H.A.I.L. Northern Ireland Haemovigilance
Haemovigilance Adverse Incident Learning

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Introduction - History of Haemovigilance in Northern Ireland
The employment of Haemovigilance Practitioners (HVP) throughout Northern Ireland (NI), was an integral part of the implementation of Circular MD6/03 and fully supported by the Northern Ireland Transfusion Committee (NITC). From the establishment of the Haemovigilance Team in 2005, they have collectively demonstrated commitment and dedication to ensuring the provision of safe quality care to all patients who require a blood transfusion.

Background – Promoting Safe Transfusion Practice by Shared Learning
The SHOT (Serious Hazards of Transfusion) Reports provide analysis of adverse events and reactions that occurred in the blood transfusion process within the United Kingdom. Where risks and problems are identified, SHOT produces recommendations to improve patient safety which are utilised by the Trust Transfusion Committees. All five Trusts in NI report to SHOT – 129 reports were submitted during 2013 (Figure 1).

In 2013 SHOT analysed 2751 reports with broad recommendations and includes a number of notable case studies. In addition to this valuable resource, a gap existed from a NI perspective as:
1. Not all NI adverse incidences were SHOT reportable.
2. NI specific issues are not detailed.
3. NI SHOT reported incidences may not be included in the SHOT case studies.
For this reason H.A.I.L. was established.

Conclusion – H.A.I.L. Northern Ireland Haemovigilance
During the Regional meetings of the HVP anonymised Haemovigilance Adverse Incident Learning (H.A.I.L.) data is shared on transfusion incidents / issues or near misses within their own Trusts that may / may not be reportable to SHOT or to the DHSSPS as a Serious Adverse Incident (SAI) as a means of promoting safer transfusion practice.

Sharing the outcome of investigation as well as changes that may have been introduced to prevent reoccurrence has significant benefits to the HVPs and their role within their Trusts. A recent survey completed by the HVP leads in NI rate H.A.I.L as having a significant impact on Haemovigilance practice.

H.A.I.L. – The Future
Availing of shared learning provides opportunity for HVPs to move from reactive change to proactive management. The next step is the implementation of a formalised process. Use of a ‘Risk Matrix’ and ‘Likelihood Scoring Table’ is being considered. A score would be allocated by each HVP on H.A.I.L. relating to each incident presented. A detailed action plan would be developed on how to prevent similar incidences. To share the learning, an annual H.A.I.L. e-zine will be developed.

"Less attention has been given in Northern Ireland to adverse incidents that do not meet the definition of a Serious Adverse Incident…Only exceptionally are they considered centrally….However, there is much to be learned from situations when something went wrong in a patient’s care but they did not die or suffer serious harm".

Examples of H.A.I.L.

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<thead>
<tr>
<th>Incident / Issue</th>
<th>Learning / Implications for practice</th>
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<tr>
<td>Near miss due to incorrect labelling of cord and maternal samples leading to blood being issued for mother from cord sample.</td>
<td>Trusts reviewed practice to ensure means of differentiating cord sample bottle from mothers’ sample.</td>
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<td>Transfusion documentation audits highlighted minimum transfusion dataset not met.</td>
<td>Integrated Transfusion Records developed with positive feedback from users and noted improvement to transfusion documentation.</td>
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<td>F1 Doctor interpreted request for two unit Group and Crossmatch to mean that the patient required a transfusion.</td>
<td>HVPs include slide in presentations to Junior Doctors regarding what is meant by a Group and Crossmatch and share this example.</td>
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References
²Serious Hazards of Transfusion (SHOT) Annual reports and summaries, http://www.shotuk.org/shot-reports

Figure 1: NI Reports submitted to SHOT 2013