Blood Matters

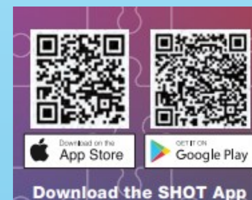
Transfusion Newsletter September '24 Vol:12

83.1% of all errors reported were wholly preventable!

The annual national SHOT Report was released in July 2024, and once again highlighted a worrying trend in transfusion.

The number or errors reported increased again in 2023:

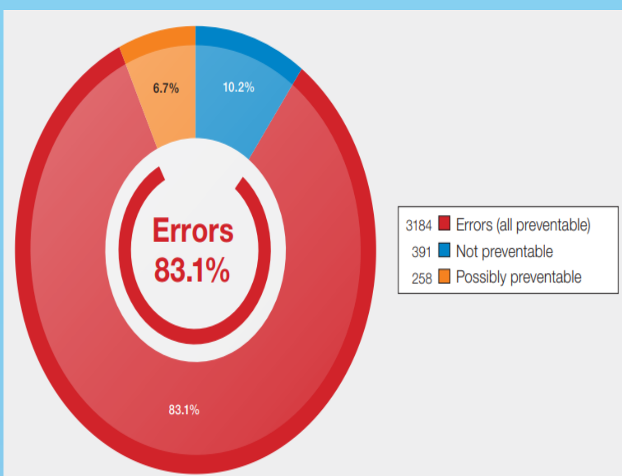
⇒ 890 reports of Wrong Blood in tube
(117 of these were in the North East and Yorkshire Region)



⇒ 38 Deaths related to transfusion, 15 of which were TACO and 9 from delays in transfusion (Both are avoidable errors in transfusion)

⇒ 212 Reports of delayed transfusions (9 resulting in death).

⇒ 10 ABO Incompatible Blood Transfusions occurred (7 Red cells and 3 Plasma)



3 Main Recommendations:

1) **Addressing patient identification errors to enhance transfusion safety**
2) **Safe staffing to support safe transfusions**
3) **Effective, timely communications to ensure safe transfusions.**

For further information see the SHOT website www.shotuk.org or download the App

If you would like any additional training or have any concerns or questions, please don't hesitate to contact the Transfusion Practitioner Team who will be happy to help.

Transfusion Practitioner Team

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Updates

Faulty Devices

There are issues with the devices freezing. This is a known issue and the software provider and Trust IT are working together to fix the issue. We hope this will be resolved soon.

September's compliance audit shows high use of the system despite these issues and we really do appreciate your continuing efforts.

If the device freezes with a white box across the screen, please restart the device. To do this press and hold the power button on the top right hand side of the device, and select 'restart the device'. The device should then be ready to use. If you have any further issues contact the Transfusion Practitioners, or IT service desk. Note: If the device can not be used you must report the issue via the IT service desk and revert to your backup methods for transfusion sampling (handwritten samples and paper request form) and administration (transfusion care pathway) form.

Mandatory Training

The mandatory transfusion training modules are available to access via the Learning Lab.

100%

Blood Transfusion: Essential Transfusion Practice

100%

Blood Transfusion: Consent

All staff involved in any stage of the blood transfusion process; sampling, authorising/ prescribing or the administration blood components **MUST** complete the mandatory e-learning modules shown on the left, every 3 years.

The updated Transfusion Competency Assessment will also be recorded on Learning lab. We will send out further communications in due course.

Blood Stocks -Amber Alert

An amber alert for group O red cells is still in place. It is vital that more people consider donating blood. Please spread the word among friends and family of the importance of blood in the hospital setting.

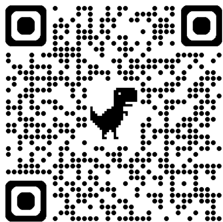
NHS

Every minute, the NHS needs 3 lifesaving blood donations

Anyone could need blood

Have you or your family considered donating blood? Follow the QR code to sign up today.

Infected Blood Inquiry



The Infected Blood Inquiry was a UK Public Inquiry launched in 2017 to investigate why infected blood products were being used to treat NHS patients prior to 1992. Between the late 1970s and early 1990s, thousands of patients with haemophilia and other patient groups needing of blood transfusions were treated with blood plasma donated from high risk sources.

The report highlighted many areas where things could have and should have been done better, including the documentation of transfusions and consenting patients. NHS England are still preparing a response to the recommendations and although we have yet to receive guidance, these are 2 areas where we can easily look to make improvements.

All staff involved in transfusion should be aware of the inquiry and its recommendations. For further information please follow the QR barcode to the website.

"Many patients treated with blood transfusions, particularly between 1970 & 1998 have died or suffered miserably, and many continue to suffer. This was not as a direct result of underlying condition or illness that took them to the NHS in the first place, but as a result of treatment itself."

"This would be catastrophic enough, if they were the only victims. The treatment have caused others to suffer to, partners, family and friends-some by being infected themselves, some by watching loved ones die, some by having to give their lives to caring for those infected. Almost every one, infected and affected suffering in almost every aspect of their lives."

Sir Brian Langstaff, a former High Court judge, chairing the inquiry.