NHS Blood and Transplant

National Comparative Re-audit of Bedside Transfusion Practice

BBTS

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Oct 2011

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Introduction

- Aims of the audit
- Audit standards
- Methodology
- Participation and sample size
- Findings
- Recommendations
- Conclusion
- Acknowledgements

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Aims of the audit

- Measure current practice against BCSH (2009) guidelines
- Measure current practice against NPSA safer practice notices (2006, 2007)
- Measure current practice against previous NCABT bedside audits
- NQIS (2006) clinical standards for blood transfusion
- Welsh Assembly Government (2007)

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Audit standards

- Presence of patient identification wristband
- Completeness and accuracy of patients details on wristbands
- Accuracy of patients details during the final bedside checking procedure
- Observations documented during the transfusion episode

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Participation and sample size

- 167 NHS Sites invited to participate
- 165 Independent Hospitals invited to participate
- Participation from Community Hospitals encouraged
- 247 sites participated
- Median 40 cases per site
- 9250 transfusion episodes

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Methodology

- Red cell usage guided quota for cases
- Data collection period 4th April – 1st July 2011
- Audits completed ‘real time’
- Time of audit not specified
- Auditors requested not to audit same patient twice ***or*** healthcare professional more than twice

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Findings

- Presented in two categories
- Standards 1,2, 3 – Positive Patient Identification
- Standards 4, 5,6 – Monitoring of the transfused patient

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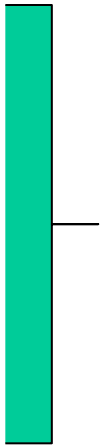
Positive Patient identification

- Wristband ID
- Verbal ID
- Prescription
- Unit of blood



Safe transfusion practice

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Positive Patient Identification

- 97.7% (n=9034/9250) wristband present
- 99.4% (n-8938/8992) wristbands detailed core identifiers:

- Surname
- Forename
- NHS Number
- Date of Birth

- 85% (n=210) sites met standard
- 98.9% (n=8840/8939) cases met ID checks

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Wristband Identification

"All patients in this renal day unit have a photograph in their notes with their first name, surname, date of birth and NHS number which staff use to check with the patient.

"Patient attends on a regular basis hence only verbal identification is obtained

"Child being transfused every other day. ……. ID band now attached to child's folder with prescription chart. Not placed on during transfusions".

"The ID band was not put on by staff as she could not print it out. ……. ….. In addition to having no ID band on the patient gave me a different spelling to his surname which did not match the surname on the bag of blood he was receiving

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Documentation Patient identification

"First name on blood tag is Baby. The baby was given a name after the blood order. Prescription chart and ID bands changed to reflect new name".

"No prescription at all. Transfused in theatre and the consultant anaesthetist said they don't need to prescribe it. Only evidence of transfusion is the traceability stickers in the patient notes".

"Whole tag, instead of just tear off section, removed and sent back to Blood Bank as proof of transfusion. Information on it matched at time of issue and administration but was missing during transfusion and audit".

A/E number on wristband, case note number and NHS number on blood and prescription".

"Addressograph label on prescription record is from another hospital within the Trust but is a different hospital number from that on the patient identification wristband and unit of blood".

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Monitoring of the transfused patient

- 85% (n=7846/9246) patients had pretransfusion observations documented
- 47% (n=4328/9250) patients had observations documented at *exactly 15* minutes
- 84% (n=7469/8909) patients had post transfusion observations documented

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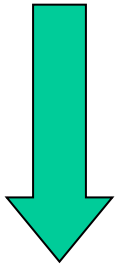
Worst case scenario

NO WRISTBAND + NO OBSERVATIONS RECORDED DURING THE TRANFUSION



0.03% (N=3) patients

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Trend analysis- NHS England sites

AUDIT YEAR		2003	2005	2008	2011
Participating Sites		160	211	180	182
Cases audited		5014	6764	6943	7936
% (n) with wristband		90	94	98 (6771)	98 (7755)
% (n) of wristbands with complete surname, first name, DOB, ID #		86	91	98 (6574/6715)	99.5 (7684/7722)
% (n) with pre Transfusion observations recorded	Temp	74	90	89 (6183)	93 (7381)
	Pulse	76	91	90 (6236)	94 (7421)
	BP	75	91	90 (6234)	92 (7305)
% (n) with temp <=30 mins**		58	64	73 (5075)	87 (6900)
% (n) with pulse <=30 mins**		59	65	74 (5152)	87(6924)
% (n) with no observations recorded during transfusion		12	13	12 (847)	4 (297)

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Key messages for healthcare practitioners

No wristband, no transfusion; no exceptions

- If the wristband is taken off or is illegible - put another one on before proceeding
- If you use an alternative ID system it must be attached to the patient and have four core identifiers
- If the patient (or parent) refuses, the risk of proceeding with the transfusion must be evaluated and recorded in the notes

Messages for hospitals about patient identification for blood transfusion

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- Should comply with NPSA standards for wristbands
- Printed wristbands are better; clearer, standardised, & there is no risk of transcription errors
- Should be 24/7 access to printed wristbands as well as a back up method for producing wristbands
- The four core identifiers must be the same (and the same format) on all IT systems used to deliver patient care (PAS, LIMS etc)
- Increasing use of NHS number, but not yet universal!

Involving patients in safe blood administration

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- Patients are already involved with positive patient ID as part of the bedside checking process; opportunity to correct inaccuracies

- SHOT recommended an “Ask me who I am” initiative; SE Coast RTC have developed a model for this

- SABTO initiative on patient information and consent just launched, highlight the role of observations in detecting adverse reactions

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Conclusion

- Safe transfusion practice continues to improve
- HTT must work with key stakeholders to continually support safe practice
- Continuous quality improvement
- Ensure the right blood is given to the right patient at the right time

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Final thought……

Are we making a difference……..

Absolutely!!

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- **Members of the Project Group**
- **The Writing Group:**

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Bedside Transfusion Re-audit

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CLINICAL STANDARDS

Royal College of Physicians

Setting higher medical standards

NHS

Blood and Transplant

Royal College of Nursing

Welsh Blood Service

Gwasanaeth Gwaed Cymru

The Royal College of Anaesthetists

Educating, Training and Setting Standards in Anaesthesia, Critical Care and Pain Medicine

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CODP

College of Operating Department Practitioners