

Serious Hazards of Transfusion

“A snapSHOT of the impact of the check-group”

The Uncertainty of it All
(NEQAS & BBT SIG)
Tue 10th November 2015

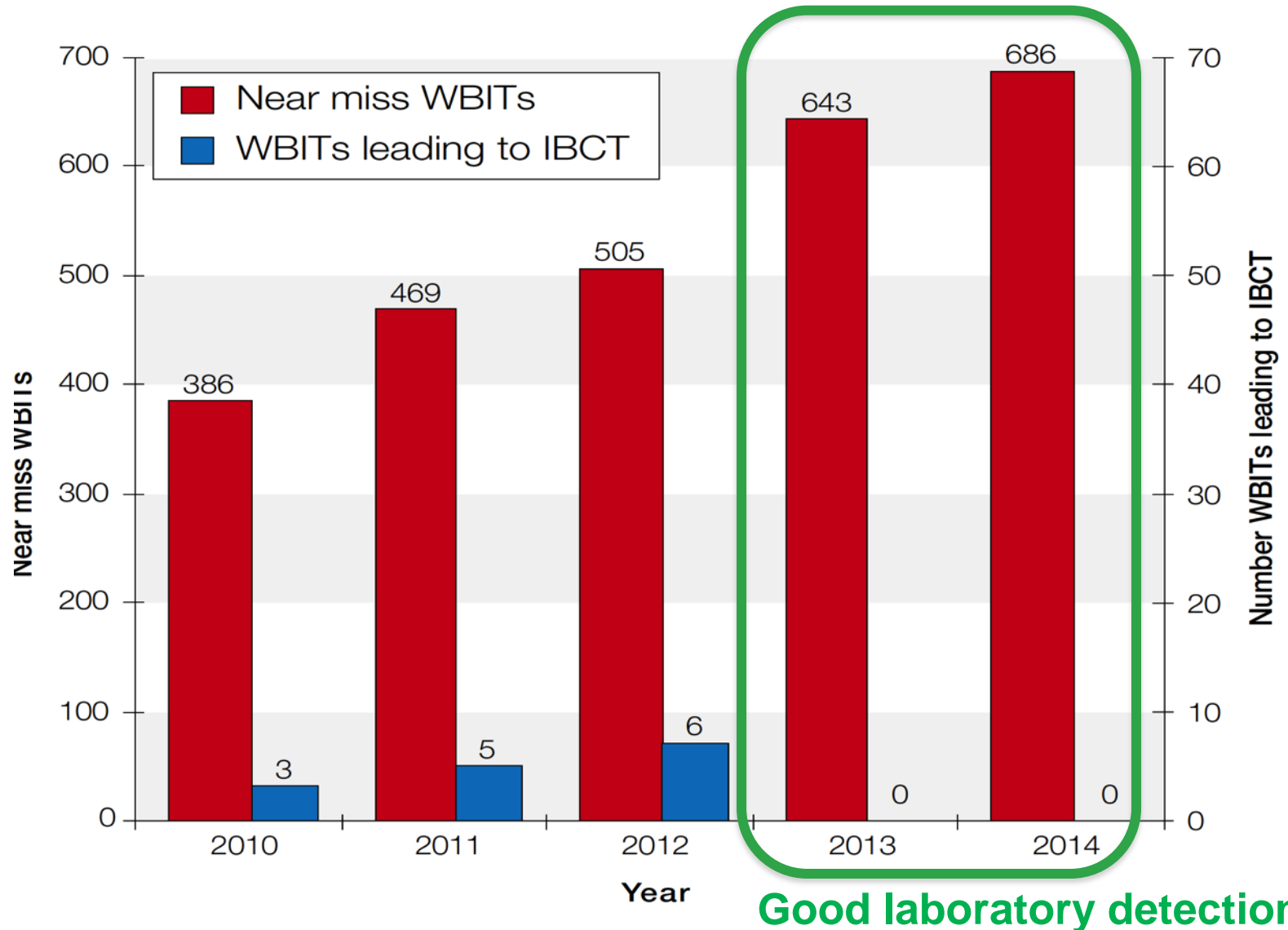
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Learning outcomes

By the end of this session you should be able to:

- Discuss the impact of wrong blood in tube (WBIT) samples
- Analyse some case studies for learning points
- Demonstrate the importance of a check-group policy

'Near Miss' WBIT incidents demonstrate a problem



Case 1 - Mismatch with historical group detects an unusual error

- A crossmatch sample was taken by the community team
- The group was different from historical sample
- The sample had been taken from the person living next door
- This person was expecting a nurse for an injection...

Case 1 – Learning points

- Ridiculous mistakes happen, never assume they can't
- Patient identity is paramount
- Always ensure there is a historical group or a second check-group sample

Importance of check-group policy

- Data from WBIT incidents reported to SHOT in 2014 were analysed to find cases where the reporter mentioned a check-group sample
- As this question is not specifically asked in the near miss questionnaire, the analysis could only be a small snapshot of cases

Errors related to check-group samples (n=27)

Outcome of testing a check-group sample		No. cases
Original sample was WBIT	Expected benefit	20
Check-group sample was WBIT	Inevitable complication	3
Circumvention of process (both samples taken at same time)	Staff non - compliance	3
Other – request for check sample alerted sample taker to original error	Unexpected benefit	1
Total		27

Case 2 - Repeat sample prevents ABO-incompatible error

- A wrong blood in tube (WBIT) incident occurred three days before the check-group sample rule was implemented in one Trust/Health Board
- At the time a check-group sample was not a requirement, but the anaesthetist sent a repeat crossmatch sample anyway and a blood group discrepancy was detected
- The emergency department (ED) sample was A D-positive, but the repeat was actually B D-positive
- If that extra sample had not been sent, the initial sample previously received from ED would have been used to issue the wrong ABO group blood

Case 2 – Learning points

- This hospital already intended to introduce a check-group policy, but some hospitals wait for an incident before realising the importance
- In addition to the snapshot of 27 cases analysed before, there were a further **12** WBIT incidents in 2014 where implementation of a check-group policy was to be considered as a corrective action following the incident

Case 3 - WBIT at hospital X discovered through a linked database at hospital Y

- A sample grouped as A D-positive in hospital X
- There was no previous history for this patient
- Approximately two weeks later a sample from the same patient at hospital Y grouped as O D-negative
- The two hospitals have linked databases, so the second hospital noticed the groups did not match
- A repeat sample confirmed the group as O D-negative
- The investigation revealed the first sample could not have been from this patient

Case 3 – Learning points

- If the patient had received a transfusion in hospital X it would have been ABO incompatible
- Deciding not to introduce a check-group policy leaves patients at risk

Key SHOT Message

Ensure a group check policy is in place as detailed in the British Committee for Standards in Haematology (BCSH) guidelines for pre-transfusion compatibility
(BCSH Milkins et al. 2013)

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SHOT Symposium 2016

The Lowry Theatre, Salford Quays

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