



Implementation of a two sample policy for compatibility testing

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UK News

Woman died after transfusion error

12:01AM BST 06 Oct 2001

A WOMAN died on an operating table after an anaesthetist pumped the wrong blood into her, the General Medical Council heard yesterday.

Dr John Prickett, 34, made a "basic and simple error" by not checking the patient's blood type. Mrs Hilary Pearce, 61, suffered a cardiac arrest five minutes after the mistake and could not be revived despite the desperate attempts.

She had been admitted to Addenbrooke's Hospital in Cambridge in November 1999 for an urgent operation on a burst blood vessel in her brain. Dr Prickett was handed the wrong blood by a hospital orderly and he checked the paperwork was correct.

But he failed to look at Mrs Pearce's identification band or patient notes before giving the transfusion of "A" positive blood. She was "O" positive. John Snell, for the GMC, said it was a fundamental mistake by Dr Prickett, who was on secondment from the Norfolk and Norwich Hospital.

Mr Snell said: "The error was so basic and so simple. Had he followed his

Safer practice notice

14



Right patient, right blood

Blood transfusions involve a complex sequence of activities and, to ensure the right patient receives the right blood, there must be strict checking procedures in place at each stage.

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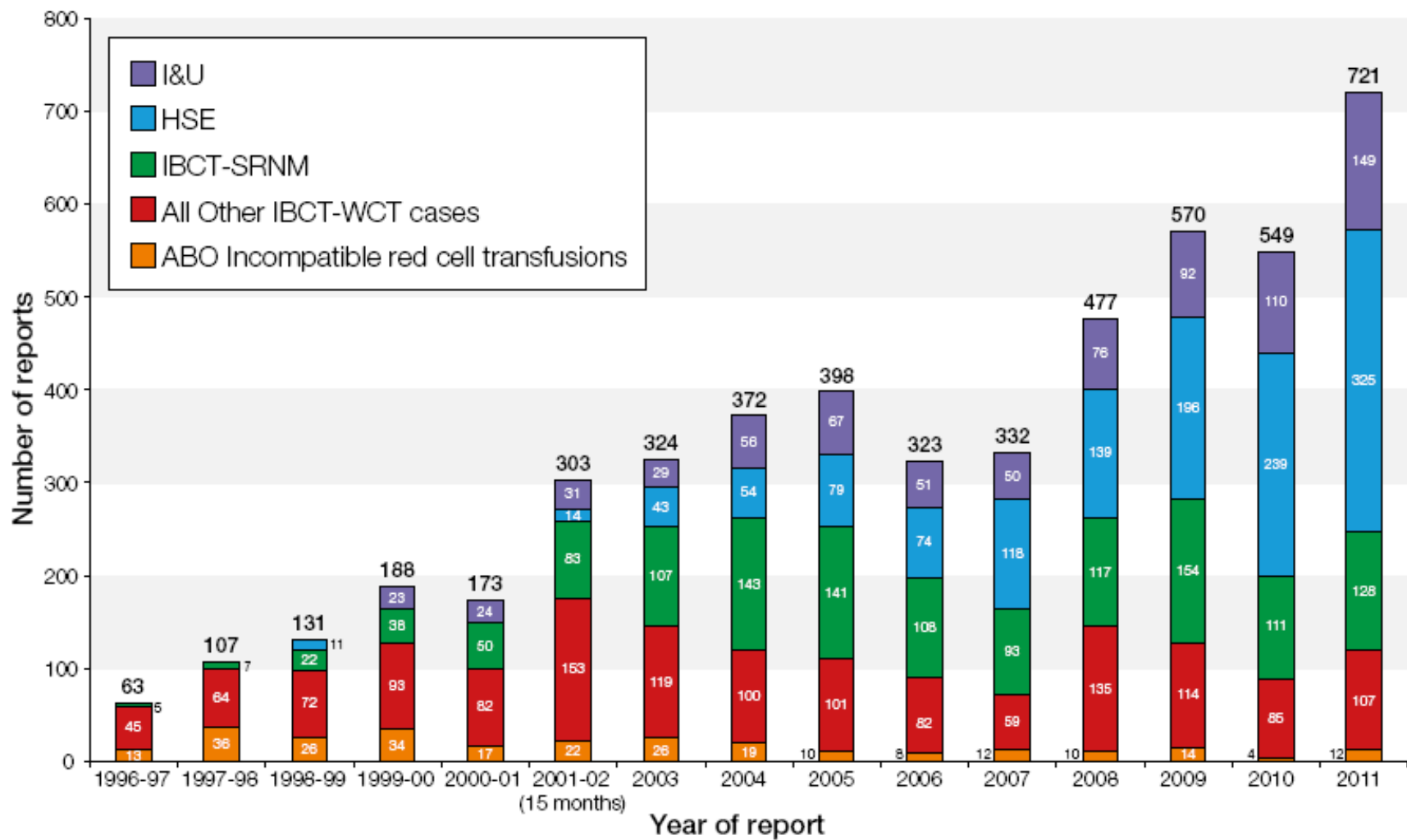
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The 'never events' list for 2011/12

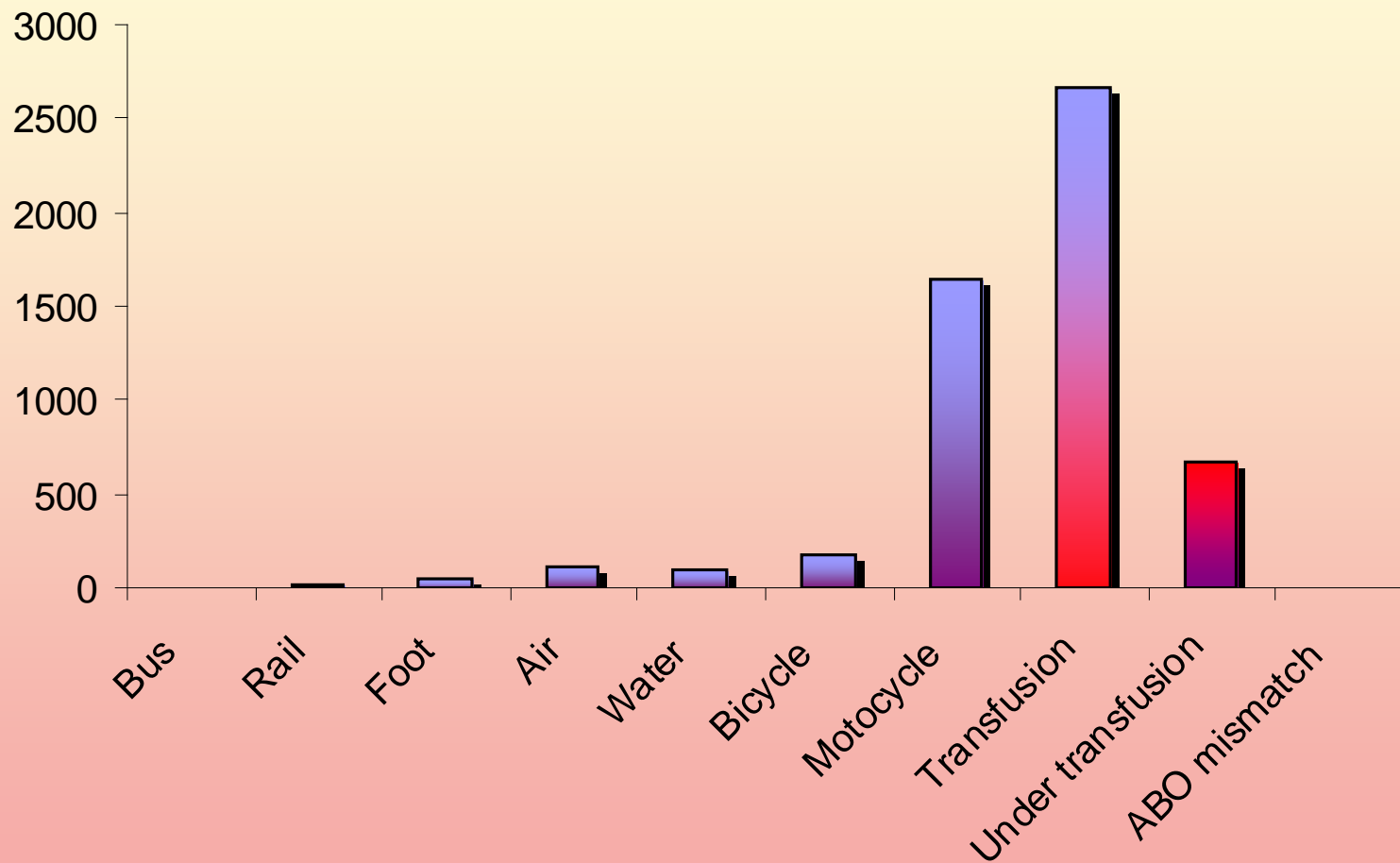
Document type:	Guidance
Author:	Department of Health
Published date:	24 February 2011
Gateway reference:	15532
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"Never events" are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

IBCT summary SHOT 2011



Deaths per billion



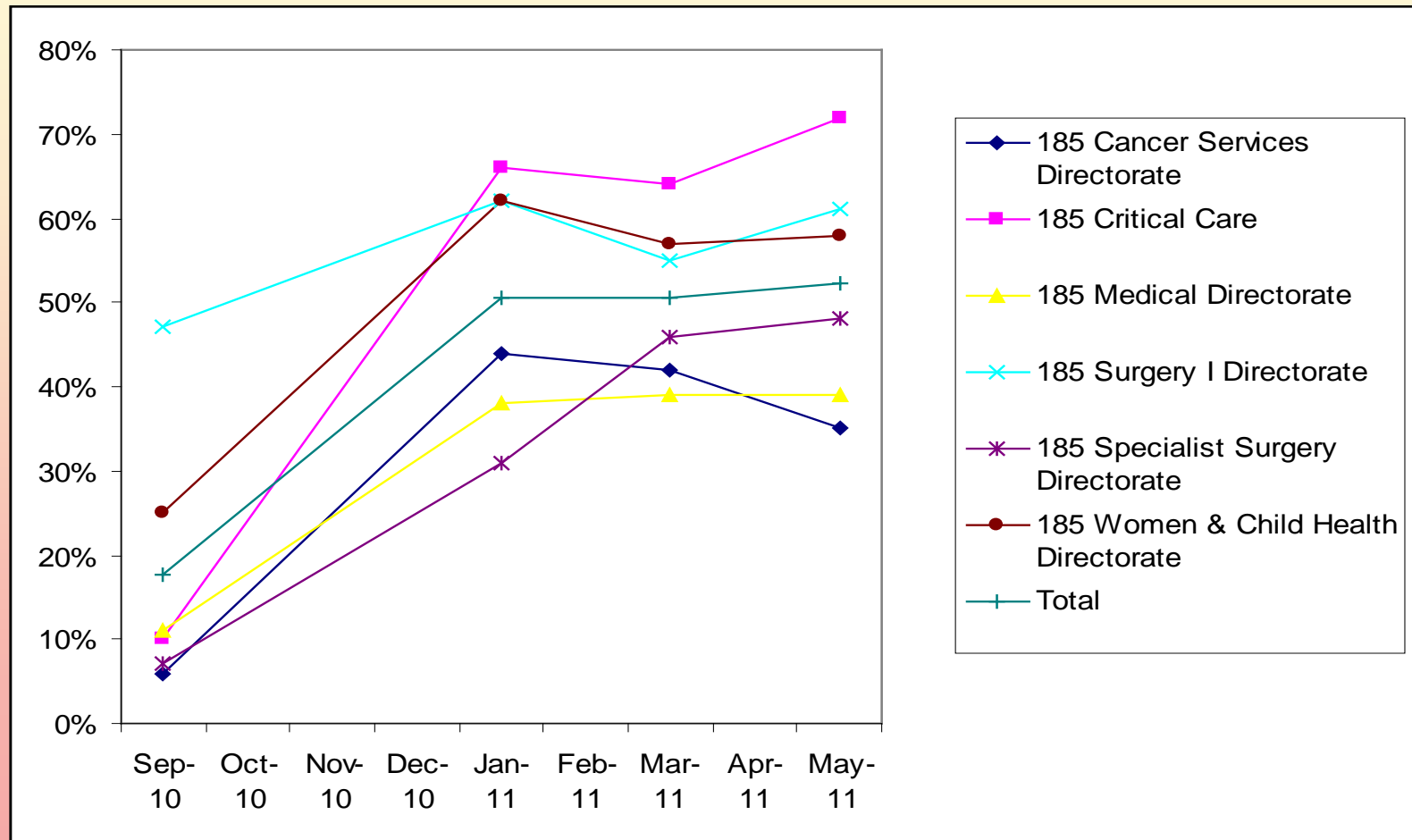


Strategies for reduction in ABO mismatch risk at Exeter

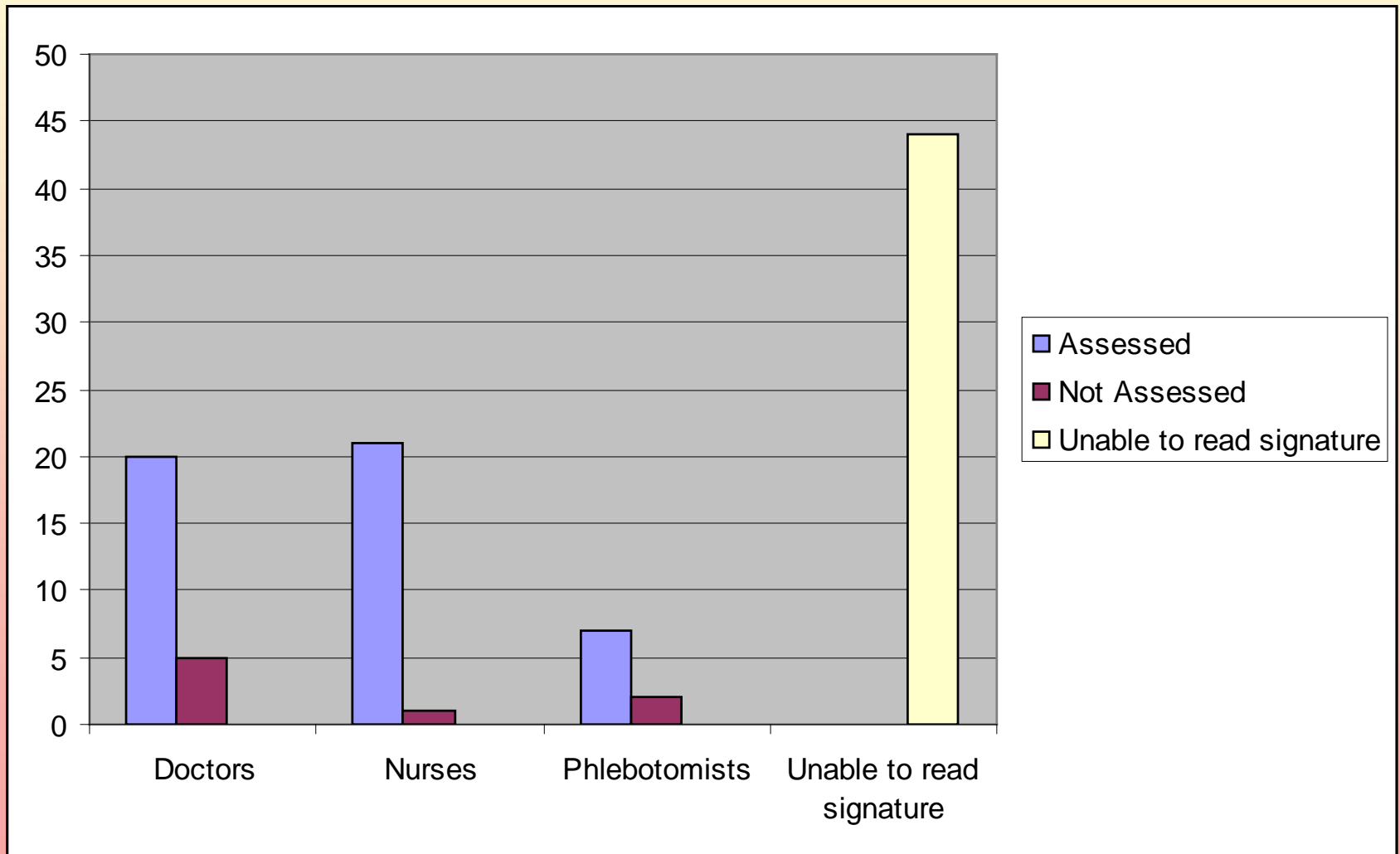
- Implementation of NPSA guidance...
 - Website
 - Involvement at Trust Board level
 - Training video



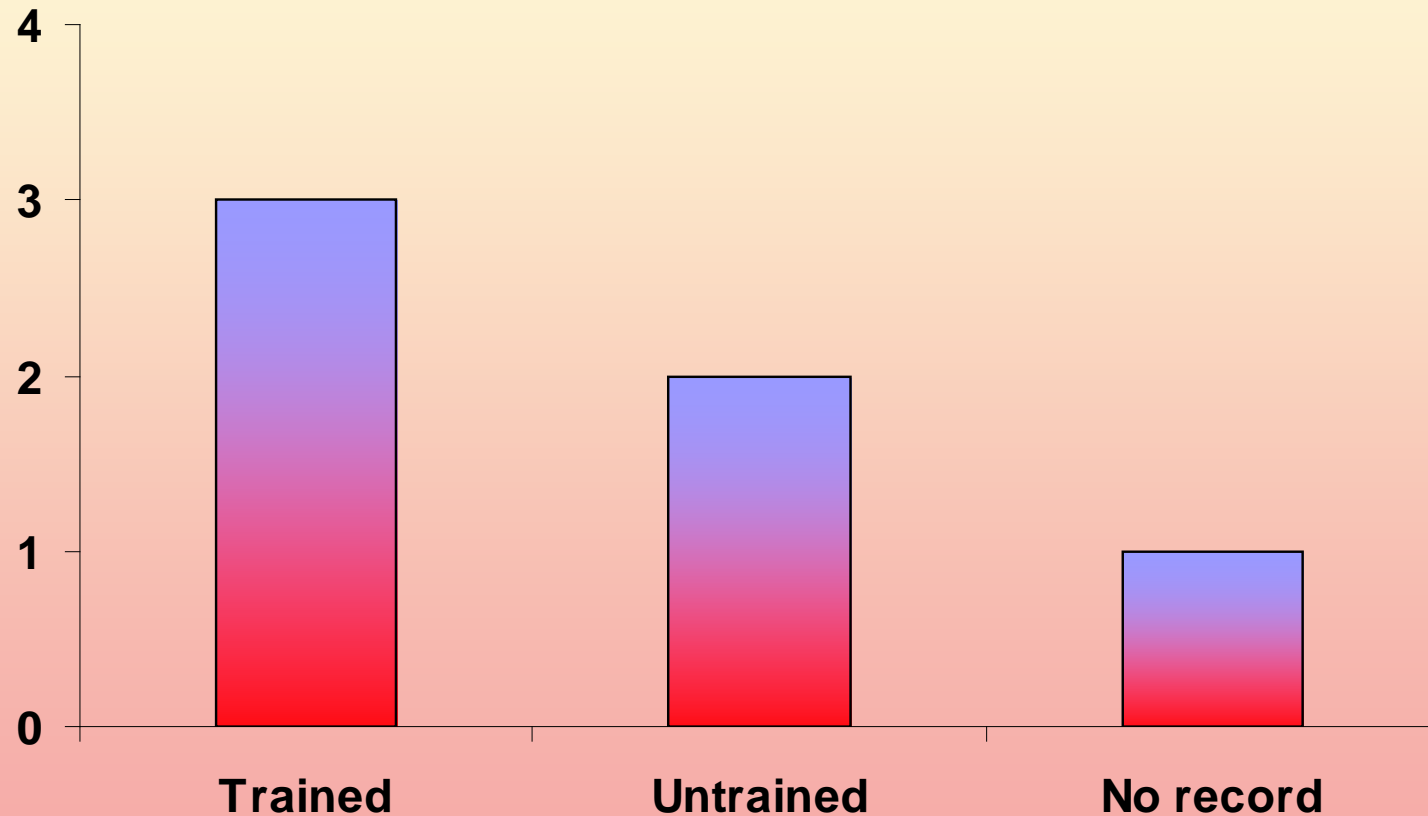
NPSA competency training numbers over time



NPSA status of staff completing transfusion forms



Training status of staff involved in WBIT events



Wrong Blood in Tube Events Summary

- WBIT rate comparable to published rate¹
- Training uptake not 100%
- Policing of staff impossible
 - Many untrained staff involved
- Community samples – ‘black hole’
- WBIT as likely to come from trained as untrained staff

¹*Murphy et al Transfusion Medicine 2004 14 113-121*

IMMUNOHEMATOLOGY

Implementation of a two-specimen requirement for verification of ABO/Rh for blood transfusion

*Lawrence T. Goodnough, Maurene Viele, Magali J. Fontaine, Christine Jurado, Nancy Stone,
Peter Quach, Lee Chua, Mei-Ling Chin, Robert Scott, Irina Tokareva, Kevin Tabb, and Paul J. Sharek*

Request blood by phone or form:

Historical sample exists

Lab checks to see if historical group exists:

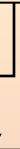
Group Specific blood issued



Request blood by phone or form:



Lab checks to see if historical group exists:



No historical

Lab requests second sample be sent



2nd sample sent



Group Specific blood issued

Request blood by phone or form:

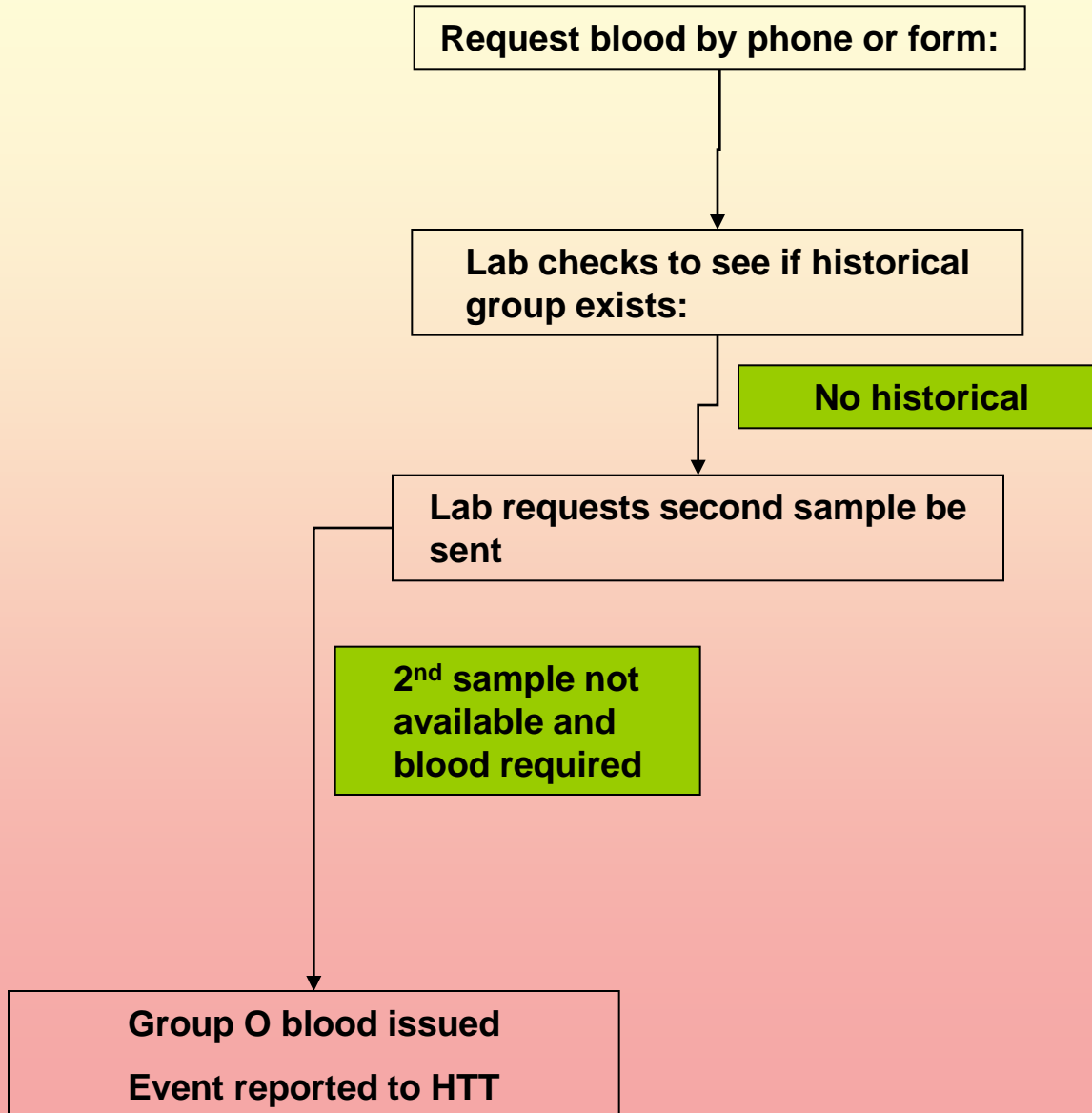
**Lab checks to see if historical
group exists:**

No historical

**Lab requests second sample be
sent**

**2nd sample not
available and
blood required**

**Group O blood issued
Event reported to HTT**



Barriers to implementation

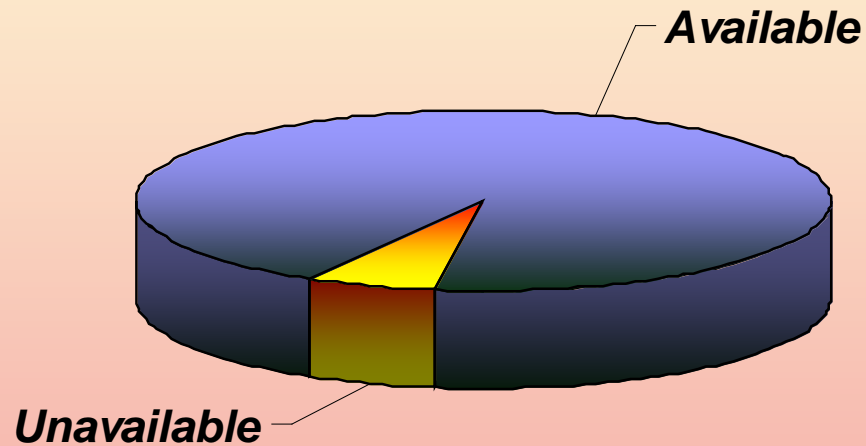
Subject: Fwd: RE: HTC MEETING - T

2 samples?

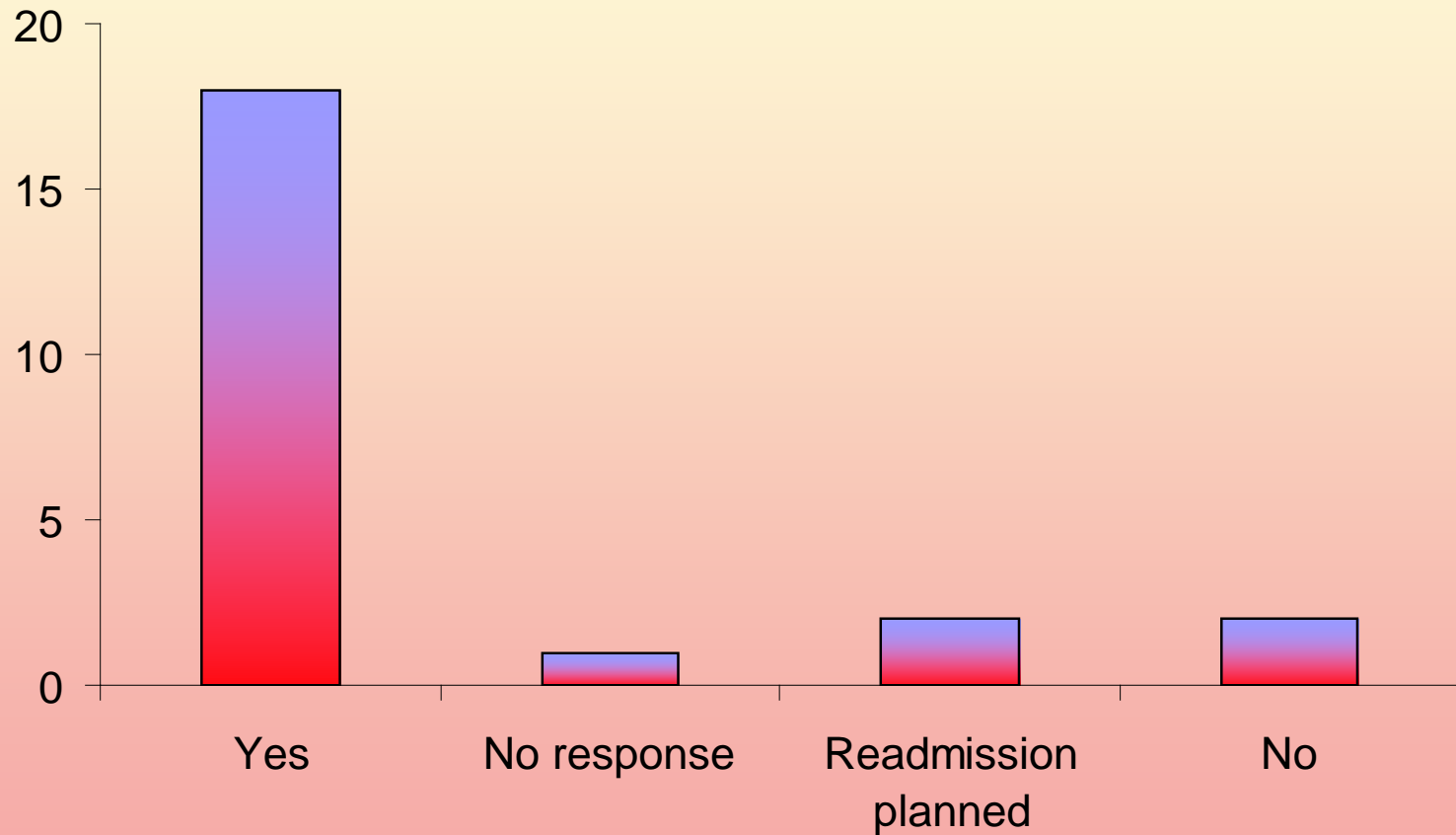
What a ridiculous idea

...

Availability of historical groups



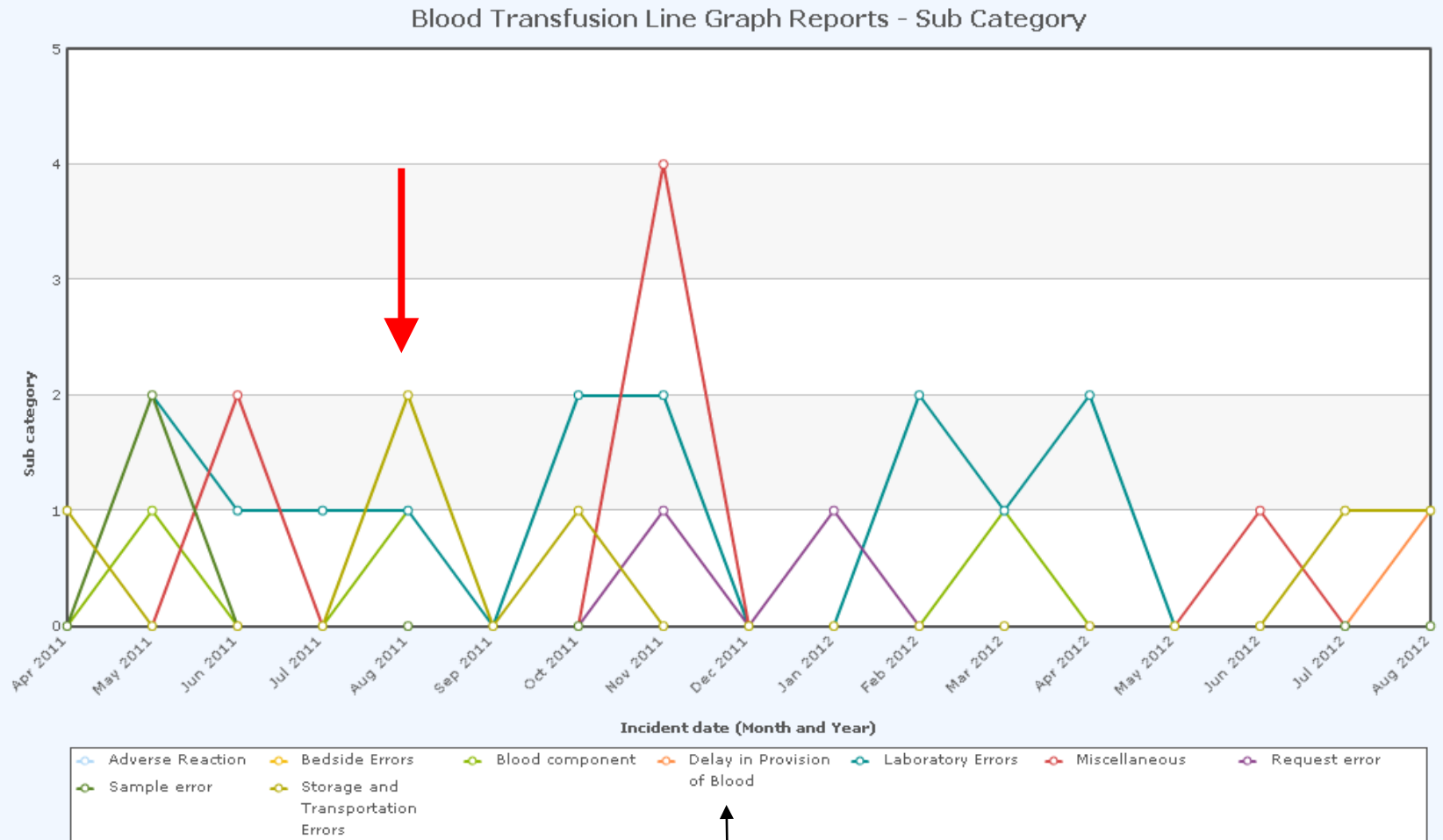
Availability of second sample on request



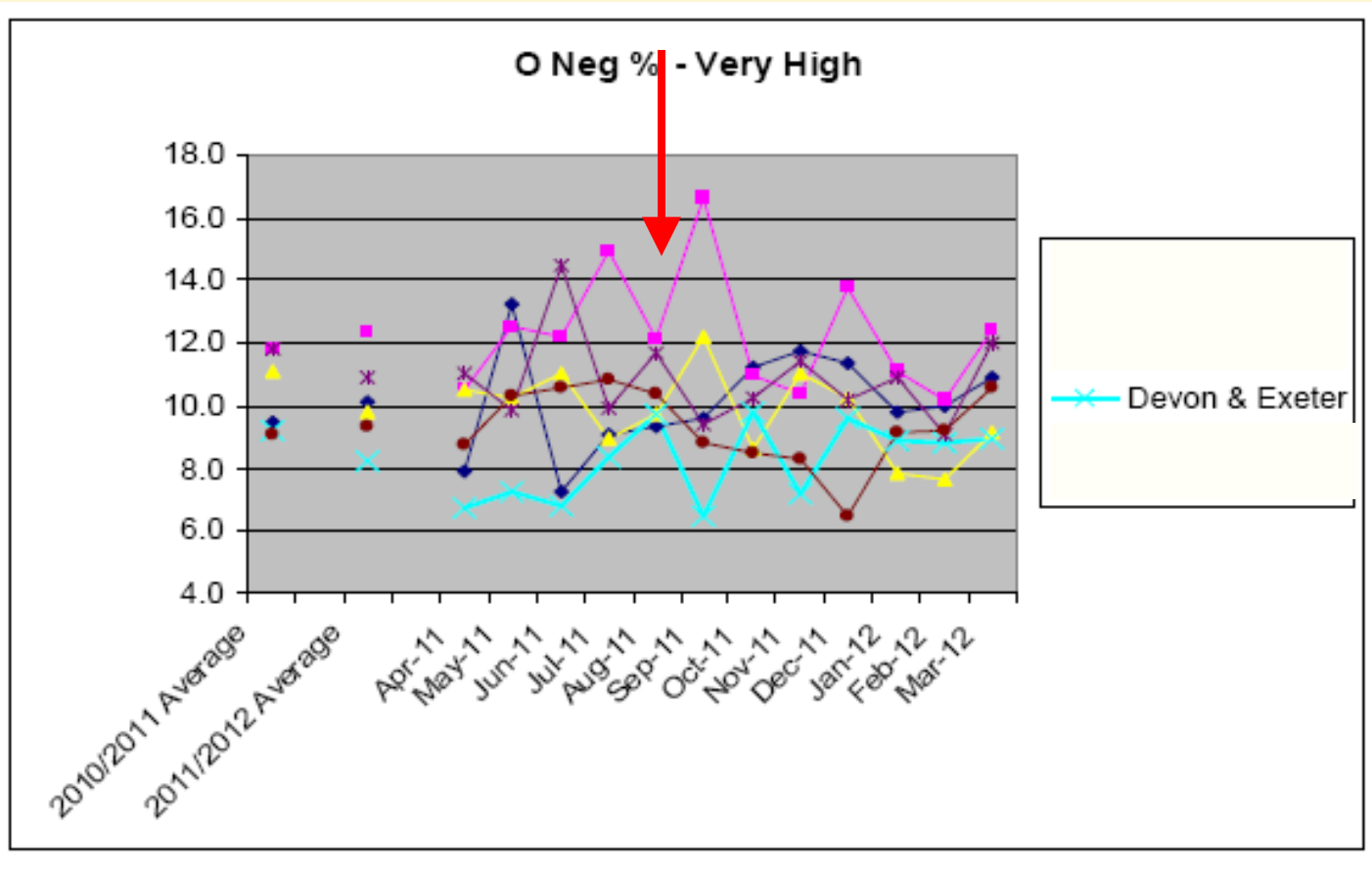
Emergencies

- Engagement of staff involved in emergency care
- Group O always available
- Need for separate samples
- Highlighting of need to incident report issues
- If no 2nd sample after 10 units, use original
- Pragmatic response if antibodies on first sample

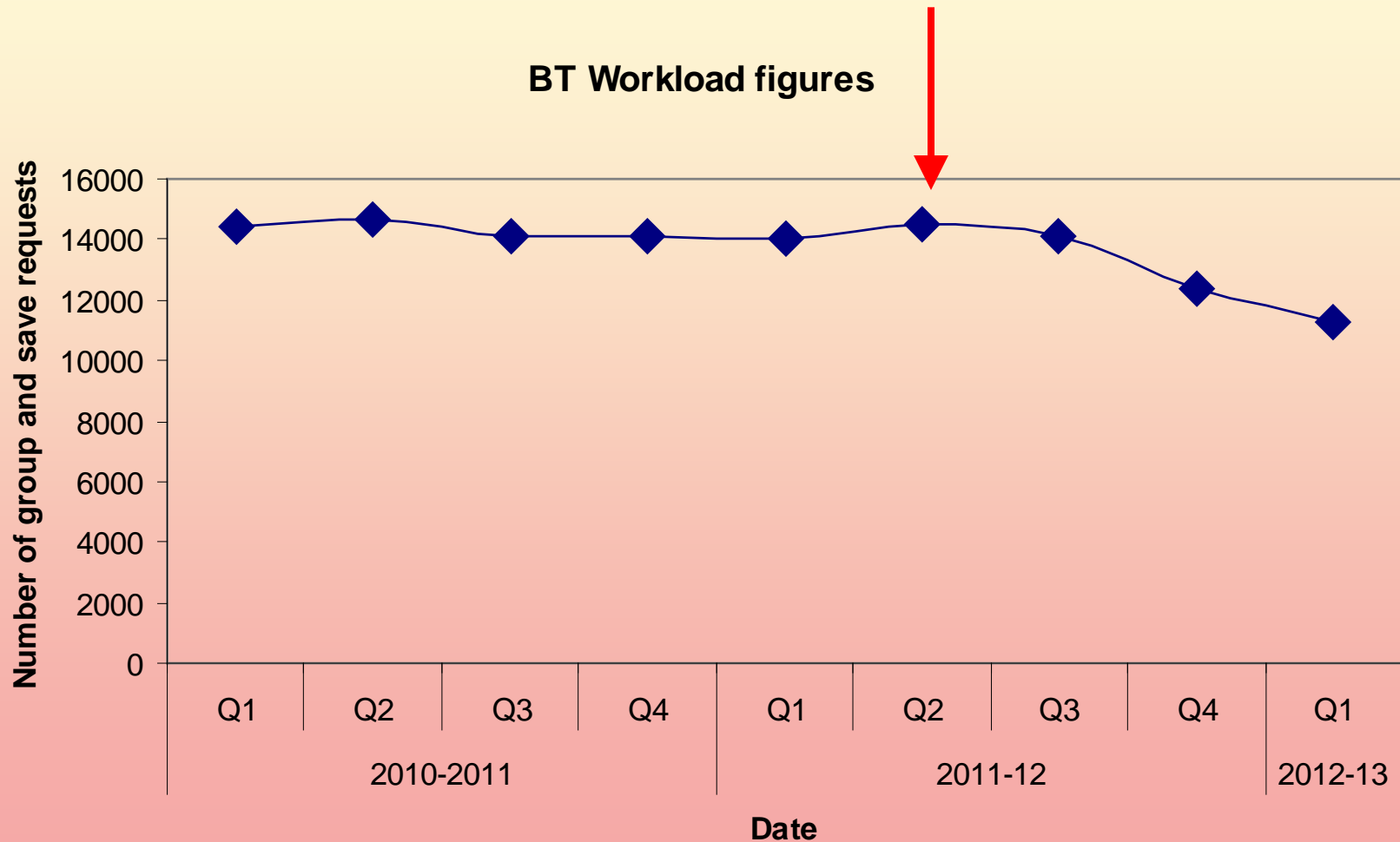
Incident reports



O neg increase



Effect on workload



Cheating

- Update training and policies
- Incident report any sample that appears to have been 'split'
- Published solution involves barcoded sample tubes



Summary

- Blood is safe (8 deaths in 3 million)
- No deaths in SHOT 2011 from ABO mismatch
- 12 non-fatal ABO mismatched transfusions
- ABO mismatch is a 'Never Event'
- Training does not entirely prevent patient mis-identification
- Dual sampling is a cheap and effective solution

Thankyous





What needs to happen next?

- Clinician discussion
- Re-write SOPs
 - Key areas
 - Pre-op
 - ED
 - MAU
 - O&G
 - Laboratory
- Clear incident reporting route
- Lab and administering must be looked at seperately

**Will there be a dramatic
increase in the number of
patients being bled?**

No. We have historical samples
recorded for 96% of patients; roughly
one additional sample per day will be
required at RDEFT.

Will there be delay in a patient receiving blood in an emergency?

No. The patient will receive O negative blood until their blood group is confirmed.

**Will medical and nursing staff
be able to 'cheat' the system
by taking two samples at
once?**

No; samples signed and labelled
by two different medical
professionals will be required.

**Will this affect neonates in
whom additional blood tests
can have negative
consequences?**

No – neonates receive O negative
blood anyway, so they are
unaffected.

Which stakeholders have been approached?

Informal discussions have taken place with paediatrics, Devon PCT, the National Blood Service and ED.

What other solutions are there?

- There is probably no substitute for dual samples for cross-match. Various other options however include;
 - ‘zero tolerance’ for samples which are from non-assessed staff
 - Significant impact on service delivery and lab staff time
 - Ordercomms for ordering transfusion samples
 - Not currently an option
 - Doesn’t cover the community
 - 3rd party IT solution eg PBARS
 - Significant financial barrier
 - Second IT system for blood sampling cumbersome