

Transfusion Safety Newsletter

North-East & Yorkshire RTC



Winter Edition – January 2023

Message from the Regional Transfusion Team & our RTC Chairs, Youssef Sorour & Ric Procter

“Happy New Year to you all”

As we welcome in 2023, with the publication of this new RTC newsletter we want to acknowledge the significant amount work that has been done to advance transfusion safety and promote appropriate use of blood across the region.

We know that for many of you staffing pressures & the ongoing impact of COVID made 2022 a challenging year. Thank you to everyone who got involved with regional transfusion activity & education, represented our region on national groups & for your hard work during the Amber Alert.

We hope you enjoy this new regional update & encourage you to get involved by sharing learning and ideas for our next edition. Please forward any ideas / items to Janice.robertson@nhsbt.nhs.uk

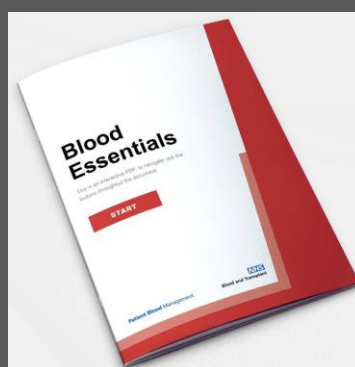
Coming soon



Quality Improvement – A new automated QS138 Audit Tool will be offered free to hospitals by the NHSBT PBM Team in early 2023. This new tool, *QS138 Quality Insights* will enable you to audit your performance against the 4 NICE Quality Statements, produce an instant automated audit report and benchmark your results against regional & national data. The audit tool has completed quality testing and the pilot phase is nearing completion. Two TPs from our region have supported the pilot for this new tool – Faye Smith, from Harrogate and District NHS Trust and Anna Bartholomew, from Northumbria Healthcare NHS Trust.

Regional Education Event – Our next RTC Education Event, *Advancing Transfusion: Going paperless* is on 17 January 2023, 13.00 to 16.15. The focus is on implementation of the digitalisation of transfusion processes. Click to - [Register for Advancing Transfusion: Going paperless](#)

For new and developing transfusion staff – The existing NHSBT PBM Team resources, A Drop of Knowledge & A Wealth of Knowledge, have been updated and combined to create a interactive PDF document, which also has a new title **Blood Essentials**. It will made available at the start of 2023. Transfusion Practitioners are the primary audience for this education resource, but no doubt new transfusion laboratory staff and haematologists starting to cover transfusion will also find this useful.





Transfusion Safety Updates

Evidence based practice

The UK Royal Colleges Tranexamic Acid in Surgery Implementation Group, Michael P W Grocott, Mike Murphy, Ian Roberts, Rob Sayers, Cheng-Hock Toh, **Tranexamic acid for safer surgery: the time is now**, *British Journal of Surgery*, 2022;, znac252, <https://doi.org/10.1093/bjs/znac252> [Open Access]

Devereaux PJ, Marcucci M, Painter TW, Conen D, Lomivorotov V, Sessler DI, et al. **Tranexamic acid in patients undergoing noncardiac surgery**. *N Engl J Med* 2022; 386:1986–1997. <https://doi.org/10.1056/NEJMoa2201171>

Richards, T., Miles, L.F., Clevenger, B., Keegan, A., Abey Siri, S., Rao Baikady, R., Besser, M.W., Browne, J.P., Klein, A.A., Macdougall, I.C., Murphy, G.J., Anker, S.D., Dahly, D. and (2022), **The association between iron deficiency and outcomes: a secondary analysis of the intravenous iron therapy to treat iron deficiency anaemia in patients undergoing major abdominal surgery (PREVENTT) trial**. *Anaesthesia*. <https://doi.org/10.1111/anae.15926> [Open Access]

Ducloy-Bouthors AS, Gilliot S, Kyheng M, Faraoni D, Turbelin A, Keita-Meyer H, Rigouzzo A, Moyanotidou G, Constant B, Broisin F, Gouez AL, Favier R, Peynaud E, Ghesquiere L, Lebuffe G, Duhamel A, Allorge D, Susen S, Hennart B, Jeanpierre E, Odou P; TRACES working group. **Tranexamic acid dose-response relationship for antifibrinolysis in postpartum haemorrhage during Caesarean delivery: TRACES, a double-blind, placebo-controlled, multicentre, dose-ranging biomarker study**. *Br J Anaesth*. 2022 Dec;129(6):937-945. doi: 10.1016/j.bja.2022.08.033. [Open Access]

Regional End-to-End Transfusion IT Group

We established a new regional End-to-End Transfusion IT Group in 2022 and the third meeting of that group was held on 9th December. The aim of the group is to sharing learning and resources related to Transfusion related IT systems. The group hopes to benefit both those starting out with new projects, teams in the midst of change, as well as those who already have established systems in place – we can all learn something new! The group will be launching an IT profiling survey on January 19th and we encourage you to complete it. If you would like to join the group contact our RTC Administrator or NHSBT Patient Blood Management Practitioner.



Sharing learning & good practice

We all know how important the sharing of learning from incidents / audit, best practice and new ideas can be to help us keep improving patient care and quality. Please send us any contributions you have for our next newsletter.

Whether it's transfusion or PBM related, key audit findings, a new project, or success story, get in touch so we can share it with the region.

We also have a North-East and Yorkshire Twitter account that you can follow if you haven't already @NEY_RTC North-East & Yorkshire RTC.

Get in touch by contacting our RTC Administrator -
Janice.Robertson@nhsbt.nhs.uk



Transfusion Safety Updates

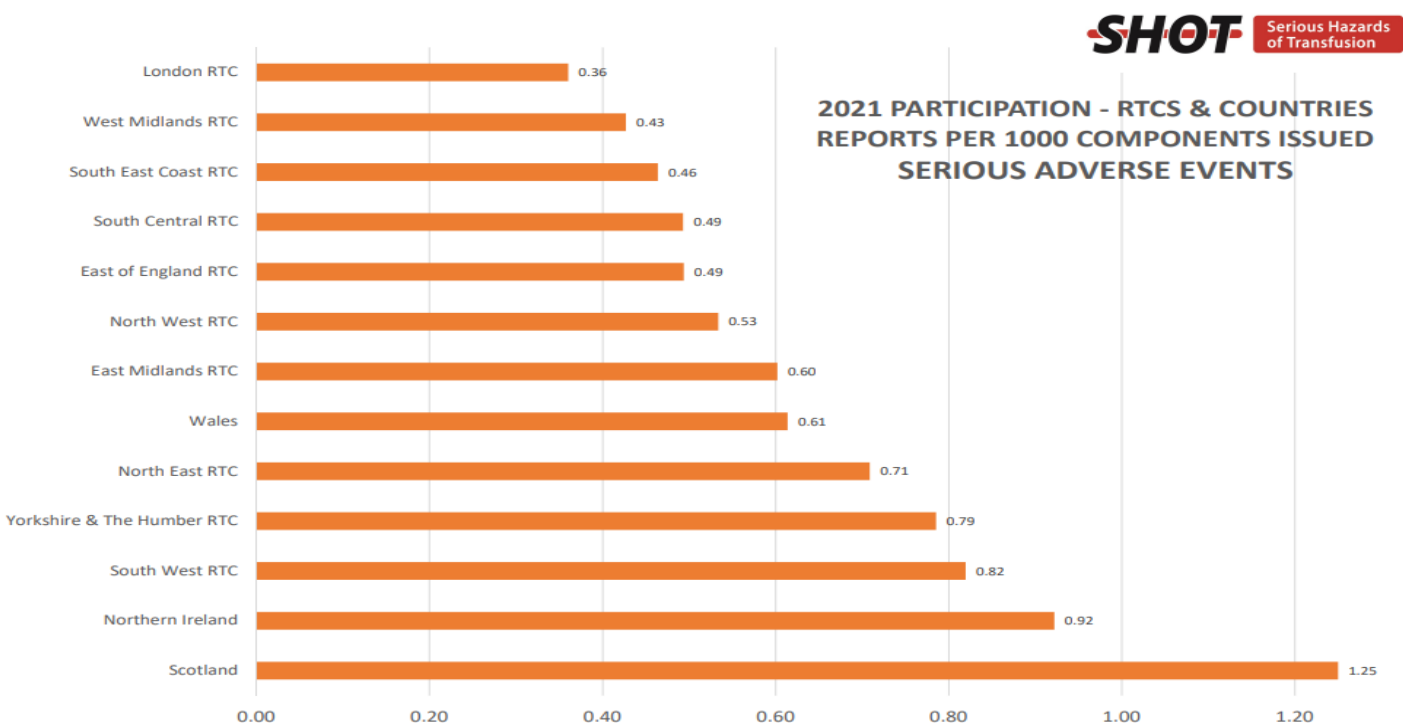


Picture credit: SHOT

SHOT Benchmarking Data 2021

SHOT have now published their 2021 Benchmarking Data, this pre-dates us joining as a region. The Serious Adverse Events data chart is below and you will see this shows an active patient safety reporting culture within our RTC

You can get further charts with regional site breakdown and participant codes when you log in – link here <https://www.shotuk.org/reporting/shot-participation-benchmarking/>



SHOT – Introduced the Acknowledging Continuing Excellence (ACE) reporting category in 2021. ACE reports are defined as “Exceptional transfusion practice by a team or department, that was above and beyond routine practice and has widespread learning opportunities”. Examples of ACE reports can be viewed by [clicking here](#).

Most of what we do in relation to transfusion practice across our hospitals goes well, but the focus for learning from what happens in practice often tends to centre on what has gone wrong. By proactively reporting examples of excellence in transfusion related practice, we can increase the breadth of our learning opportunities and provide positive feedback. This approach aligns to the Patient Safety II Approach: Learning from what goes well.



Transfusion Safety Updates



Shared Learning from Incidents

Many hospitals in the region have told us that the number of Wrong Blood in Tube [WBIT] incidents were a concern in 2022. Not following patient identification procedures is a key feature in this type of incident. This report outlines two WBIT incidents which occurred in our region, from the same patient, which occurred on consecutive days. The hospital where these incidents occurred has the electronic Blood Track Tx system in place for transfusion and it is used for pre-transfusion sampling procedure. This system promotes labelling at the patients bedside, it prompts for positive patient ID throughout the phlebotomy process and displays the patients details for at the confirmation of ID checking stage.

Use of the Blood Track Tx equipment requires patients to be wearing a wristband, and the Trust policy states that the transfusion request form must be completed in full and present during the procedure to form part of the ID check.

Patient **XY** required a routine red cell transfusion for a known blood disorder. XY attends the Unit regularly for blood tests and transfusion and so is known to the staff throughout the department. Upon checking in at the Unit XY was not asked to provide verbal identification and confirmation of their full name, DOB and first line of address before being given the transfusion request form & the ID band was applied. **XY** was given the wrong form and wristband; that of another regular patient with the same forename initial, and the exact same middle and surname (**XYZ**).

Positive patient identification was not undertaken before the sample was taken.

To print a label after a sample has been taken using the Blood Track Tx equipment requires the QR Code on the ID band to be scanned, following which the screen displays the patient details. The details on the display must be checked against the form and wristband and the user is required to confirm that they have performed all patient checks before a label will print.

The staff member taking the bloods did NOT check the patient's wristband against the screen and with the patient, however ticked the boxes on the screen to confirm they had, then printed the label. The sample and form were labelled with the incorrect patients details and sent to the Blood Bank laboratory.

As the patient details on the form and the label matched the sample was accepted and testing commenced. Upon testing it was noted that the blood group for this sample (patient XY) was B positive. The patient whose details were on the form and tube (XYZ) has always historically grouped as O positive. This alerted blood bank laboratory staff to the WBIT error.

The sample was rejected & the clinical area informed the patient, who needed to return for a repeat sample.

Unfortunately on arrival to the Unit the following day patient XY was still wearing the wristband from the previous day with the incorrect details on (patient XYZ).

The member of staff who took blood from patient XY for this second sample also failed to perform positive patient ID correctly and as per policy.

They 'looked' at the wrist band but as they did not perform positive patient ID this again resulted in the wrong patient details being labelled onto the blood sample bottle. In this instance the form was completed with the correct patient details, but the sample label was for XYZ as produced from scanning the wrist band.

As the sample and form did not match, the lab Quality Management System picked up the error. The sample was rejected & the clinical area informed of this second error. Patient XY had to be bled for a third time.

Serious incidents have been reported to SHOT in the past involving patients with the same or similar names. Had these incidents in our region not been detected they could have resulted in ABO incompatible blood being transfused.