Feeling Lucky? Wrong Blood, Wrong Patient
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BACKGROUND

The Emergency Department (ED) team from Jersey General Hospital (JGH) present a Serious Incident that took place in December 2015.

During a busy day shift, Patient 1, a 79 year old male with known myelodysplastic syndrome presents with progressive breathlessness and fatigue. There is a history of epistaxis and blood mixed with stool, and blood tests confirm a haemoglobin of 5.1g/dl.

Patient 1 is Cross Matched for 3 units of blood but transferred to a surgical ward before the blood arrives in ED.

During the same shift, Patient 2, a 51 year old male who is normally fit and well, presents with a 2 week history of black stools and increasing shortness of breath. Haemoglobin reported as 6.0g/dl.

Patient 2 is Cross Matched for 3 units of blood

The doctor who ordered the blood meets for handover with the medical team separately to the nurse who will be giving the blood

The blood from Patient 1 incorrectly arrives at ED after being requested by the surgical ward. The blood request states ED as the ward (correct when the form was filled).

The nursing team check the blood (which is for Patient 1) away from the bedside, run the blood through a giving set (Figure 1) and attach it to the intravenous line for Patient 2.

A final bedside check by the nurse revealed the error, the line was disconnected and the transfusion was never allowed to start.

KEY ISSUES

• Nursing handover 15:45 each day, doctor handover 16:00
• Staff workload mismatch
• Blood request forms are not automatically updated if a patient changes ward
• Blood was not checked at the bedside prior to running it through an IV giving set

SHOT REPORT

During the analysis of this Serious Incident, the ED team looked at the annual UK Serious Hazards Of Transfusion (SHOT) report 2015.

The SHOT report looks at nationwide errors in administering blood and blood products. Figures used are from the 2015 report -

• 3388 reports were analysed in 2015, collected from across the UK
• Of these, 2555 were human errors (76%)
• A total of 1243 near misses were identified, and 288 of these would have led to ABO mismatch
• The report estimates that around 33% of ABO mismatch transfusions would result in serious harm or death (Figure 2)

From the 2015 SHOT report – near miss incidents

To place this in context, Jersey General Hospital ED makes around 6 Blood transfusions per month

A review of documentation for blood transfusion requests to Jersey General Hospital’s new luggage tag style

A new Blood Transfusion Bedside Checklist was developed by the ED team in cooperation with the JGH Transfusion Service (Figure 4)

This style of checklist was not currently in use in JGH at the time of the incident.

A luggage tag style Bedside Checklist was developed by the ED team in cooperation with the JGH Transfusion Service (Figure 4).

This luggage tag will accompany blood from the laboratory to the receiving ward and is due to be implemented later this year

LEARNING POINTS

• Communication is paramount at all points in the transfusion process – physical checklists, such as the luggage tag system, can prompt this but are not designed as a substitute for interaction.
• Do not improvise, particularly at busy times. Follow the bedside administrative checks and act within departmental policies.
• Full transparency and thorough analysis of events helps to end a blame culture and facilitates shared learning from near misses

RECOMMENDATIONS

• The 2015 SHOT report states that the severity of the outcome is not the determinant of the seriousness of the error
• They underline the point that there is no substitute for correct patient identification at all stages in the transfusion process
• Recommend the use of a Blood Transfusion Bedside Checklist (Figure 3)

Implementing Change

• This style of checklist was not currently in use in JGH at the time of the incident.
• A luggage tag style Bedside Checklist was developed by the ED team in cooperation with the JGH Transfusion Service (Figure 4).
• This luggage tag will accompany blood from the laboratory to the receiving ward and is due to be implemented later this year

CONCLUSIONS

• A review of documentation for blood transfusion requests to become more dynamic (the ward location is not automatically updated when a patient moves ward – a problem in ED where stable patients are often transferred to medical or surgical wards).
• Continuing the high standards of mandatory blood transfusion e-learning (essential for all new staff and to be repeated every 3 years).
• A new Blood Transfusion Bedside Checklist will now bring Jersey in line with SHOT recommendations and practice in many UK hospitals.
• A review of the handover times in ED is to take place to facilitate increased inter-disciplinary communication

Blood Transfusion Bedside Checklist

Before each unit of blood is transfused, ensure you:
1. Check for blood component integrity – No clock, leak, damage, discoloration or expiry
2. Check informed consent is documented
   - Reason & risks/benefits explained? Alternatives? Information given?
3. Confirm Positive Patient Identification (PPID)
   - Ask your patient to tell you their full name and DOB
4. Check unit tag against unit label, prescription, patient ID band and PPID
   - Are there any specific transfusion requirements?
5. Perform Observations
   - Baseline, after 15 minutes, end of transfusion & as per local policy
   - Now you may set-up your safe transfusion

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