York Hospitals NHS
NHS Trust

Risk assessment document for National Patient Safety Agency Safer Practice Notice 14 Recommendations of York Hospital Transfusion Committee April 2007

The following risk assessments reflect the assessment of hazards which represent a significant risk to the staff and patients receiving a blood or blood products transfusion within the York Hospital NHS Trust.

The risk assessments have been completed using guidance from the HSE Leaflet 'Five Steps to Risk Assessment' (INDG163) and in accordance with the management of Health and Safety at Work regulations (1999) and in line with the workplace risk assessment form guidelines for the York Hospital NHS Trust version 2 Jan 2006.
The risk assessment details the following factors when considering each factor associated with the transfusion process.

Hazard
A brief summary of the hazard the risk assessment for blood transfusion refers to.

Who might be harmed?
All of the people who could be harmed by the hazard need to be considered–In this incident it will usually be the receiver of the transfusion, the patient.

Potential problem
If a hazard presents no problem and the control measures in place are sufficient, then the details have still been recorded.

Severity
Each hazard has been assessed against the risk matrix shown below in table 1 for the severity rating. The severity rating is calculated using the matrix shown in table 2.

Probability
Each hazard has been assessed against the risk matrix shown below in table 1 for the probability rating.

Control measures
The control measures for each hazard have been identified and recorded. Further assessment is detailed if existing measures are not adequate to control the risk with action plan of how to reduce or eliminate the risk as appendices on the document.

Calculate the risk
On the risk matrix in table 1, severity is the horizontal axis, and Probability the vertical axis:-
the risks are rated as:
Green = Low, Yellow = Medium, Red = High

Risk register
The risks will be placed on the Trust/directorate risk register;
Red "high" risks should be actioned/escalated as soon as is reasonably practicable. Inform Risk & Legal Services if any red risks fall outside your directorate's financial/organisational capability or if it is a Trust-wide issue that needs to be placed on the Corporate Risk Register.

Record the risk
The risks once completed will be sent to the Quality Manager of the Laboratory Medicine for his review and also to the Trust Risk and Legal department for their opinion. A copy will then be kept on Q pulse, the Laboratory Quality Manual.

Assessments will be reviewed on a regular basis by the Hospital Transfusion Committee

Table 1 Risk Matrix

Probability					
Almost certain - 5	5	10	15	20	25
Likely - 4	4	8	12	16	20
Possible - 3	3	6	9	12	15
Unlikely - 2	2	4	6	8	10
Rare - 1	1	2	3	4	5
	Negligible - 1	**Minor - 2**	**Moderate - 3**	**Serious - 4**	**Catastrophic – 5**
Severity					

Table 2 Matrix to work out severity of risk

Severity of incident	Injury / Illness	Patient Experience	Systems / project / targets/ objectives	Complaints / Claims	Financial Loss	Adverse Publicity
Catastrophic	Death or major and permanent incapacity or disability	Totally unsatisfactory patient outcome.	Failure of critical system/ project/targets/objectives	Multiple claims or a single major claim	over £1,000,000	Nationwide multi media coverage
Serious	Major injuries, or long term incapacity or disability	Patient outcome or experience significantly below reasonable expectation across the board	Partial failure of critical systems, projects, objectives or target achievement.	Above excess claim, multiple justified complaints	£50,000 - £1,000,000	Extensive local coverage and widespread NHS coverage.
Moderate	Significant injury or ill health – medical intervention necessary – some temporary incapacity.	Patient outcome or experience below reasonable expectation in one or more areas.	Resolvable problem with critical system, project, target or objectives achievement Partial failure of important system, project, target or objective achievement. Failure of peripheral system/project/target or objective achievement.	Justified complaint involving the lack of appropriate care, or below the excess claim.	£5,000 - £50,000	Coverage throughout the organisation and / or some public coverage
Minor	Minor injury or ill health – first aid or self treatment – no incapacity	Patient experience temporarily unsatisfactory – rapidly resolved.	Resolvable problem with important system, project, target or objective achievement.	Justified complaint peripheral to clinical care (e.g. Car parking / access	£500 - £5,000	Coverage limited to elements within the organisation (e.g. trade unions and /or some external stakeholders
Negligible	Injury or illness not requiring intervention	Single resolvable problem in patient experience.	Resolvable problem with peripheral system, objective or project.	Low value claim handled by an ex gratia payment	£0 -£500	Awareness limited to individuals within the organisation

RISK ASSESSMENTS – BLOOD TRANSFUSION

		Overall Risk Level	Reviewed dates:			
1	Correct Patient Request identified Clinician requests blood x-matching / transfusion	Yellow	March 2007			
2	Sampling Record / check patient ID	Red	March 2007			
3	Sampling Labels generated using CPD data – request form	Yellow	March 2007			
4	Sampling Sample taken labelled and transported to laboratory	Red	March 2007			
5	Laboratory Sample checks by lab staff	Green	March 2007			
6	Laboratory Production (selection) of blood components	Yellow	March 2007			
7	Blood Issue Blood issued from blood bank	Green	March 2007			
8	Blood issue Clinician prescribes blood	Red	March 2007			
9	Administration Collection of blood from blood fridge	Green	March 2007			
10	Administration Record blood unit arrival	Green	March 2007			
11	Administration Bedside patient check with blood components	Red	March 2007			
12	Administration Administration and completion of transfusion	Red	March 2007			
13	Administration Record made of transfusion given	Green	March 2007			
14	Traceability of Blood components	Red	March 2007			
15	Diagnosis and management of transfusion reactions	Red	March 2007			
16	Use of emergency O Negative blood	Red	March 2007			
17	Use of blood warmers	Red	March 2007			

RISK ASSESSMENT
BLOOD TRANSFUSION

York Hospitals NHS
NHS Trust

P –Probability of Hazard Occurring
S- severity if hazard occurred (minor injury – death)
R - risk rating (low to high) Green, yellow, red

Activity Assessed: Correct Patient Request identified - Clinician requests blood x-matching / transfusion

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Failure to request special requirements of blood (eg irradiation)	Mainly Haematology patients, but can include renal transplant patients, paediatrics, maternity, special care baby unit patients	1. Area to indicate special requirement on request form 2. New patients via clinic letter/telephone call from Haematology/ Renal specialist nurses 3. Fludarabine,Caldrabine, Pentostatin, Clofarabine prescribing update from pharmacy but has weekly lag. 4. Special interest flag set of Laboratory Data Management (LDM).	**3**	**3**	**9**
Inappropriate request	All patients	1. Maximum Blood Order Schedule 2. BMS review 3. Clinical review and training	**2**	**2**	**4**
Insufficient / inaccurate data on request	All patients	1. Transfusion Policy 2. Lab SOP and review 3. Phlebotomy policy	**1**	**4**	**4**
Request not communicated to others	All patients	1. Clinical checks and feedback in place. 2. Transfusion process requires written requests to back up verbal requests.	**3**	**2**	**6**

Mis-matching of haematology data to patient	All patients	1. Repeat requested for grossly abnormal haematology 2. Protocol requests pre transfusion Hb to be recorded prior to transfusion 3. 2 samples required for Electronic issuing of blood so wherever possible historical sample available	**2**	**3**	6
Request made on wrong patient	All patients	As above	**2**	**3**	6
Lack of appropriate training	All patients All staff groups	1. Transfusion Policy 2. BMS staff training records reviewed annually 3. Nurse and Medical training patchy See **Failure to request special requirements of blood**	**3**	**3**	9
Special request not explicate	Haematology patients	See failure to request special requirements of blood			
Patients requiring transfusion have similar names	Patients with similar names	1. Warning stickers available in clinical area but not in Laboratory	**1**	**1**	1
Inappropriate patient details in patient notes	All Patients	1. Transfusion Policy 2. Phlebotomy Policy 3. Laboratory checks/SOP's	**1**	**1**	1
Wrong patient notes.	All Patients	1. Transfusion Policy 2. Phlebotomy Policy 3. Laboratory checks/SOP's	**1**	**1**	1

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

All staff undertaking venepuncture will need to have 3 yearly competency assessments undertaken as per National Patient Safety Agency safer practice notice 14 Nov 2006. Annual update on Transfusion awareness available for all staff

Electronic ordering of blood components in line with electronic bar coding/tracking.

Review Date: April 2008

RISK ASSESSMENT

BLOOD TRANSFUSION

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Green, yellow, red

Activity Assessed: Sampling - Record / check patient ID

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Staff use of incorrect patient identification / information to check	All patients	1. Trust Positive Patient Identification policy. 2. Blood Transfusion Policy 3. Quality checks in Laboratory Training	1	4	4
Identification of wrong patient	All patients	As Above	1	5	5
No wristband / identification worn by patient	All Patients	As Above	2	5	10
Patient details incorrect / insufficient	All Patients	As Above	1	5	5
Patient identification / wristband not checked by staff	All Patients	As Above			
Patient unable to verify identification	All Patients	As Above 4. Unconscious unknown patients issued with unique emergency number	1	5	5
Differing hospital / NHS / A+E numbers	All Patients	1. LDM merge routine 2. CPD control measures	1	4	4
Wrong notes	All Patients	1. Transfusion Policy 2. Phlebotomy Policy 3. Laboratory checks/SOP's	1	4	4
Patient gives false identity	All Patients	None	1	1	1
Patient details illegible	All Patients	1. Laboratory SOP's	1	1	1

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Alteration of policy and procedures in line with competency based training for transfusion process

Potential reduction in risk score through introduction of electronic bar code / electronic tracking system complementing other systems in place for checking of patient identity and blood use.

Review Date: March 2008

RISK ASSESSMENT

BLOOD TRANSFUSION

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Green, yellow, red

Activity Assessed: Sampling - Labels generated using CPD data -request form

Assessor(s) : Hospital Transfusion Team

Date: March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Flaws in CPD system (allows changes to be made)	All Patients	1. Data Quality Control	1	3	3
Incorrect data entered on to system	All Patients	1. Data Quality Control 2. Bedside checks 3. Quality checks in Laboratory	1	3	3
No labels available / allowed	All Patients	1. Data Quality Control 2. Bedside checks 3. Quality checks in Laboratory	1	3	3
Writing not legible on request form	All Patients	1. Not tested in Laboratory	1	1	1
Identification not checked against request form	All Patients	1. Multiple checks throughout process, contained in Transfusion policy, phlebotomy policy, Laboratory SOP's	1	1	1
Incomplete information on form and / or sample	All Patients	As Above	1	1	1
Wrong labels in notes	All Patients	As Above	1	1	1
Patients have similar names	All Patients	1. Quality checks against historic records on LDM 2. Sample handwritten 3. Unique numbering system	1	5	5
Patient not asked – told name	All Patients	1. Transfusion Policy 2. Phlebotomy Policy			

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)
Electronic system for labelling of transfusion samples at bedside, only possible in line with complete electronic positive patient identification.
Review Date: March 2008

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BLOOD TRANSFUSION

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Activity Assessed: Sampling - Sample taken labelled and transported to laboratory

Assessor(s) : Hospital Transfusion Team

Date : March 2008

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Pre-labelling of sample	All Patients	1. Transfusion Policy 2. Phlebotomy Policy 3. Laboratory SOP's	1	4	4
Sample labelled with wrong / insufficient data	All Patients	As Above	1	4	4
Staff identification not recorded on form / sample	All Patients	As Above	1	1	1
Samples taken at same time by same person	All Patients	1. Laboratory checks, one of samples will not be tested and repeat sample requested 2. Electronic Issue operational requirements for Laboratories 3. Blood transfusion Policy	1	4	4
Wrong laboratory number on request card and sample (interface issue)	All Patients	1.Automated systems in Laboratory 2. Laboratory checks and SOP's	1	1	1
Sample / label becomes loose, broken or lost	All Patients	1. Sample not processed	1	1	1
Sample labelled away from the bedside – error	All Patients	1. Transfusion Policy 2. Phlebotomy Policy 3. Laboratory SOP's	1	4	4
Splitting of sample and form	All Patients	1. Sample not processed	1	1	1
Labelling delegated to someone else	All Patients	1. Transfusion Policy 2. Phlebotomy Policy 3. Laboratory SOP's	1	4	4
Handwritten label – poor / illegible	All Patients	1. Sample not processed	1	1	1
Size of label incompatible with sample size	All Patients	1. Sample not processed	1	1	1

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)
Electronic system for labelling of transfusion samples at bedside, only possible in line with complete electronic positive patient identification.

Review Date: March 2008

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Activity Assessed: Laboratory - Sample checks by lab staff

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Inherent laboratory problems (transposition etc)	All Patients	1. Laboratory SOP's 2. Primary sampling	1	1	1
Errors in identification – are not cross –checked with CPD	All Patients	1. Bedside checks	1	1	1
Patient details incorrectly registered	All Patients	1. Bedside checks	1	1	1
Failure to identify errors in sampling	All Patients	1. Automated System requiring 2 separate samples	1	1	1
Failure to find historical records compounds error	All Patients	No controls	1	1	1
Multiple records on lab computer	All Patients	1. Daily merge lists 2. Historic check on request	1	1	1
No historical record available	All Patients	1. Two sample policy.	1	1	1

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)
Introduction of annual training scenerios for laboratory staff from July 2007
in line with MHRA compliance report April 2007

Review Date: March 2008

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Activity Assessed: Laboratory - Production (selection) of blood components
Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Selection of wrong blood	All Patients	1. Serological checks and LDM checks 2. Bedside checks 3. Training	**2**	**4**	**8**
Unit of blood labelled incorrectly / with insufficient data	All Patients	As above	**1**	**1**	**1**
Staff identification not recorded	All Patients	1, Automated password system	**1**	**1**	**1**
Special requirements not met	All Patients	1. Serological checks and LDM checks 2. Bedside checks 3. Training	**2**	**4**	**8**
Technical failure in production of identification labels (eg missing last digit)	All Patients	1. Serological checks and LDM checks 2. Bedside checks 3. Training	**1**	**1**	**1**
Label falls off	All Patients	1. Unit will not be transfused	**1**	**1**	**1**
National Blood Service has mis-grouped unit	All Patients	1. No control measure for Electronic issued blood but would be detected if serological cross match performed	**1**	**5**	**5**

Blood not available.	All Patients	1. Clinical override in emergencies 2. Contingency plans	**1**	**1**	**1**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Potential reduction in risk score through introduction of electronic bar code / electronic tracking system complementing other systems in place for checking of patient identity and blood use.

Review Date: March 2008

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Activity Assessed: Blood Issue - Blood issued from blood bank

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Blood not in fridge	All patients	1. Lab SOPs 2. Electronic Tracking as far as blood issue fridge	1	1	1
No register of blood in fridge	All patients	1. Lab SOPs 2. Electronic Tracking as far as blood issue fridge	1	1	1
Staff identification not recorded	All patients	1. Blood Transfusion Policy 2. Electronic Tracking as far as blood issue fridge	1	1	1
Wrong blood, with similar name in fridge	All patients	1. Training 2. Lab SOP's 3. Blood Transfusion Policy 4. Electronic Tracking as far as blood issue fridge	1	2	2
Blood in wrong place in fridge	All patients	1. Lab SOPs 2. Blood Transfusion Policy 3. Training	1	1	1

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)
The recent introduction of the electronic tracking as far as the issue blood fridge in theatre reception has the potential to improve the hazards involved in removing blood from the blood fridge.
Competancy based training packages to be introduced to continue to reduce risk.

Review Date: March 2008

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Activity Assessed: Blood issue - Clinician prescribes blood

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
1. Clinician prescribes blood for wrong patient	All patients	1. Blood Transfusion policy 2. Safe identification of Patients Policy 3. Training	**1**	**1**	**1**
2. Details poorly written / illegible	All patients	1. Medicines Code Nursing Care Policy (section 1) 2. Trust Standards for Documentation	**1**	**5**	**5**
3. Prescription does not meet requirements of patient	All patients	3. Blood Transfusion Policy	**2**	**4**	**8**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Monitor incident reports and review risk assessment annually

Review Date: March 2008

RISK ASSESSMENT
BLOOD TRANSFUSION

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P –Probability of Hazard Occurring **S**- severity if hazard occurred (minor injury - death **R -** risk rating (low to high) Green, yellow, red	**Activity Assessed: Administration - Collection of blood from blood fridge** **Assessor(s) : Hospital Transfusion Team** **Date : March 2007**

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Blood taken to wrong ward	All patients	1. Blood Transfusion policy 2. Training	**1**	**1**	**1**
Collection form has incorrect / insufficient details	All patients	As Above	**1**	**1**	**1**
Wrong unit of blood taken from fridge	All patients	As Above 3. Electronic kiosk with increased security	**1**	**1**	**1**
Multiple collection made by staff at same time	All patients	As Above	**1**	**1**	**1**
Unauthorised staff collect blood	All patients	As Above 3. Electronic kiosk with increased security	**1**		**1**

Unauthorised access to electronic kiosk/blood fridge	All Patients	1. Bar coded access 2. Alarms at kiosk and in Laboratory if unauthorised user accesses blood fridge via kiosk 3. Magnetic locking device on blood fridge only accessable via electronic kiosk or numeric keypad. Code held by Lab staff	**1**	**4**	**4**
Clinical staff take blood when 'red box' appears	All Patients	1. Blood transfusion policy to be updated to include kiosk information 2. Training all staff given bar codes have received training on kiosk	**1**	**5**	**5**
Laboratory staff unavailability to correct error codes	All patients	1. 'Red box' will be present on kiosk screen when blood scanned. 2. Training 3. Updated transfusion policy	**1**	**1**	**1**
Computer links down so kiosk unavailable	All patients	1. Kiosk linked to emergency power 2. Revert to paper audit trail	**1**	**1**	**1**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Continue to complete weekly compliance report for traceability tags
Monitor incident reports and review risk assessment annually
Review Date: March 2008

RISK ASSESSMENT
BLOOD TRANSFUSION

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Activity Assessed: Administration - Record blood unit arrival
Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
1. Blood unit not recorded	All patients	1. Blood Transfusion policy 2. Training 3. Traceability procedure	**1**	**1**	**1**
2. Different blood collections arrive on ward at same time	All patients	1. Blood Transfusion policy 2. Training	**1**	**1**	**1**
3. Failure to complete protocol	All patients	1. Blood Transfusion policy 2. Training	**1**	**1**	**1**
4. Blood not expected – patient may not be on ward	All patients	1.Blood Transfusion policy 2. Training	**1**	**1**	**1**
5. Unwanted blood	All patients	1.Blood Transfusion policy 2. Training	**1**	**1**	**1**
6. Blood taken to wrong place	All patients	1.Blood Transfusion policy 2. Training	**1**	**1**	**1**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Training and assessment of competency
Update transfusion policy and protocol in line with traceability issues
Monitor incident reports and review risk assessment annually

Potential reduction in risk score through introduction of electronic bar code / electronic tracking system complementing other systems in place for checking of patient identity and blood use
Review Date: March 2008

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BLOOD TRANSFUSION

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Activity Assessed: Administration - Bedside patient check with blood components

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
1. No wristband / wrong wristband	All patients	1. Blood Transfusion Policy – no wristband no transfusion 2. Safe identification of patients policy 3. Training	**2**	**5**	**10**
2. No verbal identity possible	Unconscious / confused / children / mental disability patients	1. Blood Transfusion Policy – no wristband no transfusion 2. Safe identification of patients policy 3. Training	**1**	**5**	**5**
3. Details on unit not checked against patient identity	All patients	1. Blood Transfusion Policy – no wristband no transfusion 2. Safe identification of patients policy 3. Training	**1**	**5**	**5**
4. Details on unit not completed	All patients	1. Blood Transfusion Policy – no wristband no transfusion 2. Safe identification of patients policy 3. Training 4. Lab SOP	**1**	**5**	**5**
5. No identity check at all	All patients	1. Blood Transfusion Policy – no wristband no transfusion 2. Safe identification of patients policy 3. Training	**1**	**5**	**5**

6. Staff identity not recorded on transfusion form	All patients	1. Blood Transfusion Policy 2. Standards for record keeping 3. Professional codes of conduct 4. Training	**1**	**5**	**5**
7. Details on wristband not complete	All patients	1.. Safe identification of patients policy	**1**	**5**	**5**
8. Check not performed at bedside	All patients	1. Blood Transfusion Policy – no wristband no transfusion 2. Training	**1**	**5**	**5**
9. Baby has changed names	Babies	1. Unique numeric identifier	**1**	**5**	**5**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Training and assessment of competency
Monitor incident reports and review risk assessment annually
Potential reduction in risk score through introduction of electronic bar code / electronic tracking system complementing other systems in place for checking of patient identity and blood use

Review Date: March 2008

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Activity Assessed: Administration - Administration and completion of transfusion

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Observations not done	All patients	1. Blood Transfusion Policy 2. Protocol as reminder 3. Training	**1**	**4**	**4**
Reaction of blood product	All patients	1. Lab SOPs re x-matching of blood 2. Blood Transfusion Policy 3. Protocol as reminder 4. Training	**1**	**4**	**4**
Inadequate staff and / or training of staff to monitor information	All patients	1. Workload analysis to advise on staffing levels. 2. Training schedule	**2**	**4**	**8**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Training already in place, though no assessment of competence.
Training and assessment of competency to be developed
Annual workload analysis to inform staffing levels
Monitor incident reports and review risk assessment annually

Review Date: March 2008

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Activity Assessed: Administration - Record made of transfusion given

Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	RR
Filed in wrong patient notes	Patients	1. Safe identification of patient policy. 2. Medical Records Strategy / SOPS / 3. Training	**1**	**1**	**1**
Not filed in notes.	Patients	1. Safe identification of patient policy. 2. Medical Records Strategy / SOPS / 3. Training	**1**	**1**	**1**
Traceability tags not returned	Patients	1. Daily collection by MLA of tags used 2. Follow up on non returned tags 3. Weekly compliance report completed	**1**	**1**	**1**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Continue to complete weekly compliance report for traceability tags

Monitor incident reports and review risk assessment annually

Potential reduction in risk score through introduction of electronic bar code / electronic tracking system complementing other systems in place for checking of patient identity and blood use

Review Date: March 2008

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P –Probability of Hazard Occurring **S**- severity if hazard occurred (minor injury - death **R -** risk rating (low to high) Green, yellow, red	**Activity Assessed: Traceability of blood components** **Assessor(s) : Hospital Transfusion Team** **Date : March 2007**

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Tags attached to blood bags not collected and reconciliation not possible	All patients	1. Daily collection of Tags from clinical area by MLA	**1**	**4**	**4**
Tags not signed by clinical staff	All patients	1. Daily collection by MLA allows retrospective signing of transfusion taking place.	**3**	**3**	**9**
Loss of tags	All patients	1. Daily collection of tags by MLA allows for rapid detection of non compliance with return of tags. Secondary evidence sought and transfusion confirmed.	**3**	**3**	**9**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Continue to complete weekly compliance report for traceability tags
Monitor incident reports and review risk assessment annually
Potential reduction in risk score through introduction of electronic bar code / electronic tracking system complementing other systems in place for checking of patient identity and blood use

Review Date: March 2008

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Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Not reported	All patients	1. Blood transfusion policy 2. Training 3. Lab SOP's 4. Adverse incident reporting system	**1**	**4**	**4**
Transfusion aborted outside recognised trigger points	All patients	1. Blood transfusion policy 2. Training 3. Lab SOP's 4. SABRE/MHRA guidance documents	**1**	**4**	**4**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Monitor incident reports and review risk assessment annually

Review Date: March 2008

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Activity Assessed: Use of emergency O negative blood
Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
Not reported as being taken	All patients	1. Blood transfusion policy 2. Training 3. Lab SOP's 4. Adverse incident reporting system 5. Electronic kiosk at blood fridge	**1**	**4**	**4**
Unable to trace recipient	All patients	1. Blood transfusion policy 2. Training 3. Lab SOP's 4. Traceability procedure using tag and label	**2**	**4**	**8**
Transfusion reaction due to uncross matched blood	All patients	1. Blood transfusion policy 2. Training 3. Lab SOP's 4. Adverse incident reporting system	**1**	**1**	**1**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Monitor incident reports and review risk assessment annually

Review Date March 2008

RISK ASSESSMENT
BLOOD TRANSFUSION

York Hospitals NHS
NHS Trust

P –Probability of Hazard Occurring
S- severity if hazard occurred (minor injury - death
R - risk rating (low to high)
Green, yellow, red

Activity Assessed: Use of Blood warmers
Assessor(s) : Hospital Transfusion Team

Date : March 2007

Significant Hazards	Groups at Risk	Existing Controls	P	S	R
No training documents available	All patients/staff	1.Use limited wherever possible to selected areas, theatres and MES who have received verbal training	**1**	**4**	**4**
Limited knowledge of use in clinical areas other than theatres and Haematology areas.	All patients/staff	1. All warmers kept in acute areas, theatres, A&E, ICU where staff have received verbal training. 2. If required in other areas advised to seek assistance 3. Request lab to inform transfusion practitioner if blood warmer required for patient	**2**	**4**	**8**
Giving set on Fenwal set contains 3 way tap	All patients/staff	1.Advise staff to remove 3 way tap in general ward areas prior to priming of set.	**3**	**4**	**12**

Action Plan for Further Reduction of Risks (Docs / SWPS/ Policies / PPE)

Phase out of Fenwal Blood warmers and sets which are of significant risk.
Competency based training packages to be introduced for recently acquired blood warmers.

Review Date: March 2008

Summary

It is noted in the areas where the risk score is red the recommendations are;

- Changes to the transfusion policy and protocol to incorporate the changes required by the NPSA safer practice notice

- The introduction of competency based training in certain areas of the transfusion process as previously recommended by the NPSA safer practice notice 14.

- The introduction of an electronic bar code/ tracking system which would incorporate patient identification, electronic labelling for samples, electronic ordering of blood components, electronic traceability and electronic checking of bedside administration. This would have the additional benefit of improving compliance with the Blood Safety and Quality Regulations (BSQR 2005) as used by the Medicines and Healthcare Regulatory Authority when inspection of the transfusion process occurs.

As yet there is no Trust in the UK that has a full electronic system that meets all the NPSA/BSQR requirements, as identified by the NPSA in 2006. However, work towards acquisition of an appropriate system must be commenced as soon as an NPSA and Connecting for Health specification is available.

The NPSA also asked Trusts to look at the feasibility of using:-

1. **Photo ID cards**, these are to be trialled in the Renal Unit in the short term, with a view to extending the use to frequently transfused patients in the medical setting. They would not reduce risk of wrong blood being administered but would complement the current system as the patient would be more engaged in the checking process. The system is still reliant on human actions to ensure card is carried when required or checked by staff members.

2. **A labelling system of matching blood to patient**, The Hospital Transfusion Team felt this system would complicate the method of blood transfusion samples taken in the Trust and as such do not recommend the change in practice.