NHS
Blood and Transplant

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Dear Matthew

Expanding the list of 'never events'

I am providing feedback on your proposals for expanding the list of 'never events' on behalf of NHS Blood & Transplant and its Medical Director, Dr Lorna Williamson, and also the National Blood Transfusion Committee (Chair, Professor Adrian Newland).

We agree with the proposal that 'death or serious injury from the inadvertent administration of ABO incompatible red cells' should be included in a revised list of 'never events'. Indeed, I did suggest this to Dr Kevin Cleary some time ago.

This event meets the DH criteria of 'never events' in that:-

1) The incident has clear potential for or has caused severe harm/death
2) There is evidence of occurrence in the past (i.e. it is a known source of risk).

The Serious Hazards of Transfusion (SHOT) scheme has reported 247 ABO incompatible red cell transfusions between 1996 and 2009 resulting in or contributing to 27 deaths and many cases of major morbidity).
Serious Hazards of Transfusion. Annual report 2009. Serious Hazards of Transfusion scheme, Manchester, UK, 2010. (www.shotuk.org).

Similar data are available from around the world including the United States.
US Food and Drug Administration. Fatalities reported to FDA following blood collection and transfusion. Annual summary for fiscal year 2008. www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/ReportaProblem/TransfusionDonationFatalities/ucm113649.htm

3) There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation.

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Guidelines have been issued by the British Committee for Standards in Haematology and the UK Blood Transfusion Services on the safe administration of blood. British Committee for Standards in Haematology (2009). Guideline on the administration of blood components.
http://www.bcshguidelines.com/documents/Admin_blood_components_bcsh_05012010.pdf

UK Blood Transfusion Services (2007). Transfusion procedures. Handbook of Transfusion Medicine 4th edition.
http://www.transfusionguidelines.org.uk/Index.aspx?Publication=HTM&Section=9&pageid=1114

National safety recommendations have been issued by the NPSA.
National Patient Safety Agency. Right Patient, Right Blood: advice for safer transfusions. 2006. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59805.

Support to hospitals for the safe and appropriate use of blood is the main remit of the National Blood Transfusion Committee and the DH Better Blood transfusion initiative.

Department of Health (2007). Health Service Circular on Better Blood Transfusion: Safe and Appropriate Use of Blood. HSC 2007/001.
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_080613

The National Blood Transfusion Committee has included questions on hospitals' implementation of the NPSA recommendations for safe transfusion practice in its current survey of the implementation of the recommendations of the HSC 2007:001 Better Blood Transfusion.

4) The event is largely preventable if the guidance is implemented.

This is correct. ABO incompatible red cell transfusions are invariably due to an error (often several errors) in standard procedures for transfusion.

5) Occurrence can be easily defined, identified and continually measured.

The national SHOT scheme receives reports from hospitals of ABO incompatible red cell transfusions, and includes them in its annual reports along with recommendations for their avoidance in the future.

We do not think that the inadvertent administration of HLA incompatible blood components should be included in the 'never events' list. HLA matching for blood components is only carried out to provide compatible platelet transfusions for patients with poor responses to platelet transfusions because of HLA antibodies. HLA matched platelets are administered to a very small number of patients. Transfusion of HLA incompatible platelets to these (or indeed other) patients is not a life-threatening event.

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The United States includes 'death or serious disability associated with a haemolytic reaction due to the administration of ABO incompatible blood or blood products' on its list of 27 never events http://www.qualityforum.org/Publications/2002/06/Serious_Reportable_Events_in_Healthcare.aspx.

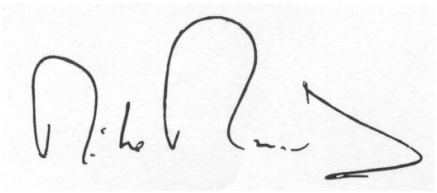
It added 'death or serious disability associated with a haemolytic reaction due to the administration of HLA incompatible blood or blood products' to the list in 2006, but the explanation justifying its inclusion (on page D8) is very unclear about why it was added.

Our response covers blood transfusion only and not organ transplantation.

Please let me know if you have any queries or need further information.

Kind regards,

Yours sincerely



Professor M F Murphy
Clinical Director – Patients, NHSBT
Secretary, National Blood Transfusion Committee

cc: Dr Lorna Williamson, Medical Director, NHSBT
Professor Adrian Newland, Chair, National Blood Transfusion Committee