prescribed 1 unit of RBC as a "top-up". The blood is checked at the bedside by a qualified nurse and a 3rd year nursing student, all checks are carried out correctly at the bedside and the unit is put up by student Lisa Cooke under the supervision of SN Karen Davies. Lisa fumbles a little and when the unit starts to run SN Davies notices a tiny smear of blood on the bag. She examines the unit carefully and can see a small hole at the top of the bag where it was spiked by accident. However the blood has already run beyond that point. The unit is no longer leaking and SN Davies covers the hole with sticking plaster. She is seen doing this by the ward sister who immediately stops the transfusion and takes the unit down. The patient received only about 5 mL blood, suffered no harm, and was given a fresh unit of blood later in the day.

Scenario number 4

Charles Stirling, aged 69, has a long history of GI bleeding. Following his latest bleed he is admitted to A&E in an emergency. Blood samples are taken which group him as B RhD neg with multiple antibodies and this result is confirmed by his historical computer record. No suitable blood is available in the blood bank so units are ordered from the local RTC. The blood is sent from the RTC by taxi and it is delivered directly to A&E instead of going to the blood bank first. Mr. Stirling's condition is deteriorating rapidly and the A&E consultant tells the nursing staff to put up the transfusion and to inform the blood bank that this has been done.

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Transfusion error involving coincidence

SHOT

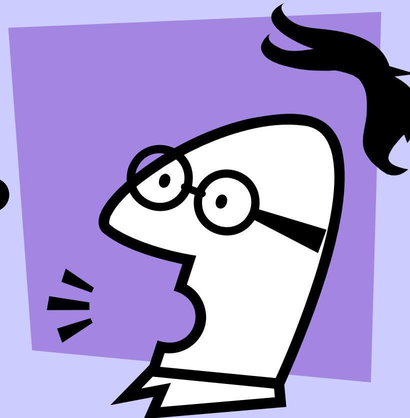
God! That could happen at *our* hospital!

With thanks to Dr. David Cummins
Royal Brompton & Harefield NHS Trust

Transfusion error involving coincidence

SHOT

God, how unlucky! That'll *never* happen at *our* hospital!



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In 2004, 67% of hospitals in the UK reported at least one incident to SHOT

That means

YOU are more likely to see an adverse event or reaction in **YOUR** hospital than not to see one❢

Please

Keep those reports

Coming in ...