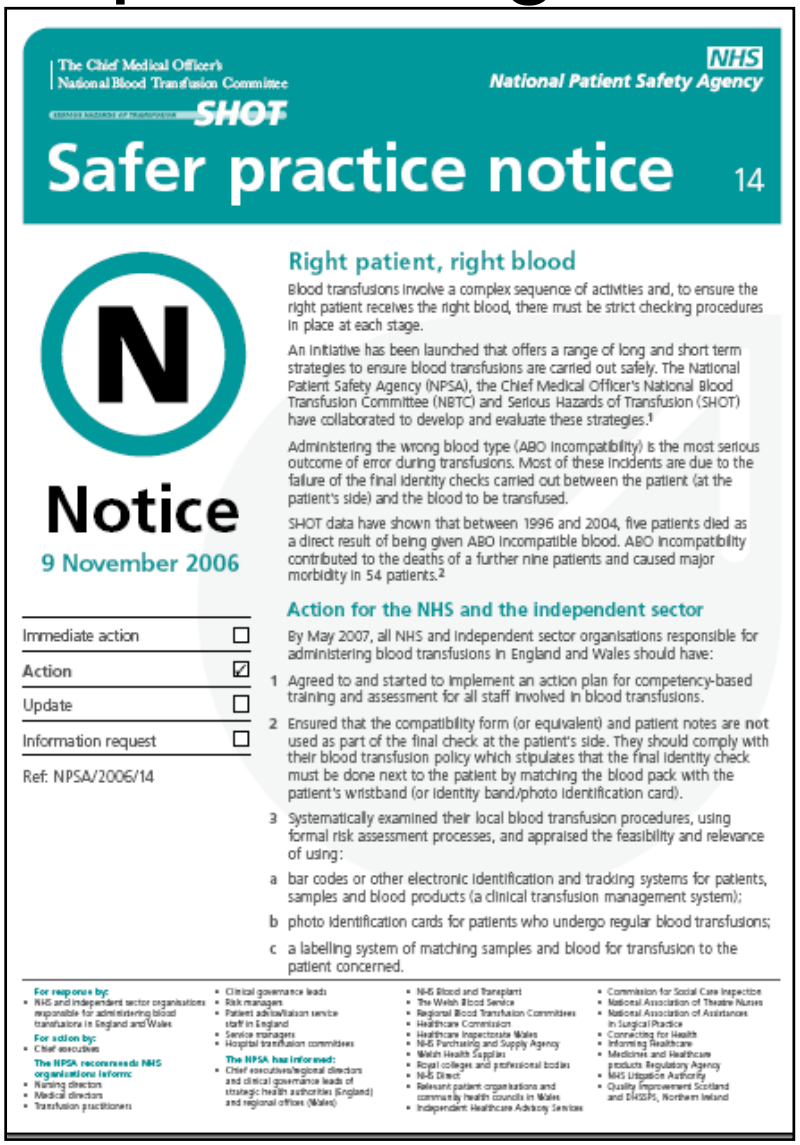
NPSA – SPN 14
Right patient, right blood



The Chief Medical Officer's National Blood Transfusion Committee

SHOT

NHS National Patient Safety Agency

Safer practice notice 14

Notice

9 November 2006

Immediate action	☐
Action	☑
Update	☐
Information request	☐

Ref: NPSA/2006/14

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.

An initiative has been launched that offers a range of long and short term strategies to ensure blood transfusions are carried out safely. The National Patient Safety Agency (NPSA), the Chief Medical Officer's National Blood Transfusion Committee (NBTC) and Serious Hazards of Transfusion (SHOT) have collaborated to develop and evaluate these strategies.[1]

Administering the wrong blood type (ABO incompatibility) is the most serious outcome of error during transfusions. Most of these incidents are due to the failure of the final identity checks carried out between the patient (at the patient's side) and the blood to be transfused.

SHOT data have shown that between 1996 and 2004, five patients died as a direct result of being given ABO incompatible blood. ABO incompatibility contributed to the deaths of a further nine patients and caused major morbidity in 54 patients.[2]

Action for the NHS and the independent sector

By May 2007, all NHS and independent sector organisations responsible for administering blood transfusions in England and Wales should have:

1 Agreed to and started to implement an action plan for competency-based training and assessment for all staff involved in blood transfusions.

2 Ensured that the compatibility form (or equivalent) and patient notes are not used as part of the final check at the patient's side. They should comply with their blood transfusion policy which stipulates that the final identity check must be done next to the patient by matching the blood pack with the patient's wristband (or identity band/photo identification card).

3 Systematically examined their local blood transfusion procedures, using formal risk assessment processes, and appraised the feasibility and relevance of using:

a bar codes or other electronic identification and tracking systems for patients, samples and blood products (a clinical transfusion management system);

b photo identification cards for patients who undergo regular blood transfusions;

c a labelling system of matching samples and blood for transfusion to the patient concerned.

For response by:
- NHS and independent sector organisations responsible for administering blood transfusions in England and Wales

For action by:
- Chief executives

The NPSA recommends NHS organisations inform:
- Nursing directors
- Medical directors
- Transfusion practitioners
- Clinical governance leads
- Risk managers
- Patient advice/liaison service staff in England
- Service managers
- Hospital transfusion committees

The NPSA has informed:
- Chief executives/regional directors and clinical governance leads of strategic health authorities (England) and regional offices (Wales)
- NHS Blood and Transplant
- The Welsh Blood Service
- Regional Blood Transfusion Committees
- Healthcare Commission
- Healthcare Inspectorate Wales
- NHS Purchasing and Supply Agency
- Welsh Health Supplies
- Royal colleges and professional bodies
- NHS Direct
- Relevant patient organisations and community health councils in Wales
- Independent Healthcare Advisory Services
- Commission for Social Care Inspection
- National Association of Theatre Nurses
- National Association of Assistances in Surgical Practice
- Connecting for Health
- Informing Healthcare
- Medicines and Healthcare products Regulatory Agency
- NHS Litigation Authority
- Quality Improvement Scotland and DHSSPS, Northern Ireland

Actions required

- Ensure that compatibility form & and patient notes NOT part of final bedside check
- Competency based training & assessment
  - 50% by May 2009
- Risk assess
  - Electronic ID & tracking systems for patient samples and blood products
  - Photo ID for regularly transfused patients
  - Additional labelling system

Compliance within South West

- Compliance included in BBT3 survey December 2008
- Further survey in SW over last 2 weeks to identify compliance more accurately

NPSA SAFER PRACTICE NOTICE NO. 14 – 'RIGHT PATIENT/RIGHT BLOOD'
SURVEY UPDATE – APRIL 2009

1 Has your Trust/Hospital implemented the removal of patient notes and compatibility form from bedside check:

Yes	No	Other
18	5	1

2(a) Has your Trust/Hospital implemented training and competency assessment for each staff group involved in the transfusion process:

	Yes	No	Other
Registered Nurses	24	0	0
Doctors	14	9	1
HCAs	20	1	3
Phlebotomists	21	2	1
TNs/ODPs	24	0	0
Porters	13	3	8

2(b) Are you using the NPSA competency assessment questions:

Yes	No	Other
19	4	1

2(c) Has your Trust/Hospital achieved the 50% competency assessment target for each group:**

	Yes	Not But Close to Achieving 50%	Not Achievable in the Near Future	Other
Registered Nurses	7	12	5	0
Doctors	3	6	14	1
HCAs	3	12	5	4
Phlebotomists	15	6	2	1
TNs/ODPs	12	5	7	0
Porters	8	5	2	9

Three Trusts included **all staff in their percentages for the competency assessment targets, with two Trusts achieving 50%+ and one close to achieving 50%

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SURVEY UPDATE – APRIL 2009

3 Has your Trust/Hospital implemented an electronic tracking system for patients, samples and blood products:

Yes	No	Other
6	17	1

If yes, estimated percentage of transfusions administered using bedside IT:

<50%	>50%
1	5

If yes, estimated percentage of samples taken using bedside IT:

<50%	>50%
0	5

4 Has your Trust/Hospital implemented an additional labelling system for matching samples and blood for transfusion to the patient, e.g. Red Label System:

Yes	No	Other
0	24	0

5 Has your Trust/Hospital implemented photo ID for regularly transfused patients:

Yes	No	Other
1	23	0

Conclusion

- More than 25% hospitals not removed notes and compatibility form from bedside check or was it my wording of the question?
- Nursing staff most engaged and doctors least in competency training and assessment
- Some hospitals not using NPSA assessment questions
- ~25% implemented electronic tracking
- No one using photo ID cards