NHS
Blood and Transplant

The Importance of Patient Identification & Obtaining Consent

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Caring Expert Quality

The Importance of positive Patient Identification

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Identify your patient properly!

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Why?

- Patient identification was a factor in **69.6%** of near misses
- Wrong Blood in Tube (WBIT) is the most common near miss incident

The wrong blood group can kill

- **7** ABO incompatible transfusions – **6** from clinical error

These are ***Never events***

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- **23.3%** of near misses were ABO incompatible
- **33.3%** WBIT were ABO incompatible
- Multiple errors are common
- Median number of clinical errors made is **3**

Data from the 2016 SHOT Report

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Near misses

- Often errors do not contribute to adverse outcomes
- Systematic failures will inevitably lead to a true unwanted event

- Wrong blood in tube
  - Deviation from correct practice
  - Contributing factors: work load, emergencies, language barriers

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How can we prevent this?

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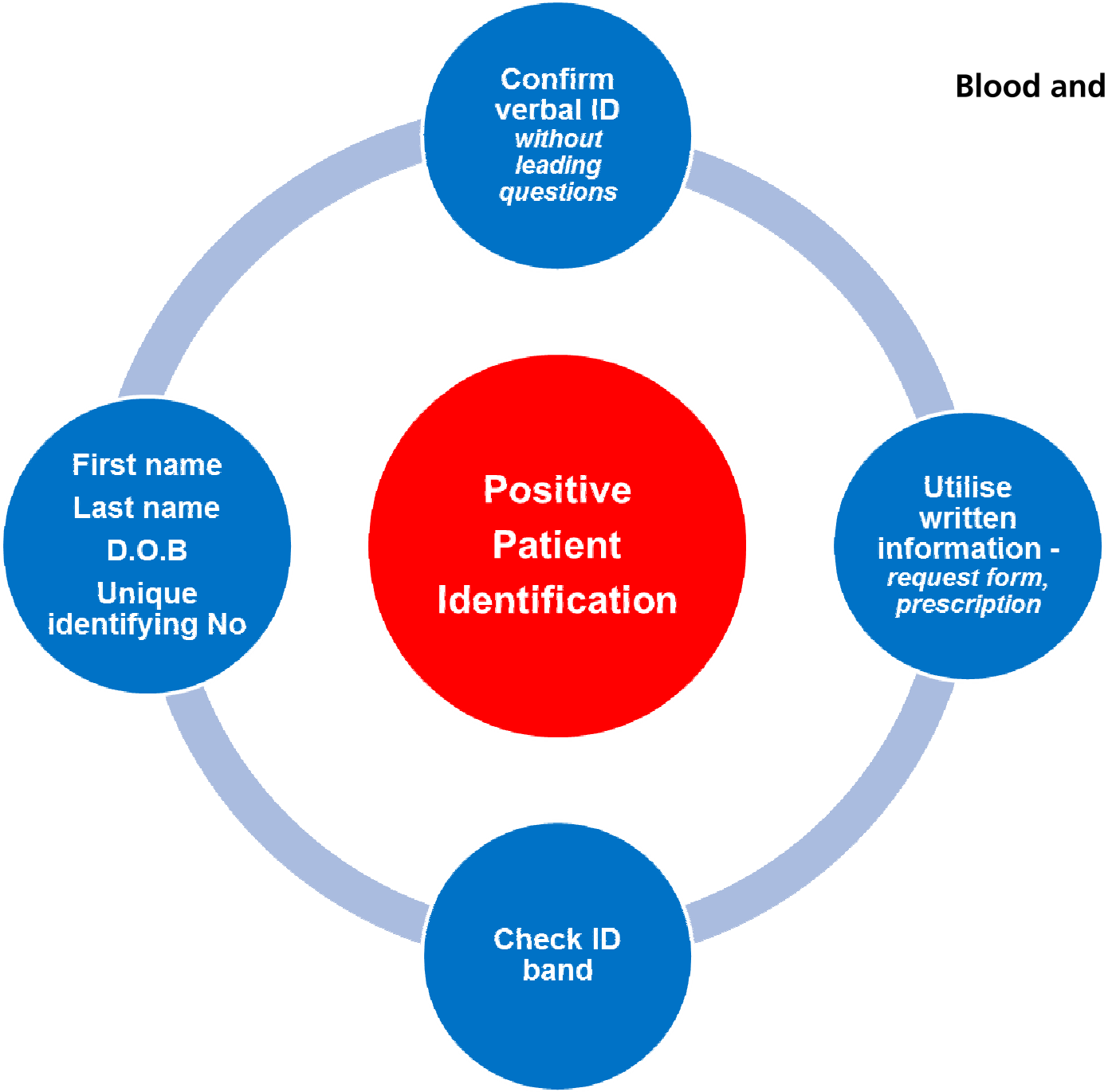

Avoid errors!

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Sample Taking

- Complete patient identification, sample acquisition and labelling as one continuous and uninterrupted event
- The entire process ***must*** be carried out by the person taking the sample at the time of sample taking

Administration

- Do not allow interruption when undertaking patient ID and pre-administration checks
- If you are interrupted ***STOP*** and start the process again from the beginning

Back to basics

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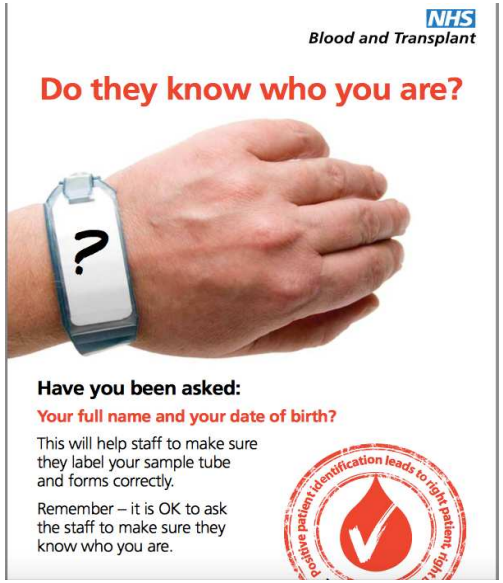
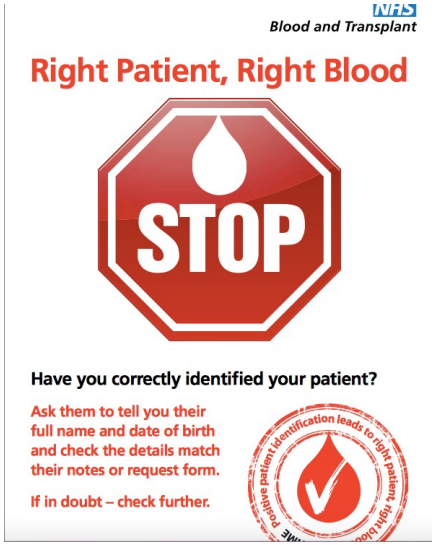
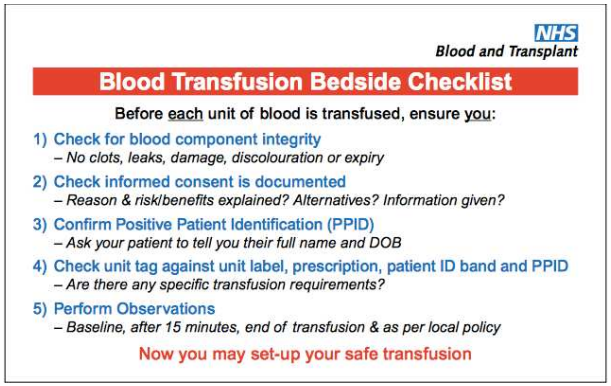
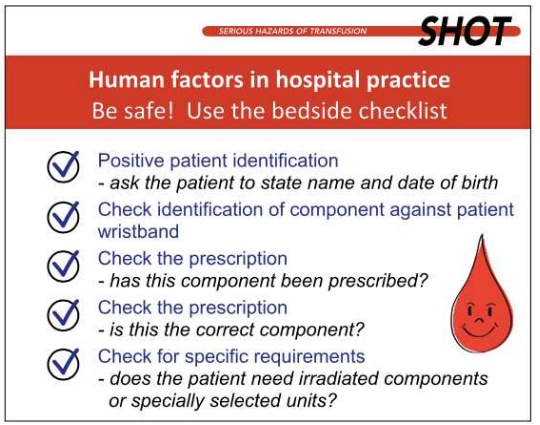
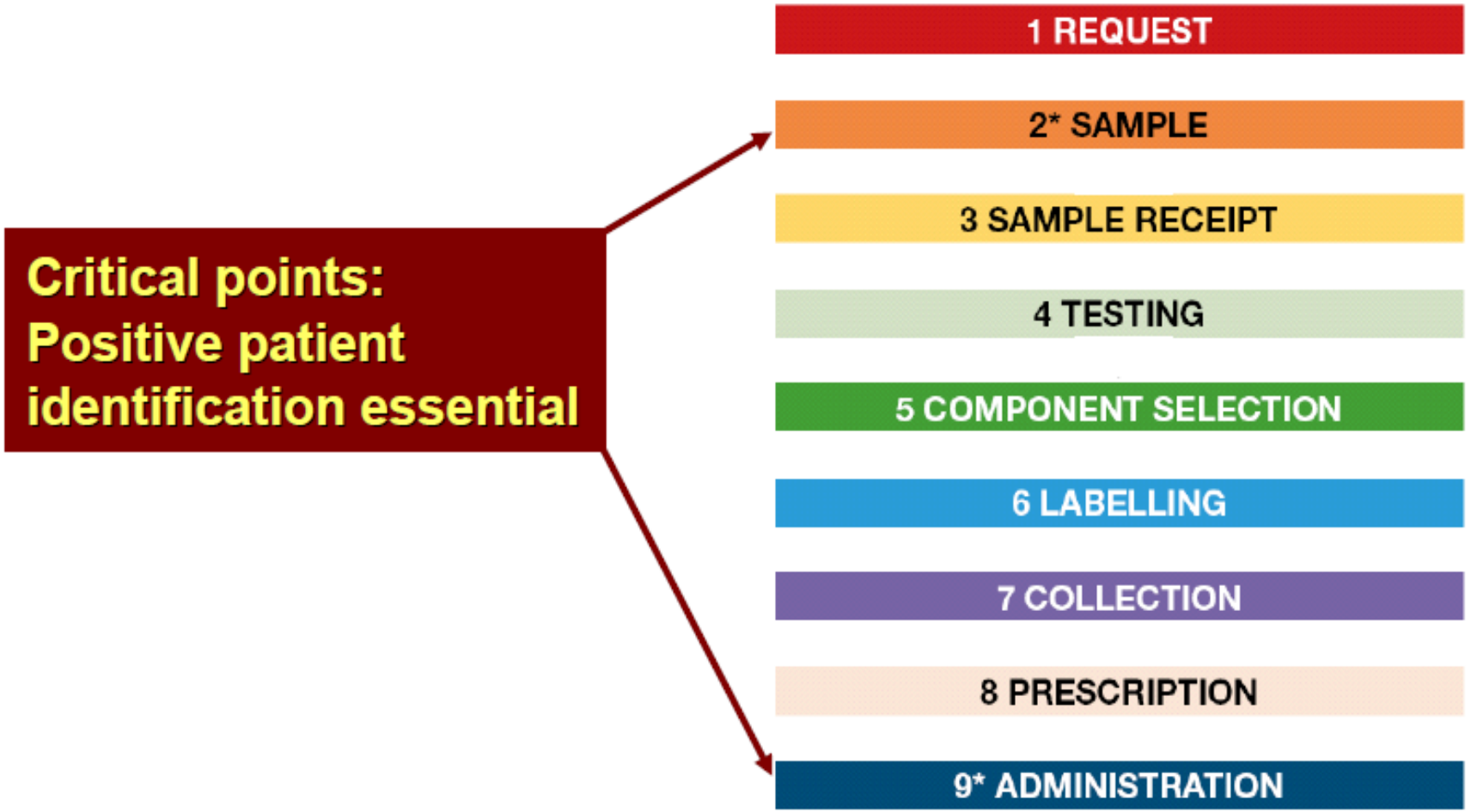








Critical points in the transfusion process



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But What If?

The correct procedure for labelling a pre-transfusion sample?

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- Positive patient identification
- Labelled in the presence of the patient by the person taking the sample
- 4 points of ID

Case study 1

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- A Nurse working in a Haematology day ward took samples from 2 patients who were attending the following day for transfusion. Neither patient had an ID band on as they were outpatients.
- The nurse was familiar with the patients as she saw them regularly, she did not take their notes, or a request form to the clinic room or follow the correct process for verbal ID. Her pen did not work when she went to label the 1st sample so she put it in her right pocket. She then took the sample from the 2nd patient and put it in her left pocket.
- She went back to the nurses station, took a label from each patient's notes which she stuck on blank request forms and put a sample in each.
- She took the samples to the lab, but was caught labeling them at the reception desk and they were disposed of.

What do you think the outcome of this could have been?

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- Both patients received the correct Blood
- 1 or both patients received an ABO compatible transfusion
- The error was detected by the laboratory
- The wrong blood groups go down on the patient records

All of the above

Case study 2

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A woman self referred to a maternity department after the onset of labour. She was asked her name but no other identifiers. She was given hospital notes to take to the ward. Bloods were taken and labeled from a printer but as the patient was being cannulated ID bands were not applied at this point.

The patient was anaesthetised for an emergency caesarean and it was then noted that the antenatal notes had a different name to the ID band. In maternity reception the patient had been given the notes of a patient with a similar sounding surname. The patient did not require a transfusion.

There were several opportunities for the mistaken identity to be corrected:

Where should this error have been picked up?

- On arrival in reception
- On arrival in the ward
- When the emergency team were preparing for an emergency C section
- When the blood samples were taken
- On transfer to theatre for prior to administration of GA

All of the above

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When ‘What if?’ Happens…

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Filipina nurse who killed a pensioner when she mixed up his name with another patient and gave him the wrong blood during a transfusion is facing jail

News › Crime

London nurse who killed patient by giving him wrong blood type in transfusion is convicted

SAPHORA SMITH | Wednesday 14 December 2016 20:57 GMT

'We will invite you to find that that series of mistakes was so bad, so exceptionally bad, that she is criminally liable for the death of her patient, that it was an unlawful killing, and therefore the serious crime of manslaughter on which she is charged.'

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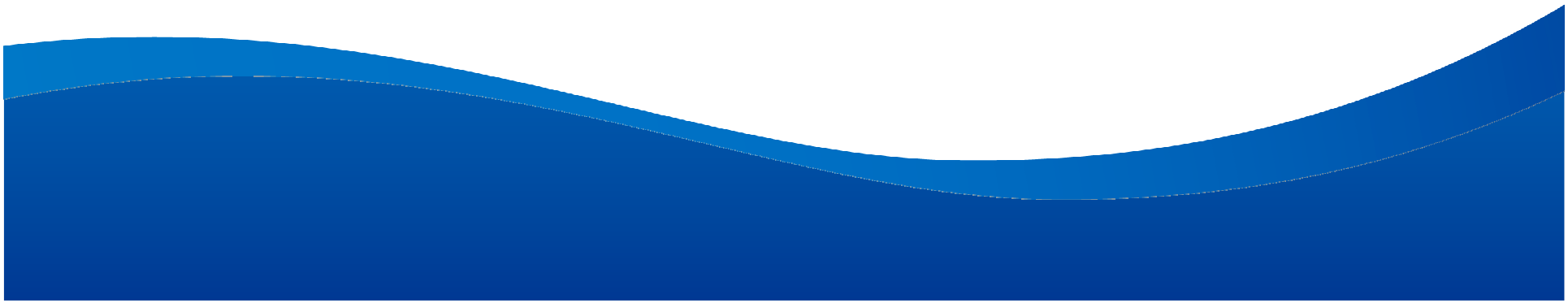
Consent & Patient Information



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What do you understand by ‘informed’ or ‘valid’ consent?

Informed or valid consent

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- Consent can be defined as "…a patient's agreement for a health professional to provide care."

- Informed (or valid) consent can be defined as "an ongoing agreement by a person to receive treatment, undergo procedures or participate in research, after the risks, benefits and alternatives have been adequately explained to them."

Consent for Transfusion

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SaBTO
Advisory Committee on the Safety of Blood, Tissues and Organs

In March 2010 SaBTO initiated a public consultation on patient consent for blood transfusion

SaBTO = Advisory Committee on the **Sa**fety of **B**lood, **T**issues and **O**rgans

Why?

•***Patient Choice***: Many patients may not wish to receive a blood transfusion and / or may wish to know what the alternatives are.

•***Public Health***: Recipients may not be aware that they have received blood and then go on to donate.

•***General legal and ethical principle***: Valid consent should be obtained from a patient before they are treated.

•Its aims were Identify the preferred option for recording consent

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Key issues identified:

- Patients are not always given information on the risks, benefits, and alternatives to transfusion, or the right to refuse transfusion
- Patients are not always made aware that they have had a transfusion
- Patients who are unaware that they have received a transfusion may go on to donate blood when they should not
- There is inconsistent practice across the UK

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Therefore...

- Valid consent should be gained
  - document in the patients notes
- Retrospective information
- Modified consent form for the long term multi-transfused

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Montgomery *v* Lanarkshire March 2015

- The Bolam test is no longer applicable
- The law now requires a Dr to take:
  - "reasonable care to ensure that the patient is aware of material risks involved in any recommended treatment and of any reasonable alternative or variant treatments."
- The assessment of whether a risk is "material" cannot be made on percentages alone
- The significance of a risk will vary between patients and is not purely dependent on magnitude
- The Dr must ensure the information provided is understandable

What does this mean in practice?

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- Does the patient know the “material” risks of the proposed treatment?
  - What risks would a reasonable person want to know about?
  - What other risks would this particular patient want to know about?
- Does the patient know about available alternatives?
- Have you tried to ensure the patient understands all the information?
- Have the details of the consent process been documented?

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Exceptions!

1. The patient requests not to be informed
2. Clinical situation means consent cannot be obtained
3. There is a genuine and significant risk of harm associated with providing the patient the information at that time

Being too busy is not an adequate reason!!

(or legal defence!)

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So where are we with this?

National Comparative Audit

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- Patient Information and Consent (2014) results:
  - 164 sites, 2784 cases audited
  - 81% had documentation of the clinical indication
  - 43% had documentation of patient consent which was largely verbal
    - 80% obtained by doctors
  - 38% received information on risks
  - 8% received information on alternatives

Patient Blood Management Survey 2015

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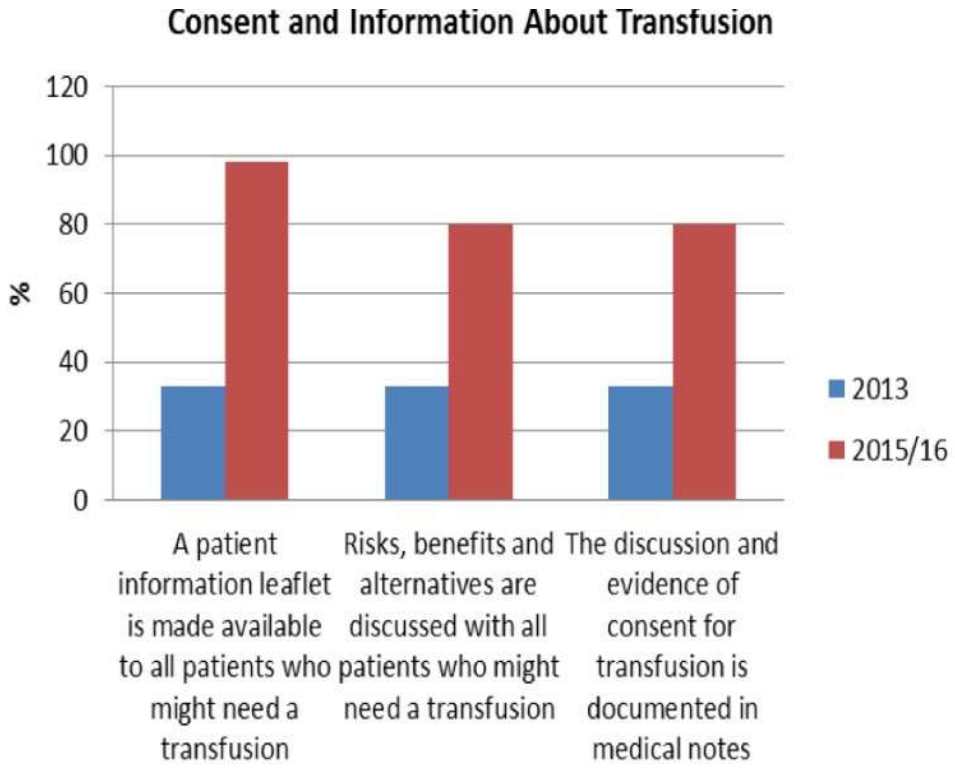
- There has been substantial improvement in the provision of information relating to consent since the 2013 survey
- **98%** of Trusts provide information for patients who might need a blood transfusion
- **85%** of Trusts provide information to most surgical patients



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Why is it so important we explain these risks?

Risks associated with transfusion

Risk of potentially infected donation entering the blood supply 2012-2014	
Hepatitis B	1 in 1.6 million
Hepatitis C	1 in 26 million
Human immunodeficiency virus	1 in 6 million
Risk of death or serious harm from transfusion per components issued (imputability 1-3) 2015	
Death	1 in 100,000
Death from error	1 in 320,000
Major morbidity	1 in 15,500

vCJD

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Since 2004, exclusion of blood donors who have previously (since January 1980) received a blood transfusion

Have any of you really looked at a blood bag label recently?

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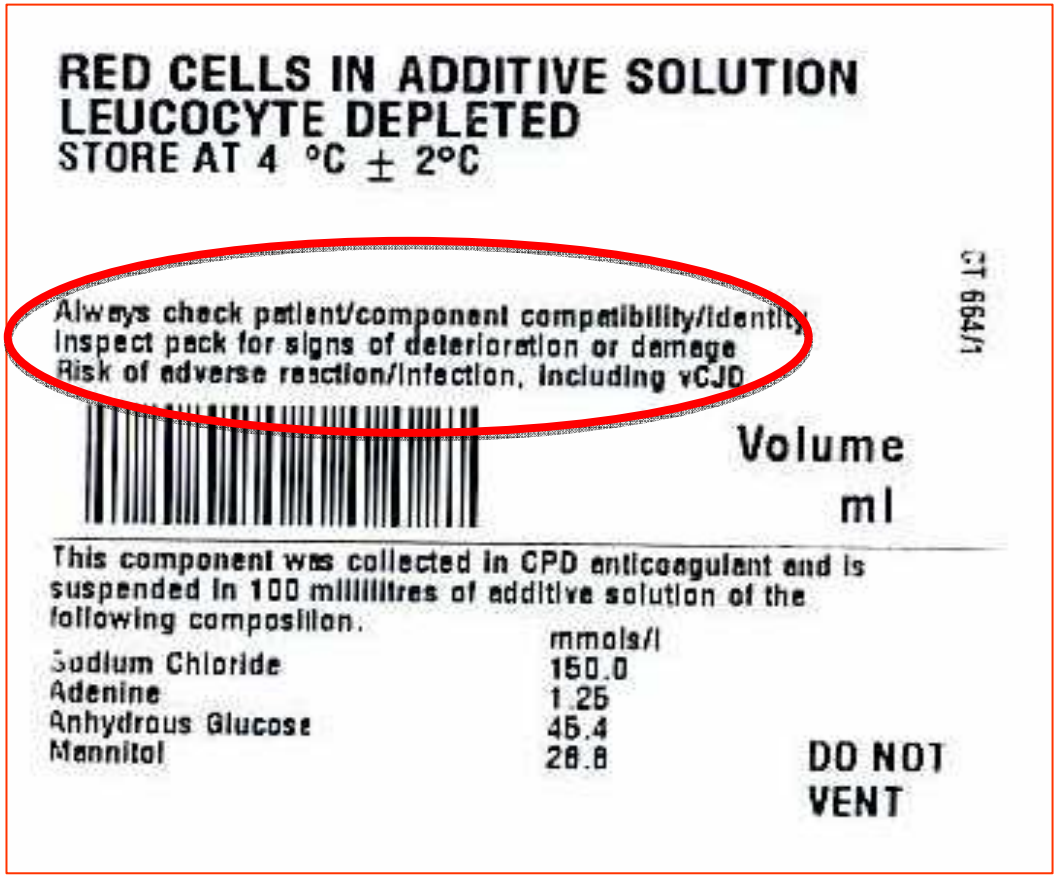

Effective from
1st July 2007

Why is vCJD specifically mentioned?
This was in response to legal advice because the magnitude of risk for vCJD is unknown compared to other known infectious risks such as HIV or HCV.

So what do we need to cover for transfusion consent?

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- Type of blood component
- Indication for transfusion
- Benefits
- Risks
- Possible alternatives
- Administration and Positive Patient Identification
- Following transfusion the patient can no longer donate blood

Make sure the patient understands and is satisfied with the information provided

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Patient information

- Why are blood transfusions needed?
- Are there any alternatives to transfusion?
- What can I do to reduce the need for transfusion?
- Is transfusion safe?
- How will I feel during the transfusion?
- Patient information leaflets are available at http://hospital.blood.co.uk/patient-services/patient-blood-management/patient-information-leaflets/

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Will I need a blood transfusion?

Patient information

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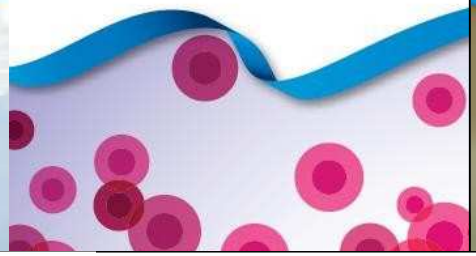
Anaemia

Patient information



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Will I need a platelet transfusion?

Patient information

Right Blood, Right Patient, Right Time

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Transfusion 10 commandments

1. Transfusion should only be used when the benefits outweigh the risks and there are no appropriate alternatives
2. Laboratory measures are not the sole deciding factor for transfusion
3. Transfusion decisions should be based on clinical assessment underpinned by clinical guidelines
4. Anaemic patients do not necessarily need transfusion
5. Discuss the risks and benefits of transfusion with the patient
6. Initial resuscitation in acute blood loss should be with IV fluids but do not delay ordering blood
7. Patients must wear an ID band (or equivalent)
8. The patient should be monitored during the transfusion
9. The reason for transfusion should be

Failure to check patient identity can

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Information for patients needing irradiated blood

Patient information

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Iron in your diet

Patient information

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Information for patients who have received an unexpected blood transfusion

Note: This leaflet should be read alongside the NHS Blood and Transplant patient information leaflet **'Will I need a blood transfusion?'**

While you were in hospital, it was necessary for you to receive a blood transfusion. There are many reasons why patients may need a transfusion, some of which are discussed in the 'Will I need a blood transfusion?' leaflet. However do please ask a member of your healthcare team about why you needed a blood transfusion. They will be able to answer any questions you may have.

Are blood transfusions safe?

Yes, the risk that a blood transfusion may make you ill is very low. More information about any potential infection risks, and all the measures that are taken to ensure your safety, is included in the leaflet 'Will I need a blood transfusion?'.

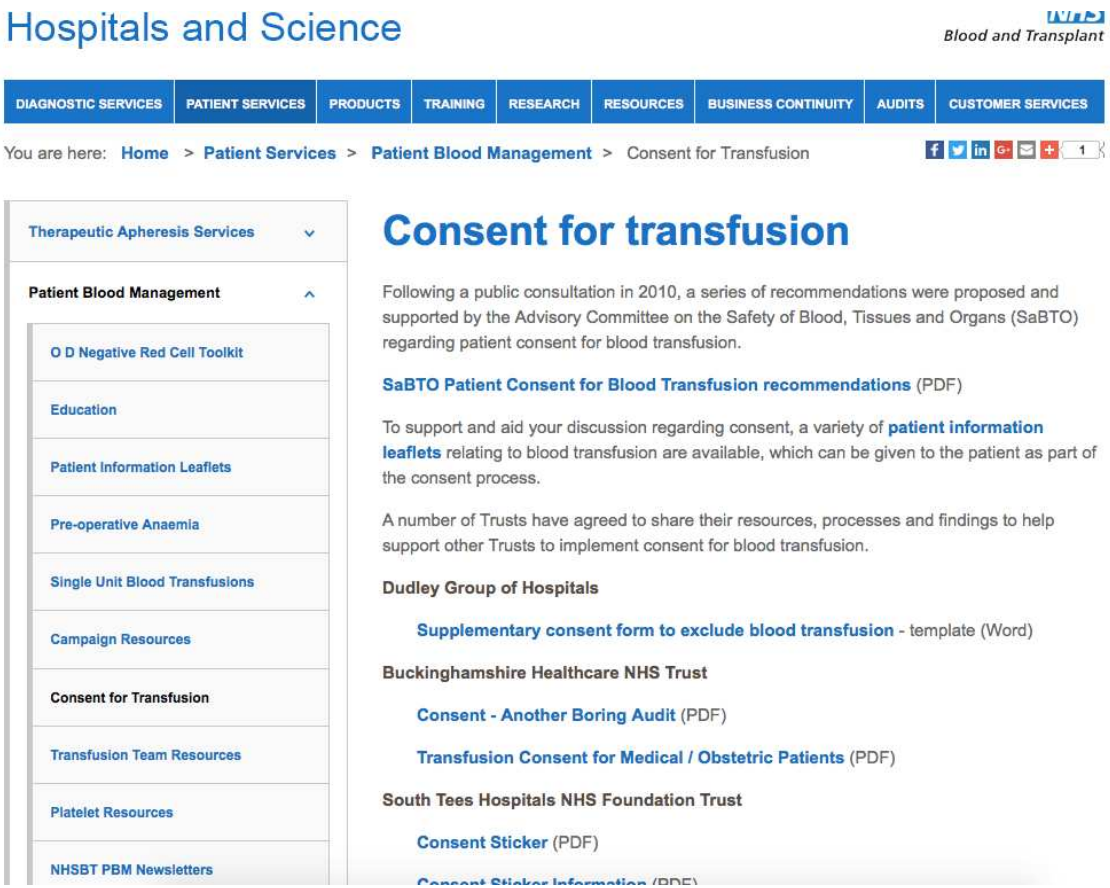
I'm a blood donor. Can I still donate?

As a precautionary measure to reduce the risk of transmitting variant Creutzfeldt-Jakob Disease (vCJD), people who have received a blood transfusion since 1980 are not currently able to donate blood.

Do I need to tell my doctor?

The hospital should include information in the discharge letter to your GP to tell them that you have had a blood transfusion, and to explain why it was carried out. The hospital should give you a copy of this letter; if they don't, you can ask the hospital for a copy.

Resources for Healthcare professionals



http://hospital.blood.co.uk/patient-services/patient-blood-management/consent-for-transfusion/

Moving Forward

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NICE National Institute for Health and Care Excellence

NICE Quality Standards for Blood Transfusion 2016

People who may need or who have had a blood transfusion are given verbal and written information about blood transfusion

Information should cover;

- Reason for transfusion
- Risks and benefits
- Any alternatives available and how they may reduce the need for transfusion
- That they are no longer able to donate blood

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What next?

- Hospitals in the process of implementing the NICE guidance and Quality Standard
- CQUIN for Transfusion around patient information and consent?
- Ensure your practice covers all aspects of patient information and consent adequately

Carry on the good work