

**‘To err is human,  
but to report is divine \*’**

Reflections on 10 years of error reporting  
and what can we learn  
Dr Emer Lawlor, National Haemovigilance Office  
19<sup>th</sup> November 2010

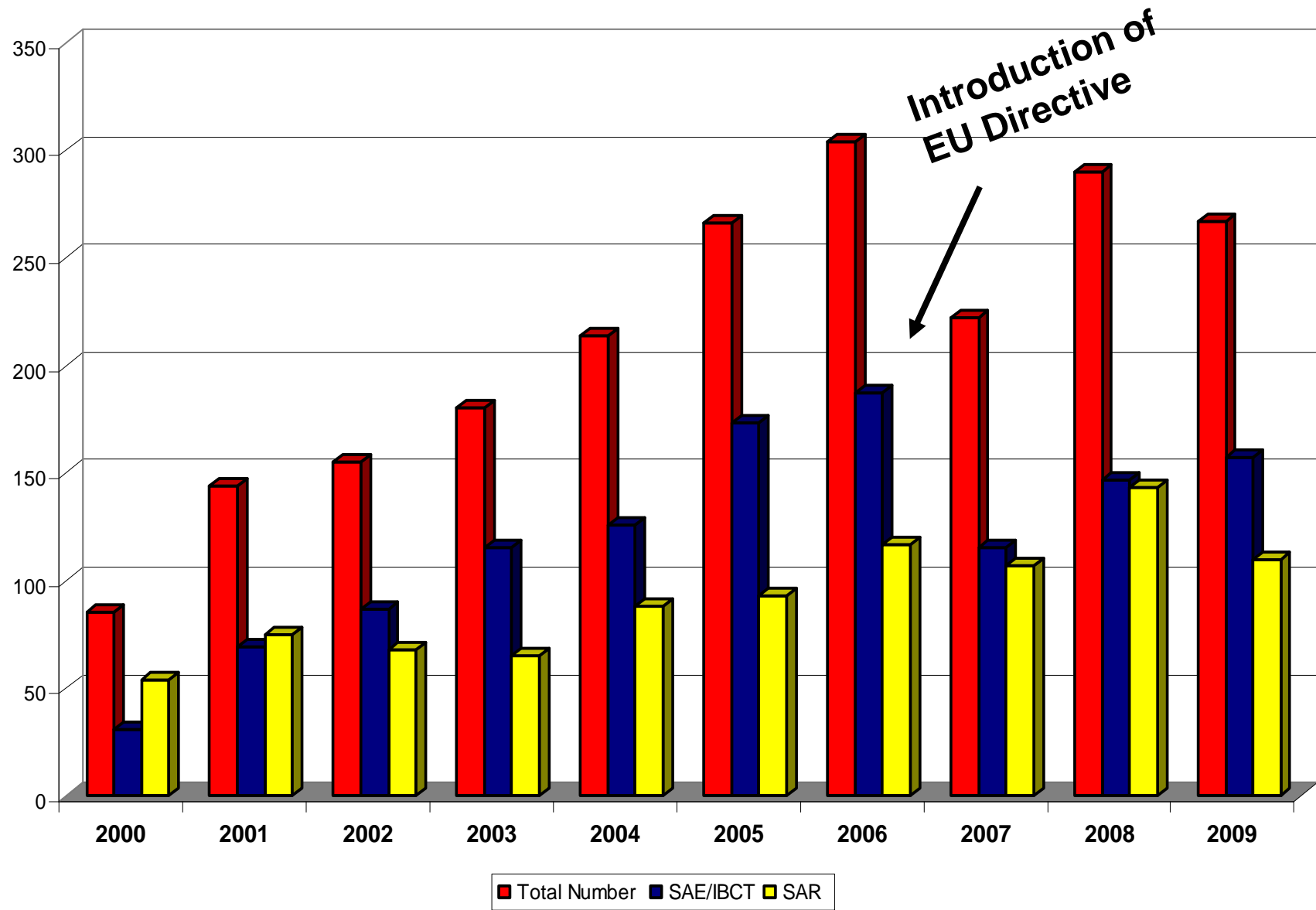
\*Marion Webb, AABB News Nov/Dec 2001 p25

# Official Launch NHO Oct 1999



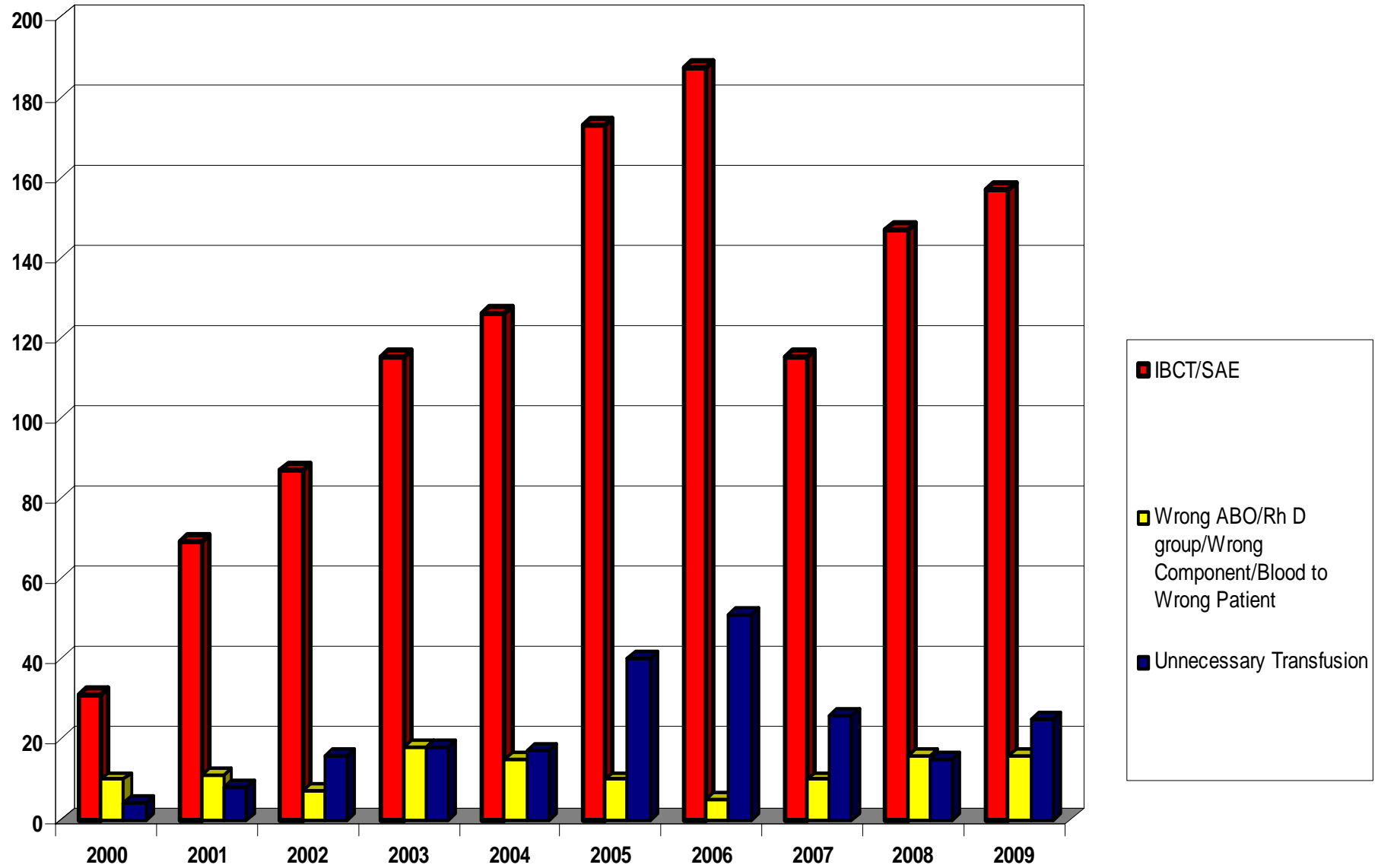
*Ref: IBTS Photographic Archive*

Breakdown of NHO incidents accepted 2000- 2009 (n=2127)



Changing Profile of SAE/IBCT  
Reports  
Post Implementation of EU  
Directive 2002/98/EC

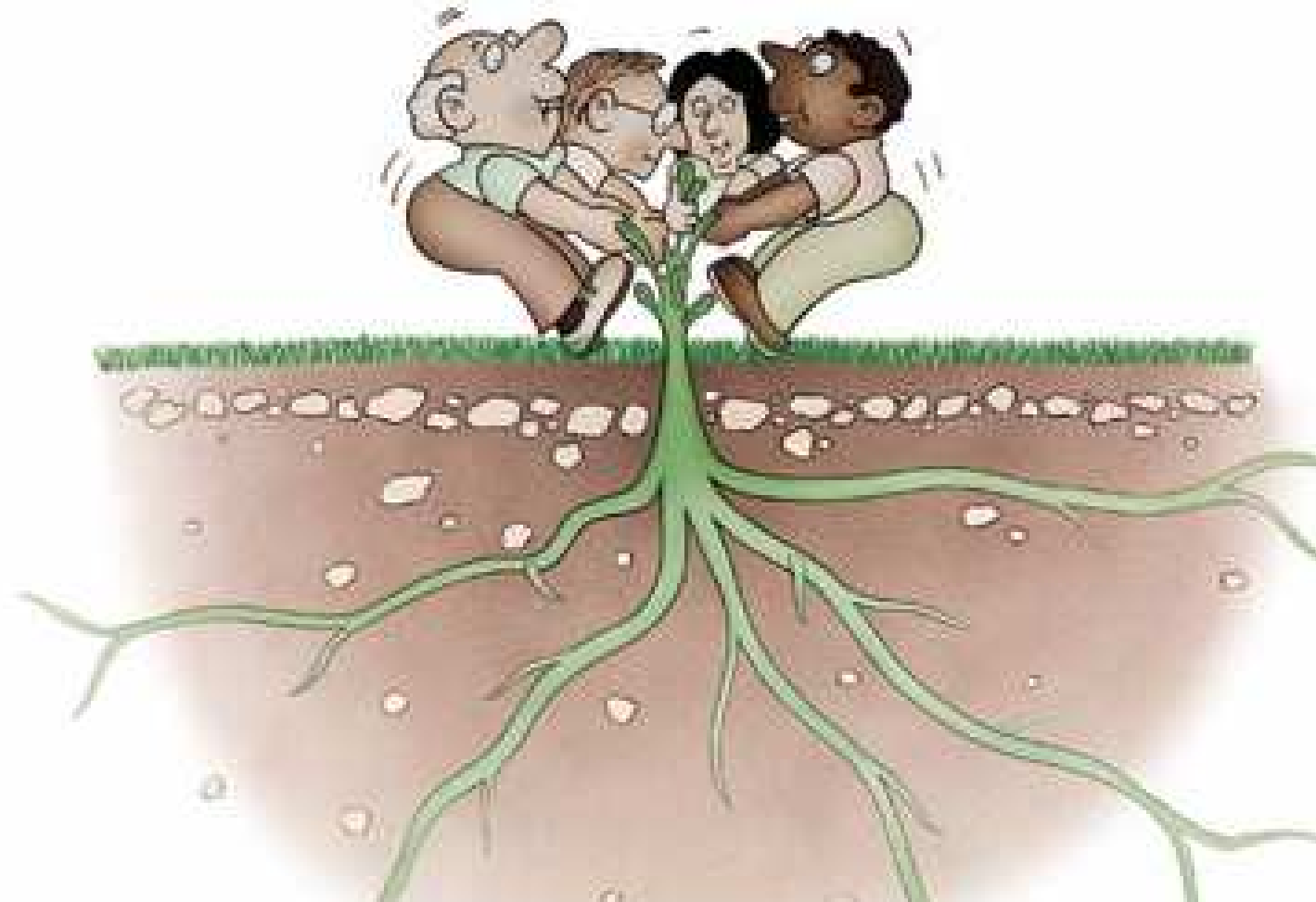
Changing profile of SAE/IBCT reports 2000-2009



# Root Cause Analysis :an earlier gift from Europe

*Member States shall ensure that reporting establishments evaluate serious adverse events to identify preventable causes within the process,*

Article 6.3.(a) EU Commission Directive  
2005/61/EC



**The user friendly Root Cause method  
to solve Complex, Multifaceted Problems**

# Root Cause Analysis



- **Avoids rush to judgement**
- **Avoids 'Blame and Train'**
- **Drills down**

Sentinel Event Policy April 1996 Joint  
Commission AHO  
Marion Webb, AABB News Nov/Dec  
2001 p25

The blood transfusion laboratory and haemovigilance in SJH began undertaking Root Cause Analysis (RCA) on all serious adverse events (SAE) reported to the NHO in June 2008.

Since June 2009 extended to Near Miss Events.

# Number of RCA's undertaken in SJH

<i>Year</i>	<i>SAE's and Serious Non- conformances</i>	<i>Number reported to NHO</i>	<i>Number of RCA's undertaken</i>
2008	33	11	7
2009	24	14	18
2010 (to end of September)	26	5	26

## Seven hundred and fifty-nine (759) chances to learn: a 3-year pilot project to analyse transfusion-related near-miss events in the Republic of Ireland

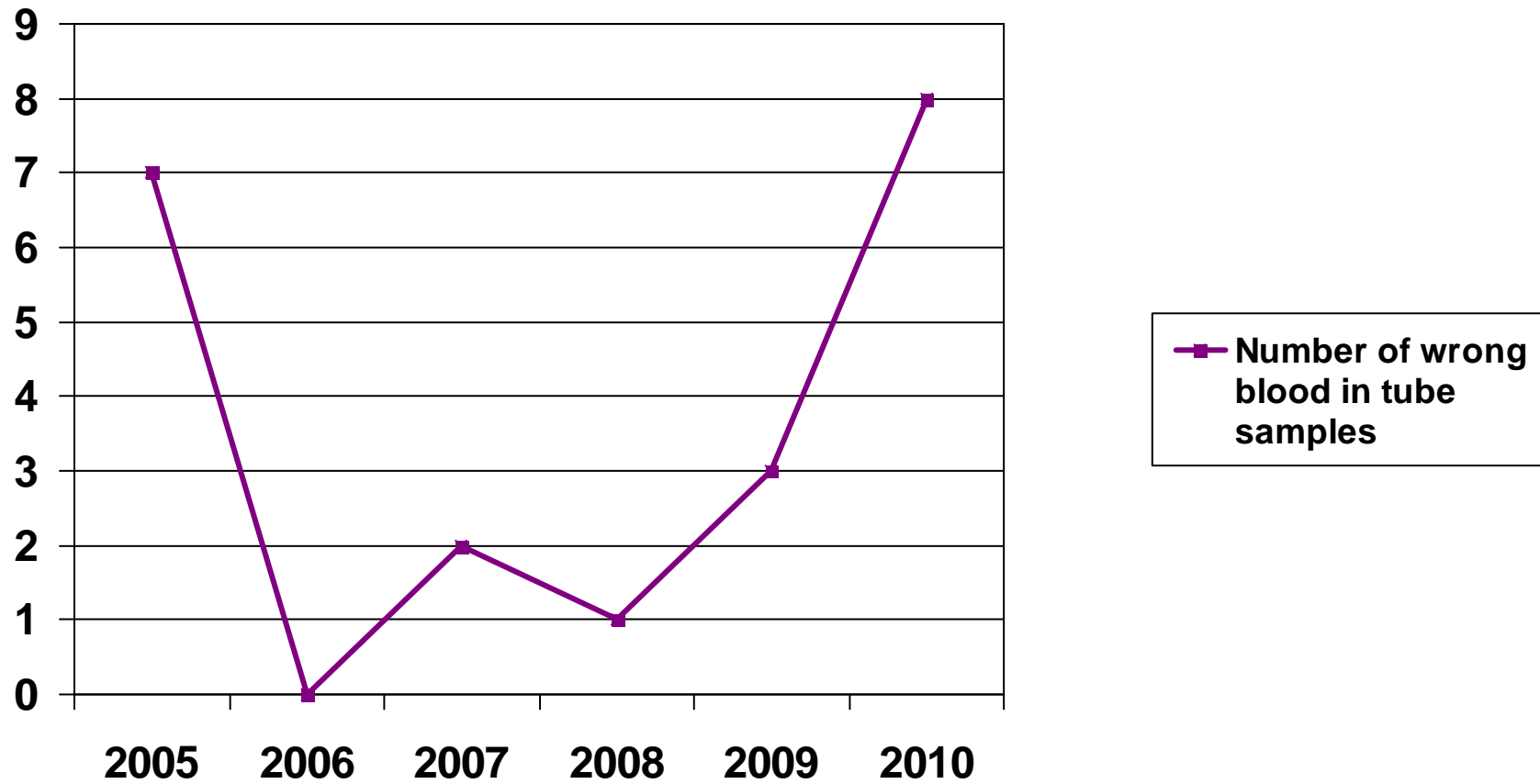
D. Lundy,<sup>1</sup> S. Laspina,<sup>1</sup> H. Kaplan,<sup>2</sup> B. Rabin Fastman<sup>2</sup> & E. Lawlor<sup>1</sup>

<sup>1</sup>National Haemovigilance Office, Irish Blood Transfusion Service, National Blood Centre, Irish Blood Transfusion Service, Dublin 8, Ireland

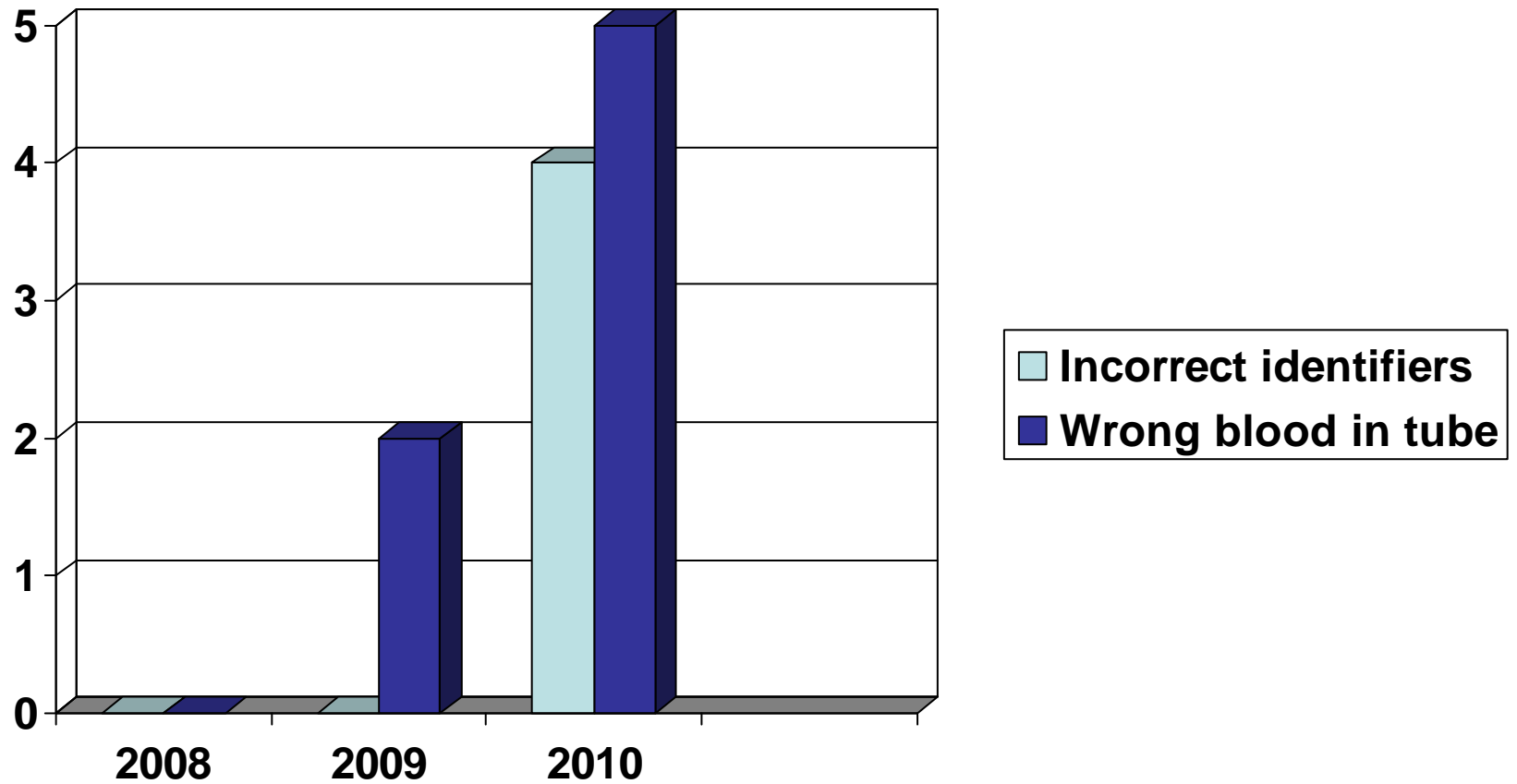
<sup>2</sup>Department of Pathology, College of Physicians & Surgeons, Columbia University, New York, NY 10032, USA

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- There were **59 events with high risk** of potential harm
  - 13 of these events involved the sample being taken from the wrong patient
  - 13 involved the sample being taken from the correct patient but being labelled with another patient's details
  - **26 Wrong Blood in Tube (WBIT) events in total** responsible for 44% of high risk events
  - **All involved doctors**

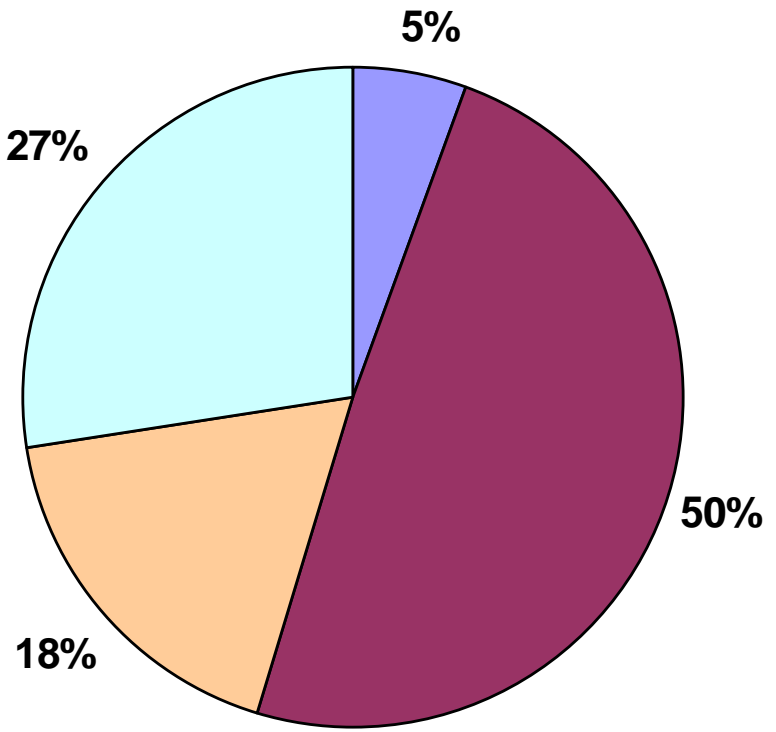
# Wrong Blood in Tube SJH 2005 - 2010



# Breakdown of Sample errors 2008-2010 SJH



### **% Total Corrective/ Preventative Action Taken/Suggested**



**Audit   Training   Policy/Procedure amendment   New Initiative**

# Examples of some of the new initiatives relating to sampling.

- In response to the increase in sample errors there has been an extension of the phlebotomy services to cover weekends.
- Evaluation of extension of pre-admission clinics where blood transfusion samples can be taken
- There is a recommendation for extension of BloodTrack® Tx sampling in certain areas of the hospital.

# Preassessment Clinics

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- Identify correctable causes of anemia
- Identification of patients with special transfusion requirements - previous antibodies
- Samples can be taken for Group and antibody screen and can be used for crossmatch if necessary if special patient ID protocol followed
- Necessary response to increase in 'day of admission' surgery

*‘Improvements can only take place if everyone working in the health service is prepared to work in an open and honest way that acknowledges our failures in order to learn from them’*



Minister for Health & Children Mary Harney launching *Patient Safety First* initiative  
Sept 2010

# Improvements due to haemovigilance

- Better patient identification in hospitals
- Improved bedside checking for blood transfusion
- Data to support electronic sample taking and administration systems
- Data to support HIQA recommendation on patient Unique ID
- Appropriate management of warfarin reversal
- Reduction in TACO with FFP/SD plasma
- Reduction in TRALI
- Reduction of AA/FNHTR with platelets in PAS

# NHO The future

- Should not be the primary collector of mandatory reactions and events. Role of NHO should be help in investigation, advice, expertise if needed.
- Primary collector should be IMB with dual reporting to NHO. Both should be online (UK model)
- The NHO needs a Steering Group representing clinical and laboratory stakeholders

# NHO should focus on patient safety

- **Champion introduction National Antibody Register**
- **Help produce guidelines for appropriate use of blood**  
– including CMV negative , irradiated product
- **Collect delays?**  
NPSA 11 deaths in UK between 2006-2010, 83 patients harmed
- **Collecting Mandatory Near Misses since Jan 2010**  
Collect clinical near misses?  
All or subset? Wrong Blood in Tube ?
- **These will require IT resources and may have staffing implications**

# Thanks to NHO Team Members 1999 - November 2010

## **Past HVOs**

- Donna Harkin
- Phil Keane-Egan
- Derval Lundy
- Ann O'Connor
- Siobhan O'Connor
- Mairead Sheahan

## **Temporary Director (2005)**

- Stefan Laspina

## **Past Administrative Staff**

- Paula Bolger
- Marie Carolan
- Angie Corr
- Elaine Corrigan
- Maria Flanagan
- Gillian Horgan
- Marion O'Raw

## **Present**

- Roisin Brady
- Marina Cronin
- Kathleen Heery
- Emer Lawlor
- Cathy Scuffil
- Jackie Sweeney
- Marcia Kirwan (seconded to DCU)

## **SJH HVOs since 1997**

### **Present**

Deirdre Gough  
Lorraine Egan  
Mary Shine

### **Past**

Joanne McCormick  
Phil Keane-Egan  
Mairead Breen  
Carmel Whelehan  
Kerry Stoll

Thanks also to all staff in IBTS and HHB St James's Hospital;