IBCT

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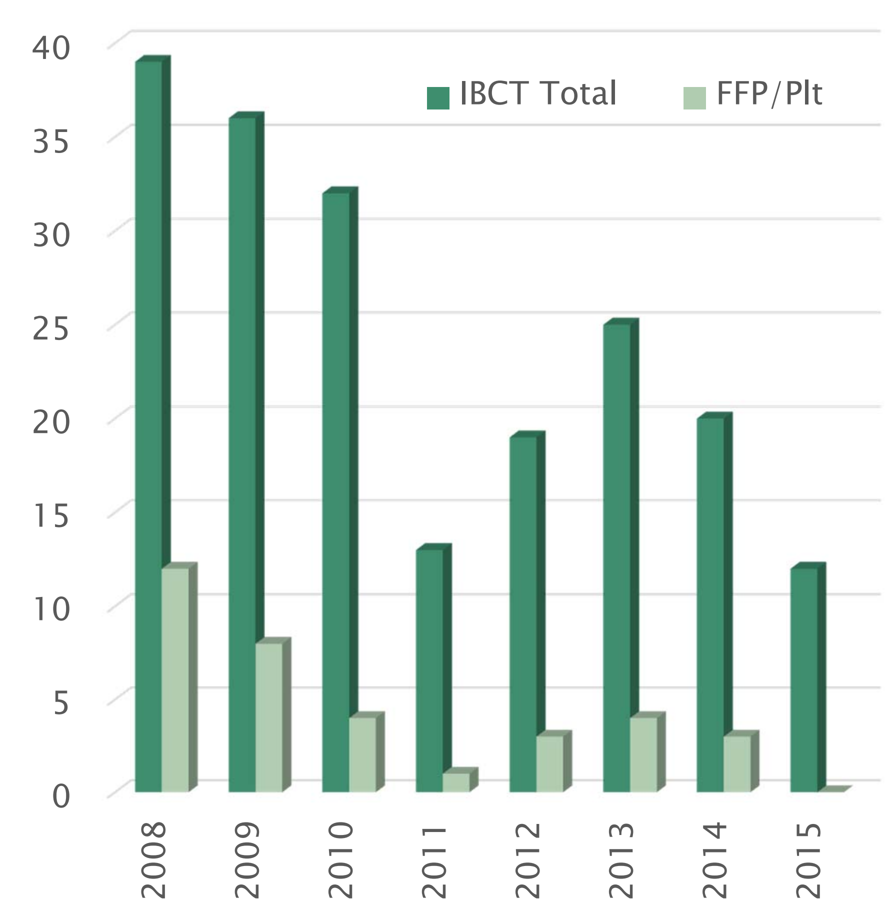
Our Incident

- Incorrect Blood Component Transfused
  - *The transfusion of a blood component or product that was intended for another patient or one that did not meet the patient's requirements*.
- Patient transfused 2 units of Fresh Frozen Plasma instead of 2 units of Platelets
- SAC 2 event *(National Severity Assessment Score)*
- Reportable Haemovigilance event

National Statistics
(NZBS Haemovigilance Programme)

- Lakes DHB has high reporting rate.
- IBCT involving FFP and platelets continue to occur.
- 2012 exact same incident occurred.



It's fine to celebrate success but it's more important to heed the lessons of failure.

Bill Gates

What happened? (in ward)

- Patient with lung cancer receiving palliative chemotherapy, with PR bleeding.
- Platelet count <10 x 10^9/L
- 2 units platelets prescribed
- Nurse caring for patient was unfamiliar with platelet administration
- Referred to protocol
- Comfortable with procedure

What happened? (Blood Bank)

- Nurse telephoned Blood Bank and requested 2 units of Fresh Frozen Plasma.
- Blood Bank staff questioned the request – warfarin reversal?
- Confirmed as Plasma not for Warfarin Reversal but unwell patient
- Blood Bank thawed FFP
- Transfusion Record received and 2 units issued to patient

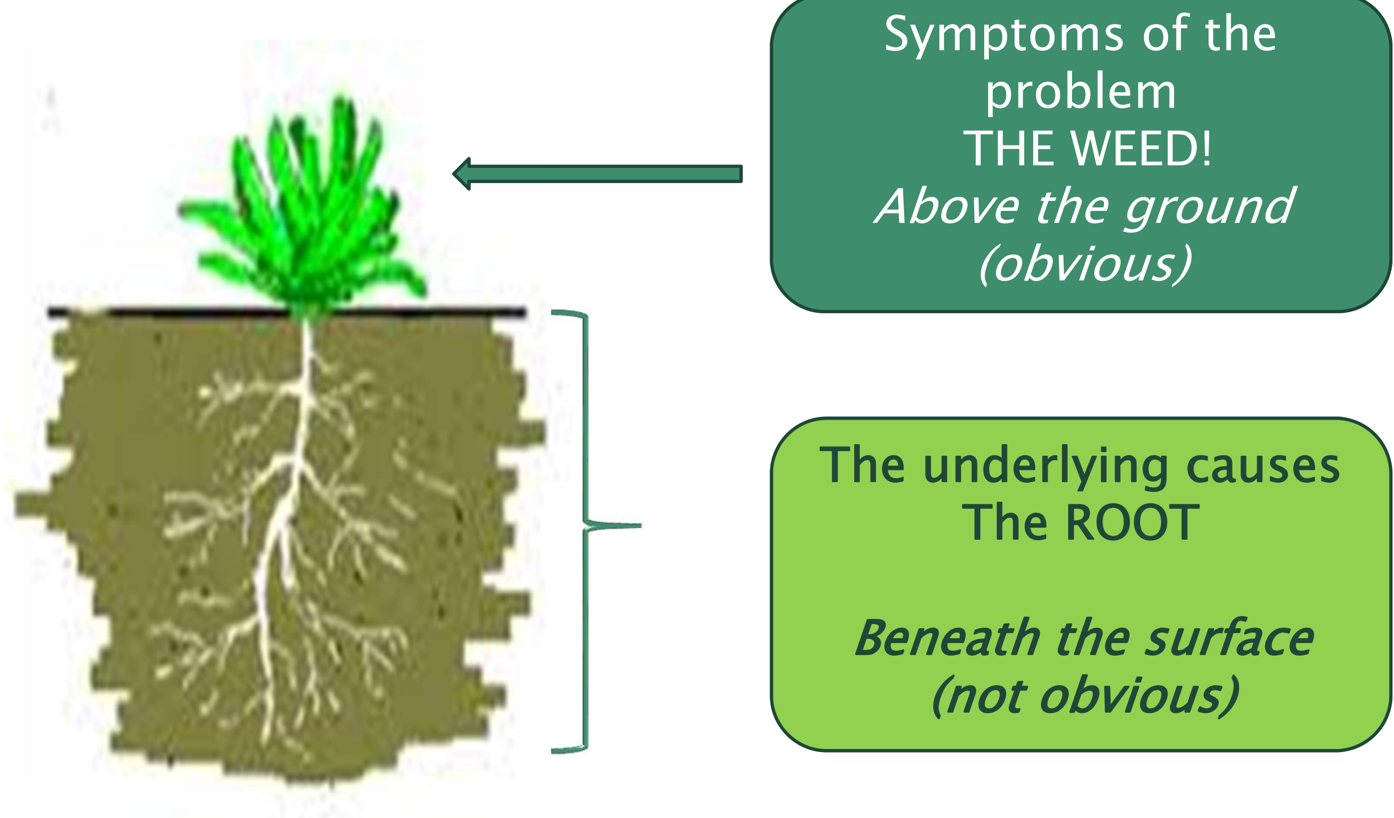
What happened? (Bedside)

- Nursing staff followed administration procedure, including reading out aloud the prescription for platelets (but not registering that this was a different product).
- 2nd staff member confirmed all details in same manner.
- Documentation was signed and FFP administered.
- Post transfusion platelet count checked.

The Discovery

- Plt count still $<10 \times 10^9/L$
- More Platelets ordered
- Night nurse noticed previous labels for Plasma
- Platelets administered
- Platelet count $83 \times 10^9/L$
- Patient did not suffer ill effects and was informed of incident prior to discharge

Root Cause Analysis Basics



The word root in this context relates to underlying causes and not the ONE cause

Root Cause Analysis / Case review

- Establish what happened and why.
- Identify system contributing factors and root causes of the incident.
- Formulate recommendations and a final report once RCA complete.
- Present final report to Hospital Transfusion Committee, Clinical Governance Group and NZBS Haemovigilance team

Contributing Factors

- Staff involved
- Policies and procedures
- Documentation
- Common Practice
- Recognition and Perception

Staff

- Senior staff
- Well experienced
- Consulted protocol
- Double checked

The older I grow, the more I distrust the familiar doctrine that age brings wisdom!

H. L. Mencken

Policies and Procedures

- Consent, requisition and collection of blood and blood products
- Blood and Blood Product Administration Protocol
- Blood Issue Protocol
- Telephone Request

Documentation

- Patient's clinical record
- Laboratory results
- Prescription Chart
- Transfusion Record
- Bedside checks

Recognition and Perception

- Word Recognition
  - Bouma shape – overall outline or shape of a word
  - Parallel letter recognition – letters in a group perceived simultaneously
  - Frequency effect – words that appear the most are easier to recognise

Preconceived messages

Plasma component

Preconceived messages

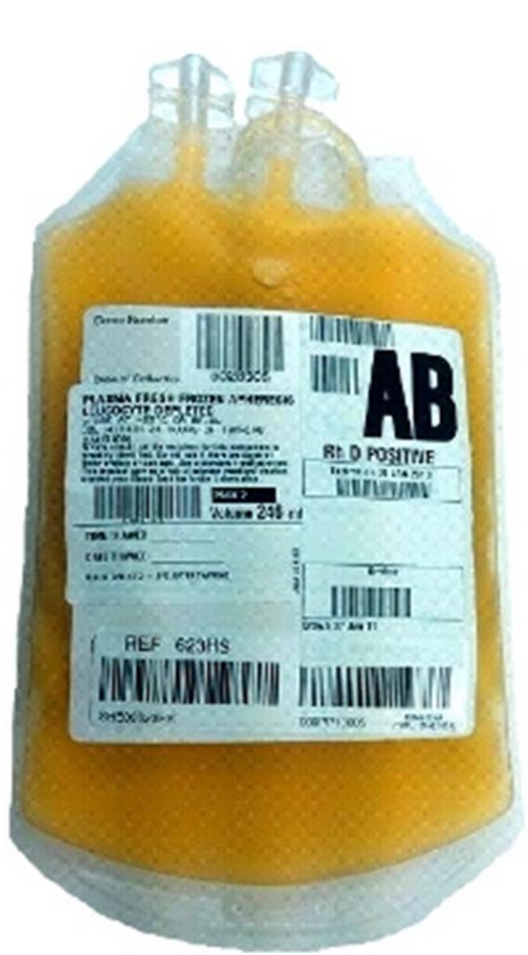
Platelet component

Preconceived messages

Fresh Frozen Plasma

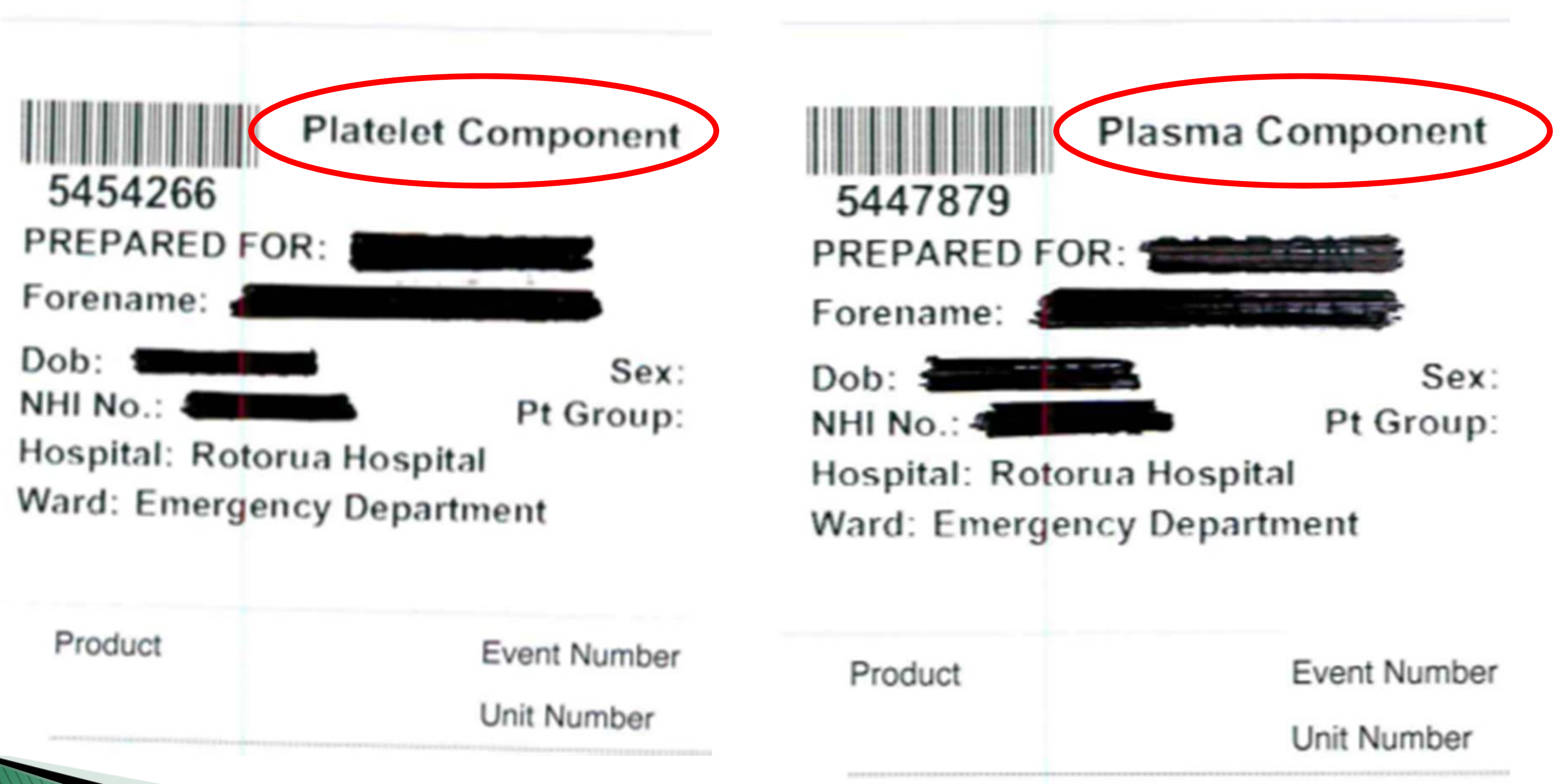
Recognition and Perception

- Visual Recognition



Recognition and Perception

Platelet Component | **Fresh Frozen Plasma**



Recommendations

- Change to telephone requesting
- Sighting of prescription in Laboratory
- Change in order of bedside checks
- NZBS consider changes to the Plasma component label

Follow-up

- IV Transfusion Study Day (Nursing staff) ☺
- Updated Blood and Blood Product Admin protocol☺
- Change in Blood Bank issue protocols ☺
- Notification to other DHBs (Alert) ☺
- Awaiting feedback from NZBS **Pending…**

Is it working?

COMPLIANCE TABLE	33 records	43 records	39 records
Record Criteria	2011	2013	2015
Signed prescription present	80%	77%	**96%**
Signed prescription complete	80%	77%	**92%**

References & Acknowledgements

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- *Davis P, Lay-Yee R, Briant R, et al. 2001. Adverse Events in New Zealand Public Hospitals: Principal findings from a national survey (Occasional Paper No. 3). Wellington: Ministry of Health.*
- *NZBS Annual Haemovigilance Reports 2010 – 2015*

- *Christopher Corkery –Transfusion Resource Nurse NZBS Waikato*
- *Charlotte Foley – Lakes DHB Quality & Risk Team*