Characteristics of a State System: New York Reporting System

Advisory Committee
Blood Safety and Availability
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New York State Reporting System

- Established 1989
- Mandatory
- 240 facilities + 100 LTS
- Reports confidential per law
- TA IDs and tx errors
- Reportable if unit released (+/- tx)
- Considers underlying factors/root causes
- Assist facilities with evaluation if needed
- Some feedback given

Findings

Frequency of Erroneous Transfusion (RBCs) in New York, 1990-1999

	Number	Frequency
ABO-incompatible	237	1/38,000
ABO-compatible	221	1/41,000
Total	462	1/19,000
Adjusted Total	659	1/14,000
Fatal AHTR	5	1/1,800,000

Linden et. al. Transfusion 2000 40:120 7-13

Sources of Transfusion-associated Errors NYS, 1990-1999

Nature of Error	No.	(%)
Non-blood bank error alone	259	(56)
Blood bank error alone	135	(29)
Compound error	67	(15)
Could not be determined	1	(0.2)
Total	462	(100)

Sources of Transfusion-associated Errors NYS, 1990-1999

Nature of Error	No.	(%)
Non-blood bank error alone		
Identification error	171	(37)
Phlebotomy error	62	(13)
Incorrect order sent	22	(5)
Other	4	(1)
Total	259	(56)

Contributory factors identified

- Bypass safeguards (removal of wristband)
- Preprinted labels for tubes
- Same/similar names on floor or in OR
- Consecutive identifiers
- Telephone/verbal communications
- Faxed communications
- Manual procedures for release

Systems failures identified

- Lack of delineation of responsibilities
- Absence of proper SOPs
- Absence of proper training
- Insufficient training in recognizing AHTR
- Unapproved equipment available for use

Context as Systems of Contributory Factors

Means of performing tasks

Staff Member

Patient

Ambient environment

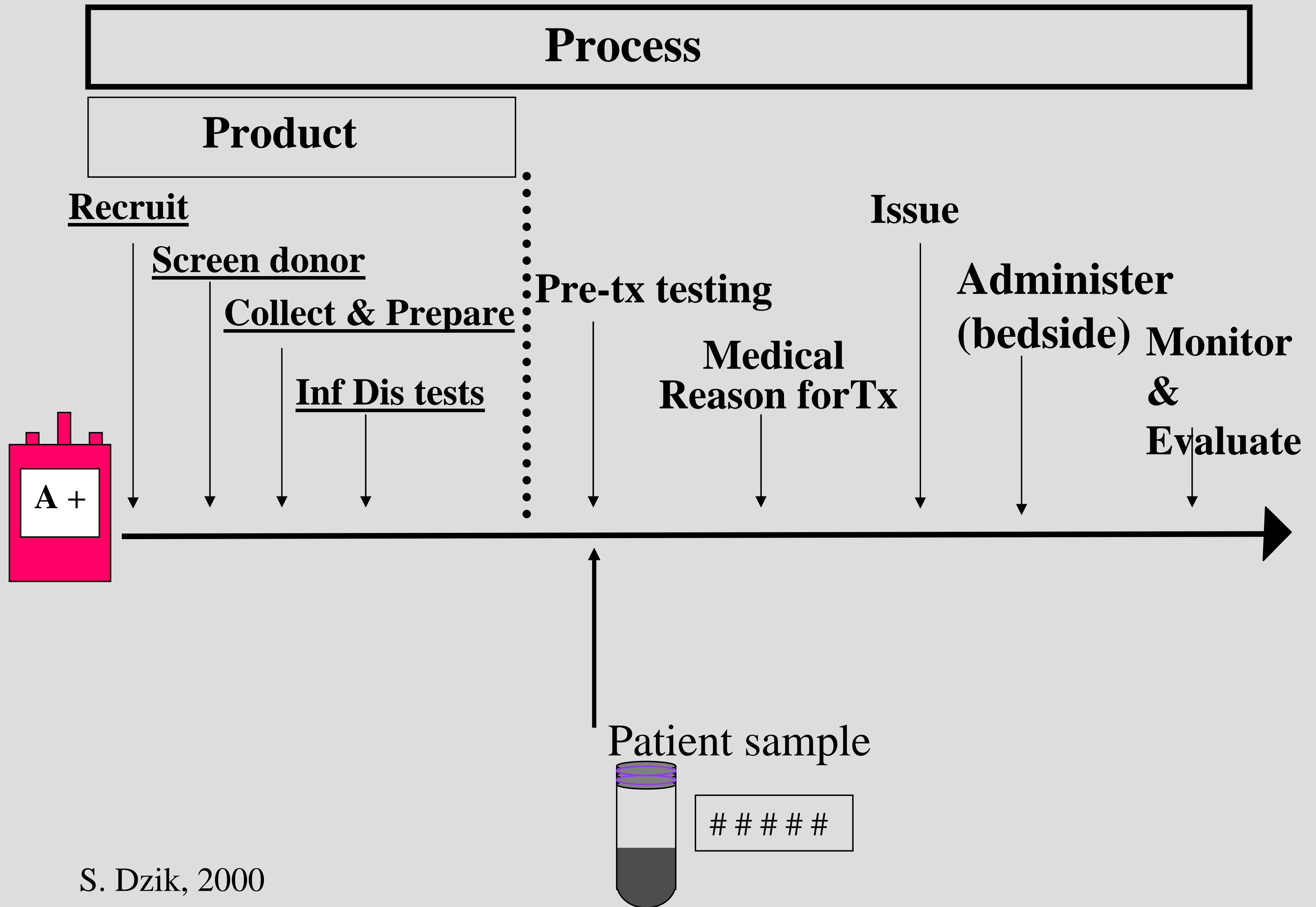
Social

Physical

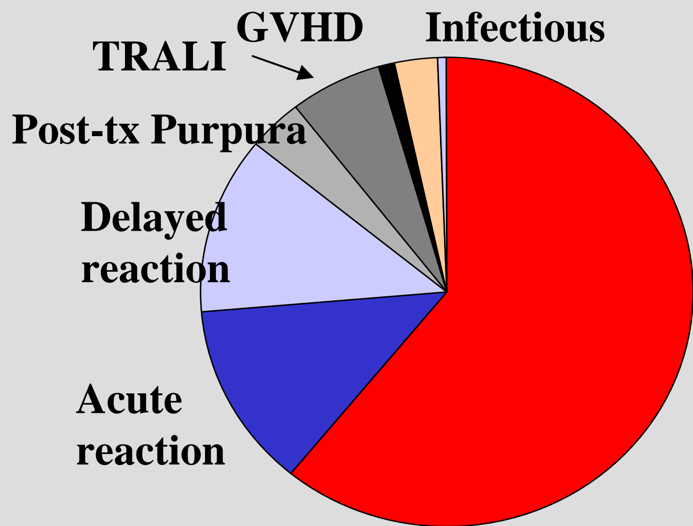
Organization

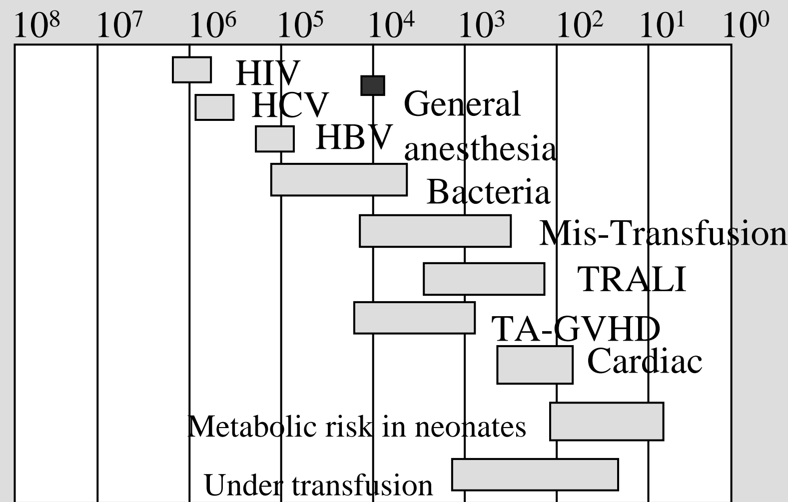
Legal-regulatory-reimbursement-culture

Safe Transfusion: Processes not just product.

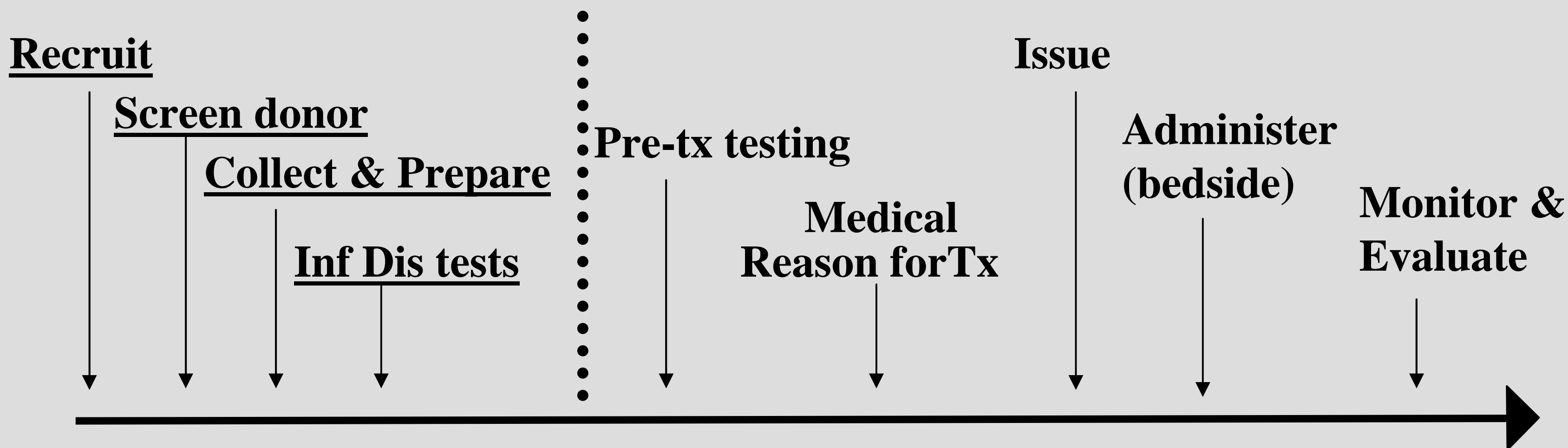


SHOT: Cumulative Data 1996 - 2004





Transfusion Safety: A new priority in transfusion medicine



Hospital-acquired infections surveillance effort

- Law passed 2005
- Provides for confidential reporting
- Requires results reporting (aggregate then facility-specific)
- Results provided for Department staff
- Resources to fund pilot facility projects

Goals

- Develop and implement meaningful reporting system
- Ultimate goal is prevention
- System will evaluate interventions, risk factors, risk adjustment strategies

Evaluation of existing systems

- Existing administrative data not useful (e.g. D/C, billing data)
- Standard case definitions necessary
- Standard methods/protocols necessary
- Need to consider post D/C detection
- Most surgery outpt – need to capture

Reporting System

- CDC's National Healthcare Safety Network (NHSN)
  - Standard definitions
  - Standard surveillance methods
  - Standardized risk assessment
  - Standard protocols
  - National benchmark/comparison data

Benefits of NHSN

- Hospitals can compare to larger number of facilities
- Access to broad array of patient and employee infection-related indicators
- NYSDOH only has access to information specifically granted by facility
- Hospital sees exactly what DOH sees
- Bi-directional flow of information is a priority
- Benefit to facilities in networks
  - National system so more likely to be adopted by neighboring states if legislation is passed elsewhere
  - Group functionality can be used for multiple purposes

Indicators Selected

- Central line-associated sepsis in ICUs
- Surgical site infections
  - CABG
  - Colon surgery

Status

- Currently training
- Reporting to begin 1/1/07
- First 150 procedures
- Report on pilot after one year
- Eventual facility-specific reporting
  (in some fashion TBD)

Conclusions/Recommendations (IMHO)

Attributes

- Thorough, sufficient detail to be meaningful
- Must include entire tx process, all players
- Post D/C events require different approach
- Consider root causes, underlying factors
- Participants may need assistance/prompting
- Existing data sets unlikely to be helpful

Attributes (cont.)

- Standardized definitions
- Should facilitate analysis
- Should result in opportunities for risk reduction/intervention
- Impact measurable

Compliance/participation

- Participants need to buy in (all)
- Not be punitive/used for enforcement
- Data not releasable other than aggregate
- System should be easy to use
- Resources important
- Reported in format needed

Focus - most important issues

- New issues requiring data
- Most frequent problems
- Problems amenable to intervention (measurable)