AUDIT OF THE ADMINISTRATION OF BLOOD- PATIENT IDENTIFICATION

By Caren Chu, Sarveen Gajebasia and Amy Holman

Aims

- Background
- Blood Administration
- Standards
- Method
- Analysis of the data
- Strengths and limitations
- Key Messages
- Action Plan
- Questions

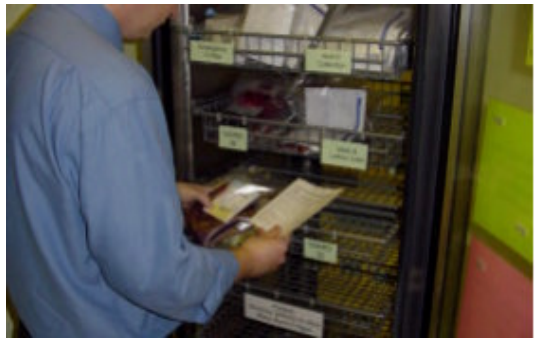
Background

- Better blood transfusions 1998 and 2002
- 2006 – right patient, right blood
- 159 events reported to SHOT
- Correct patient identification a key recommendation.
- Previous studies looked at wrist bands.

- To observe the patient identification process by staff preceding blood transfusions.

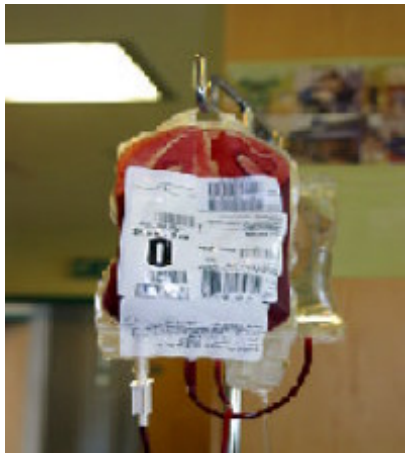
Blood Administration

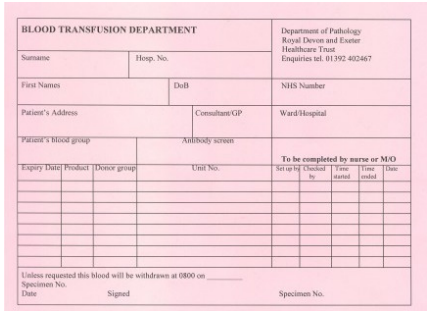
Blood is checked out of blood bank fridge



Blood is relocated to satellite fridges

Blood is taken to patient bedside





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Surname | Hosp. No.

First Names | DoB | NHS Number

Patient's Address | Consultant/GP | Ward/Hospital

Patient's blood group | Antibody screen

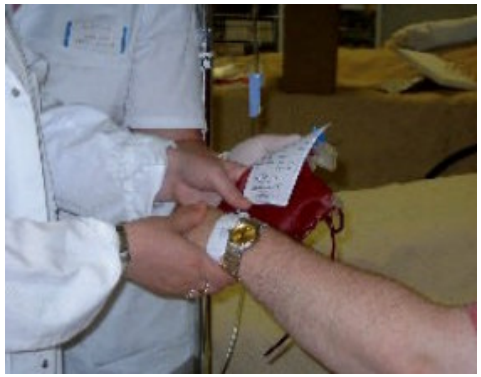
To be completed by nurse or M/O

Expiry Date	Product	Donor group	Unit No.	Set up by	Checked by	Time started	Time ended	Date

Unless requested this blood will be withdrawn at 0800 on _____
Specimen No.
Date | Signed | Specimen No.

Positive identification

Nurse A should check the patient's ID band to the traceability tag.



Nurse B to repeat process

Blood is administered to the patient.

Standards

1. The final administration check should always be conducted **next to the patient.**
2. The checking/administration process is carried out by two registered practitioners conducting a **double independent check**.
3. The **compatibility form** and the patients clinical records should **not** form part of the final bedside identification check.
4. The patient should be asked to **state** their full name (first and last) and date of birth.

Standards

5. The patients details must be checked to confirm that they are the same as the patients identification band and the patient identifiers on the **traceability tag** on the unit of blood.
6. For patients who are unable to identify themselves (paediatric, unconscious, confused, language barrier) verification should be obtained from a **parent or carer** (if present).
7. In circumstances where the patient cannot state their details and no parent/carer is available, the patients **ID band** will be the only means of positive patient identification.

Method

- Royal Devon and Exeter
- 13th November – 22nd November.
- Asked permission to observe the whole process of the blood transfusion.
- Patient confidentiality was maintained.
- Each bag of blood components was counted as separate transfusion.

AUDIT OF THE ADMINISTRATION OF BLOOD – PATIENT IDENTIFICATION
SEPTEMBER 2012

Date:.....

Ward:.....

Question 1: **Is this patient**

An in-patient? ☐

A day-case? ☐

Question 2: **Is this patient**
An Adult? ☐

A child? ☐

A neonate? ☐

Question 3: **Was the final administration check carried out**
Next to the patient? ☐

At the nurses station? ☐

Other (please state).....

Question 4: **Was the checking/administration process carried out by**
Two registered practitioners carrying out an independent check? ☐

Two registered practitioners checking together? ☐

One registered practitioner checking? ☐

Other (please state).....

Question 5: **Were the compatibility report form and the patient's clinical records used as part of the final bedside identification check?**
Yes ☐

No ☐

Question 6: **How did the registered practitioners identify the patient?**
Asked the patient to state their full name and date of birth? ☐

Offered the patient their name and date of birth and asked them to confirm? ☐

Asked the patient their date of birth only? ☐

Asked a parent/carer to identify the patient because the patient was unable to identify themselves ☐

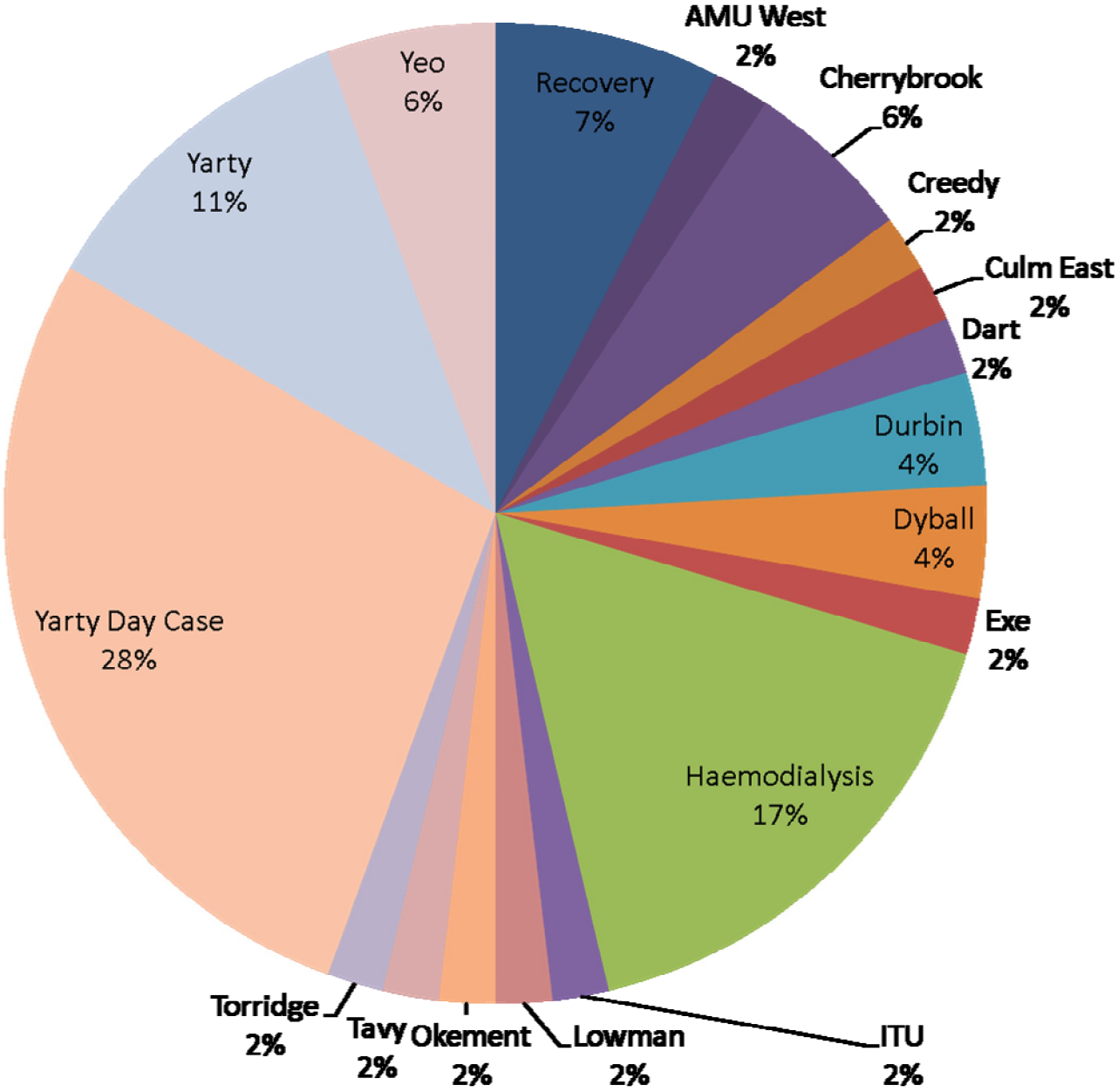
Checked the ID band only because the patient was unable to identify themselves and no parent/carer available ☐

Other (please state).....

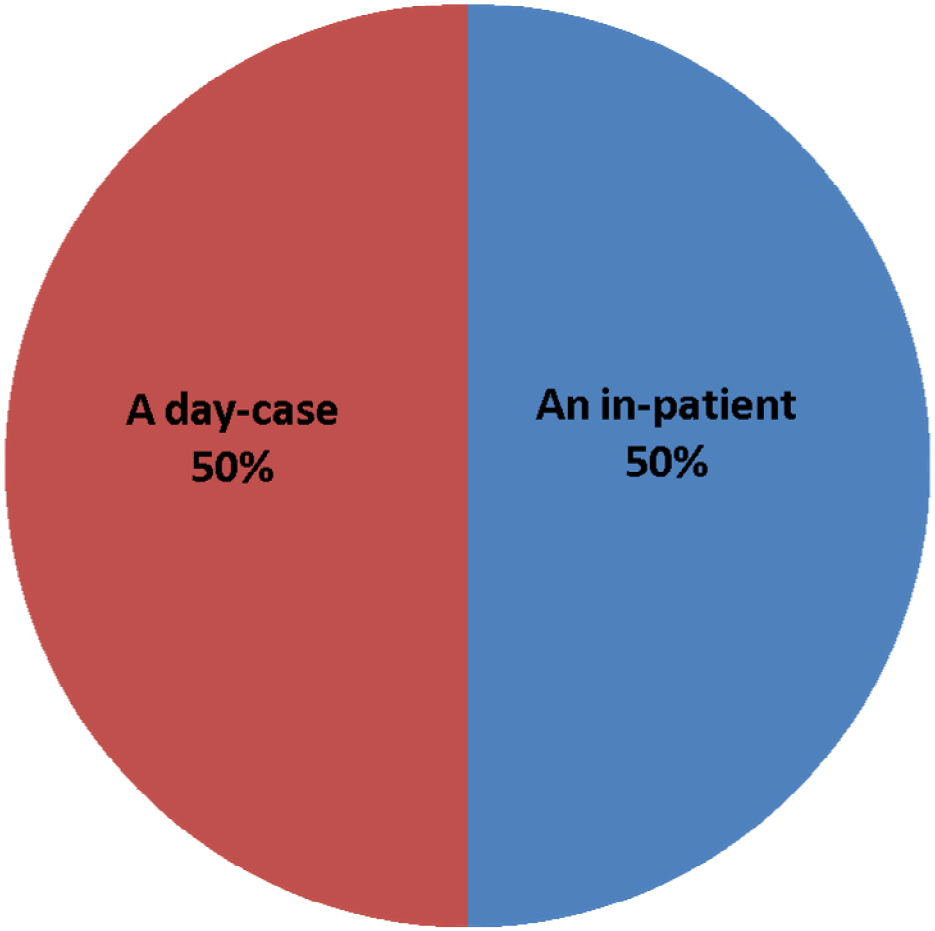
Question 7: Did the registered practitioners check the patient details matched on the ID band and the compatibility tag on the unit of blood?
Yes ☐

No ☐

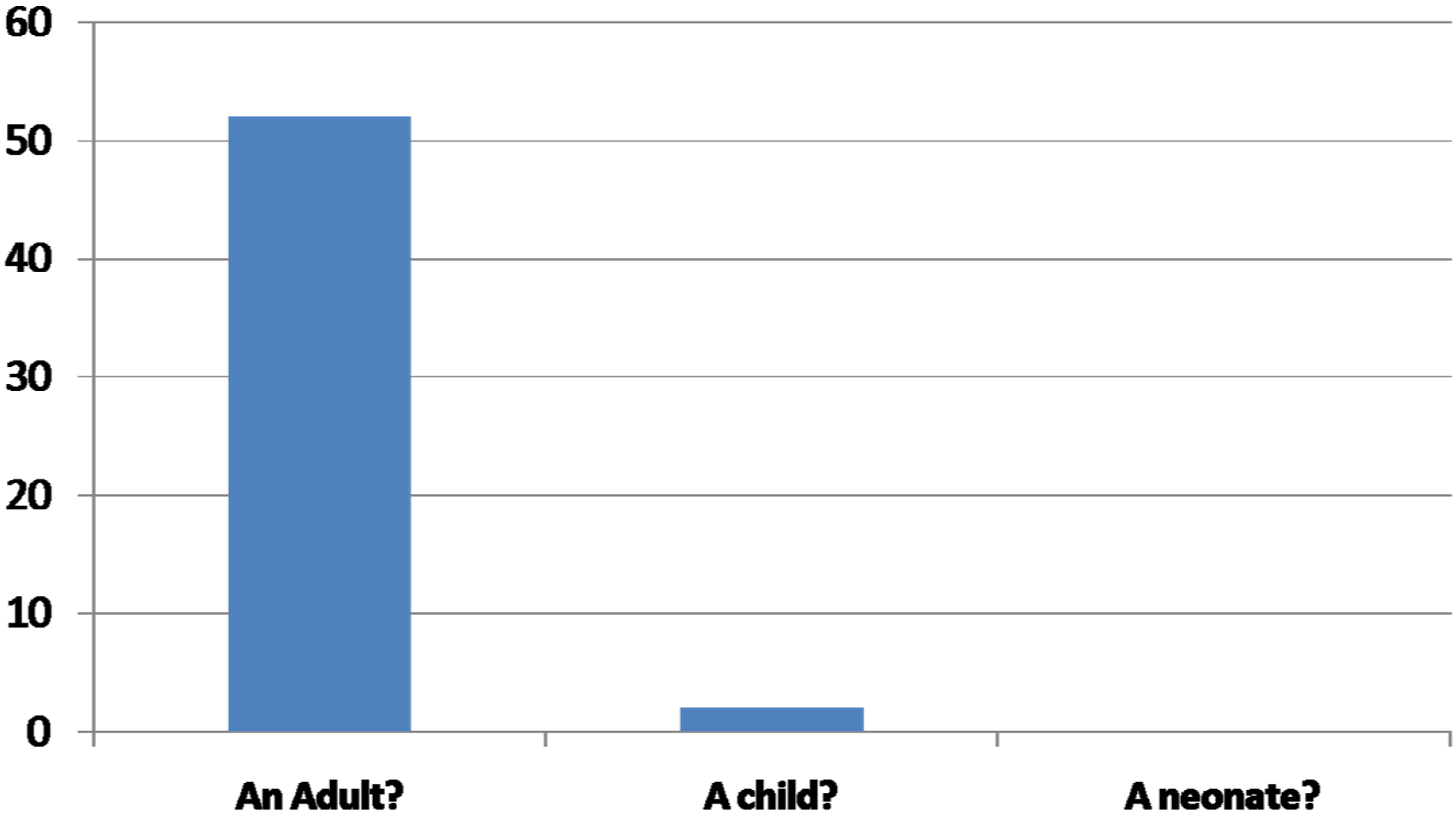
Q1: “Ward”


Recovery
7%
AMU West
2%
Cherrybrook
6%
Creedy
2%
Culm East
2%
Dart
2%
Durbin
4%
Dyball
4%
Exe
2%
Haemodialysis
17%
ITU
2%
Lowman
2%
Okement
2%
Tavy
2%
Torridge
2%
Yarty Day Case
28%
Yarty
11%
Yeo
6%

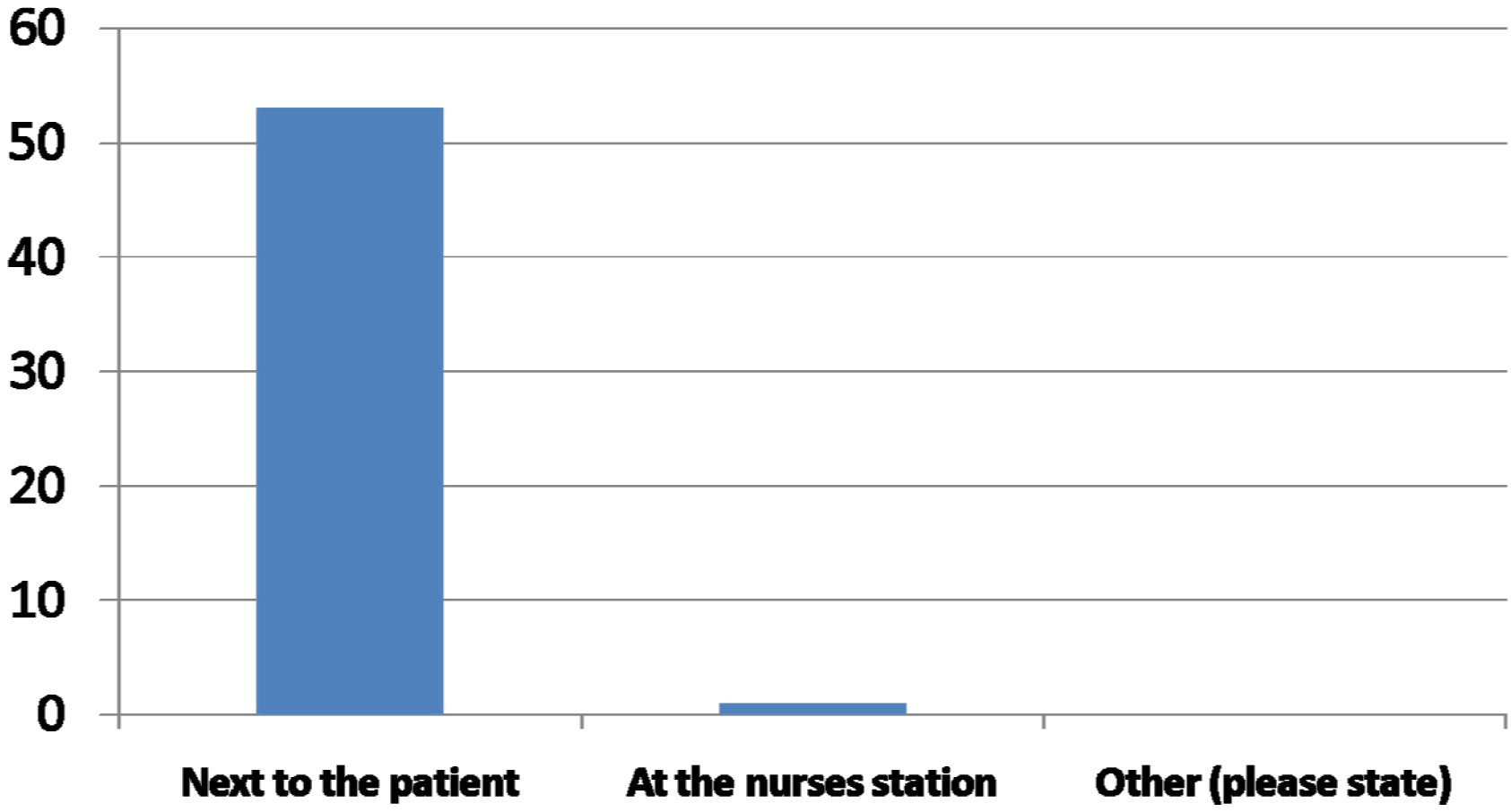
Q3: Is this patient an in-patient or a day case?



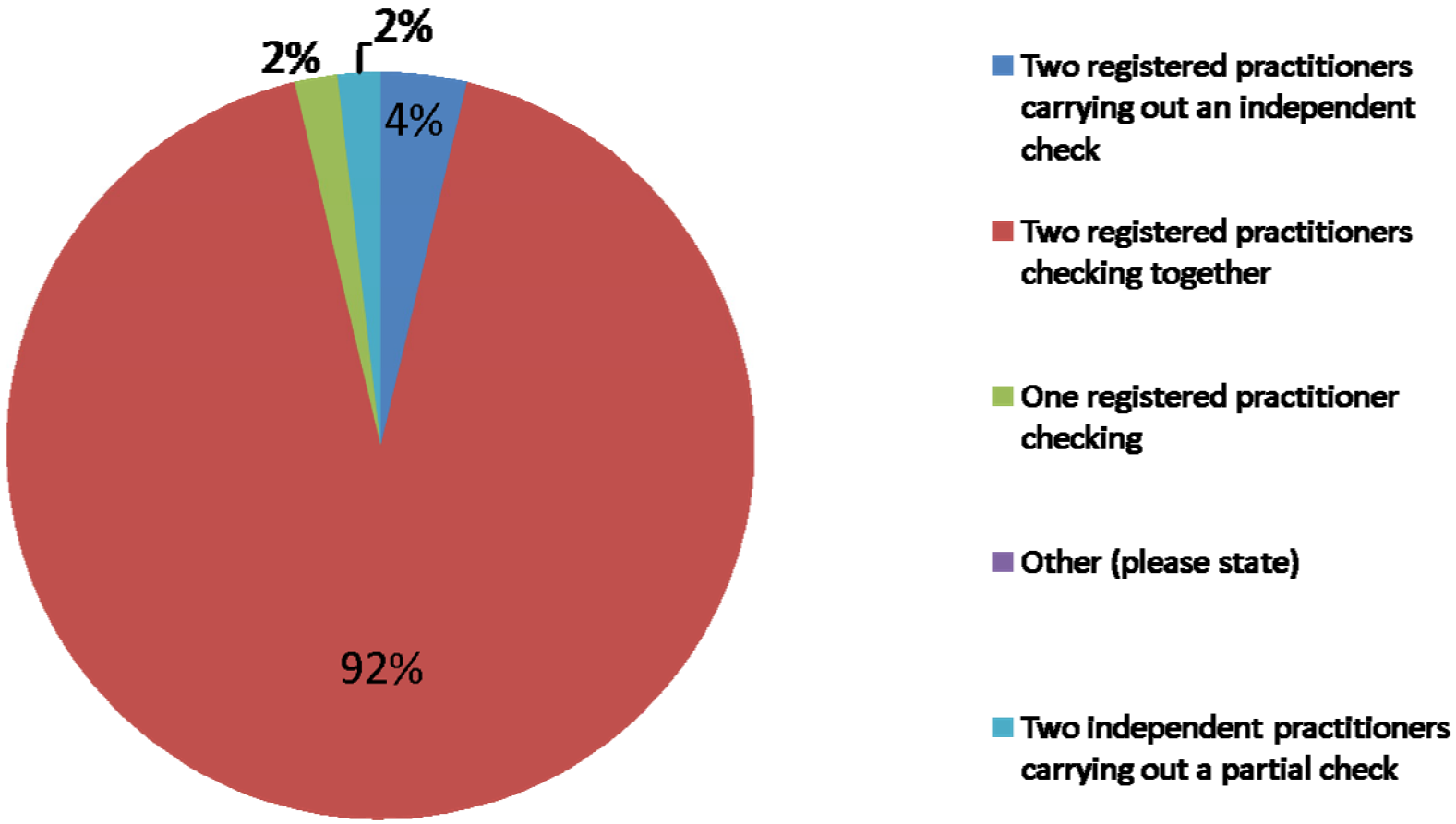
Q4: Is this patient an adult, child or neonate?



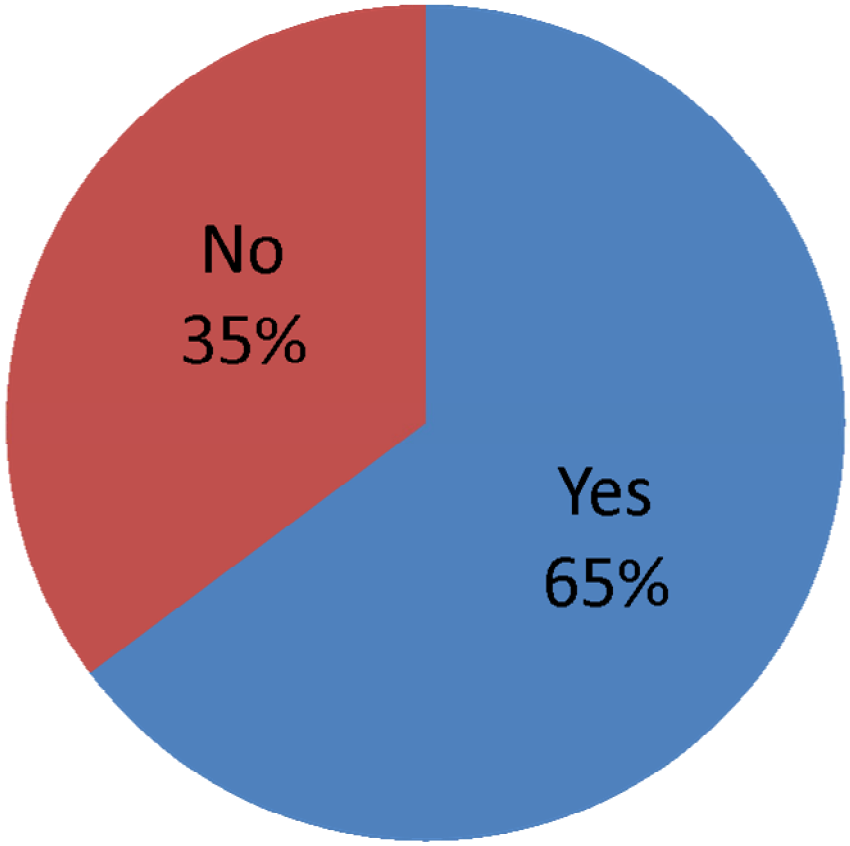
Q5: Was the final administration check carried out next to the patient, at the nurses station or other?



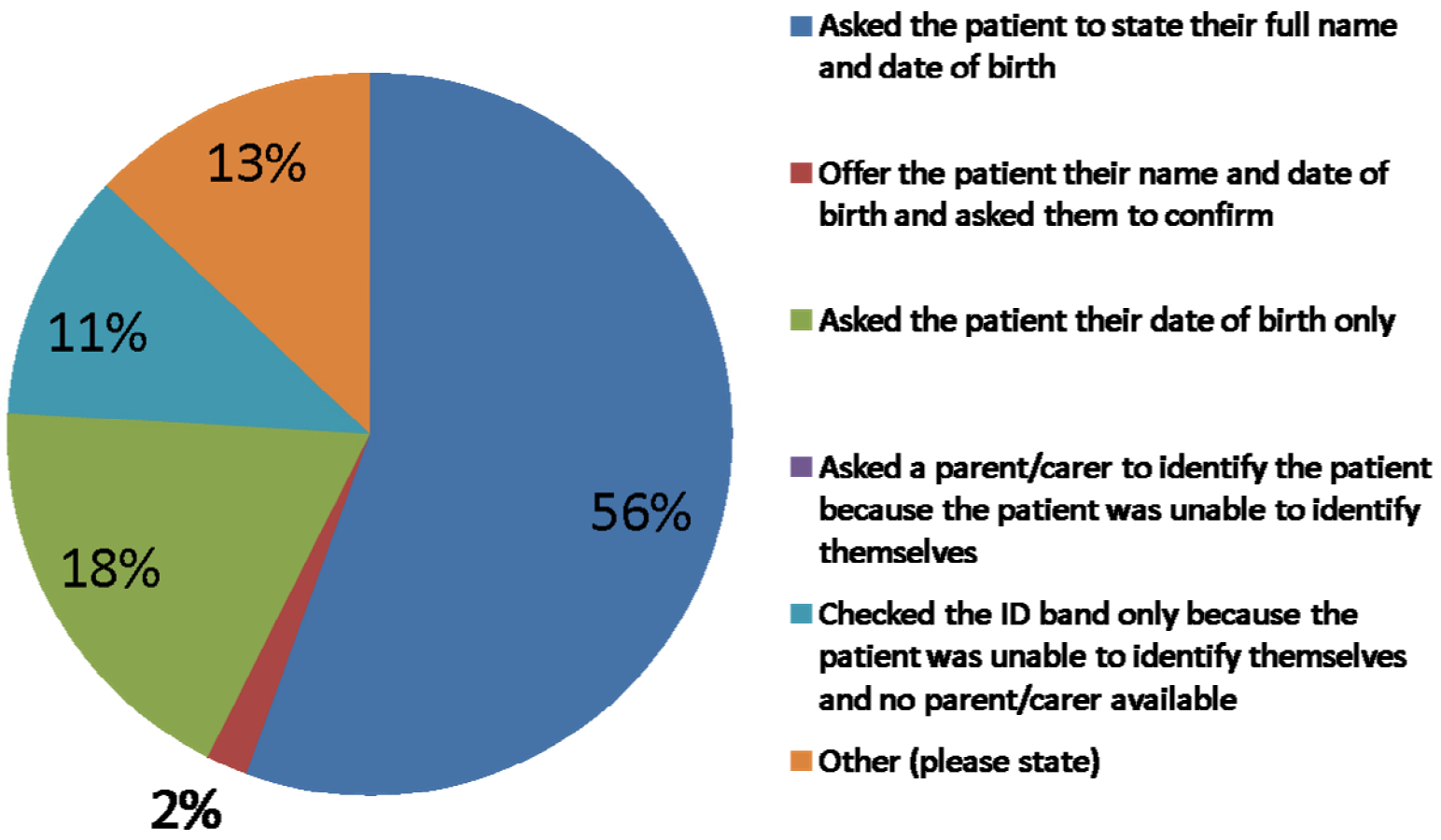
Q6: Was the checking/ administration process carried out by:



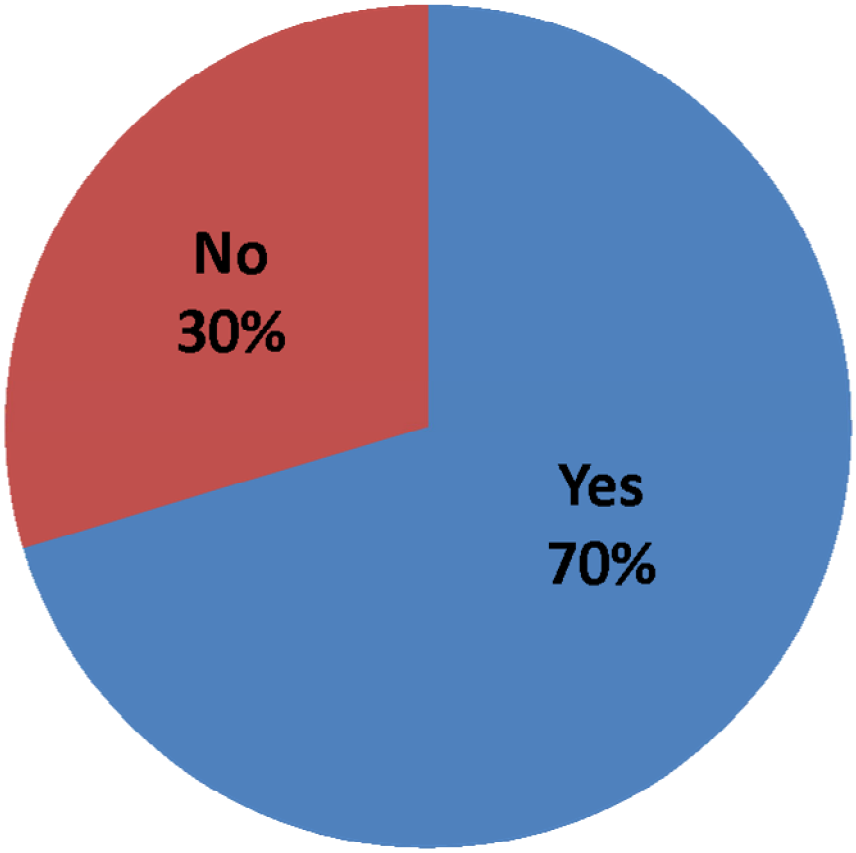
Q7: Were the compatibility report form and the patients clinical records used as part of the final bedside identification check?



Q8: How did the registered practitioners identify the patient?



Q9: Did the registered practitioners check the patient details matched on the ID band and the compatibility tag on the unit on blood?



Comparison of the Data Against the Standards

1. 98% of final administration checks were conducted next to the patient.
2. Staff checked together in many of the transfusion.
3. The compatibility form was used in the final bedside check.
4. 18% only asking for the date of birth.

Comparison of the Data Against the Standards

5. 30% of cases the ID band wasn't checked against the unit.

6/7. On 3 occasions only the ID band was used for positive identification.

Strengths

- Reduced selection bias.
- Anonymous.
- Prospective data collection.
- Easy method of data collection.
- Reduced observer bias as the outcome not directly related to the observers.

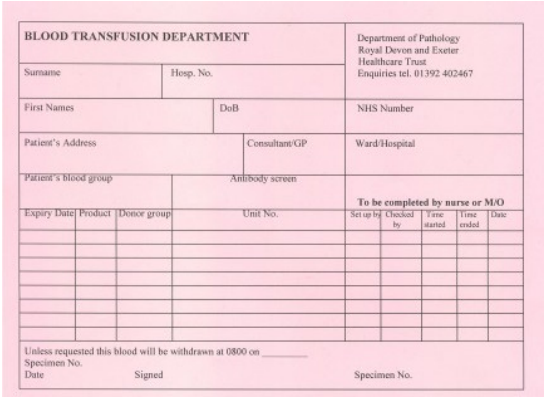
Limitations

- Small amount of data collected.
- Not representing all the transfusions taking place.
- Missing overnight and out of hours transfusions.
- Observer-dependant.
- Hawthorne effect?

Key Messages

- 2% of patient identification took place away from the patient.
- Issues over the correct identification of patients who are well known to clinical staff.
- Confusion over the procedure of the 2 person independent check.
- Confusion around how the compatibility forms fits into the checking process.

Action Plan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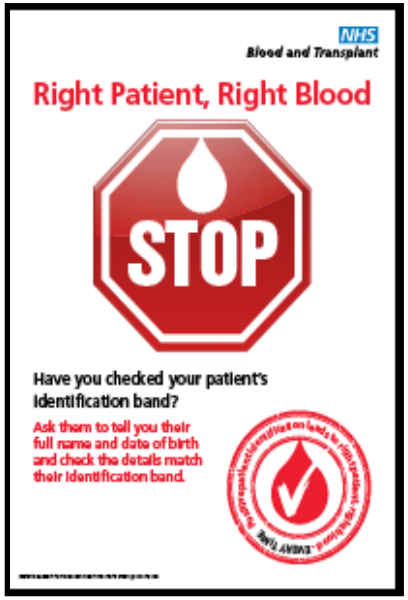
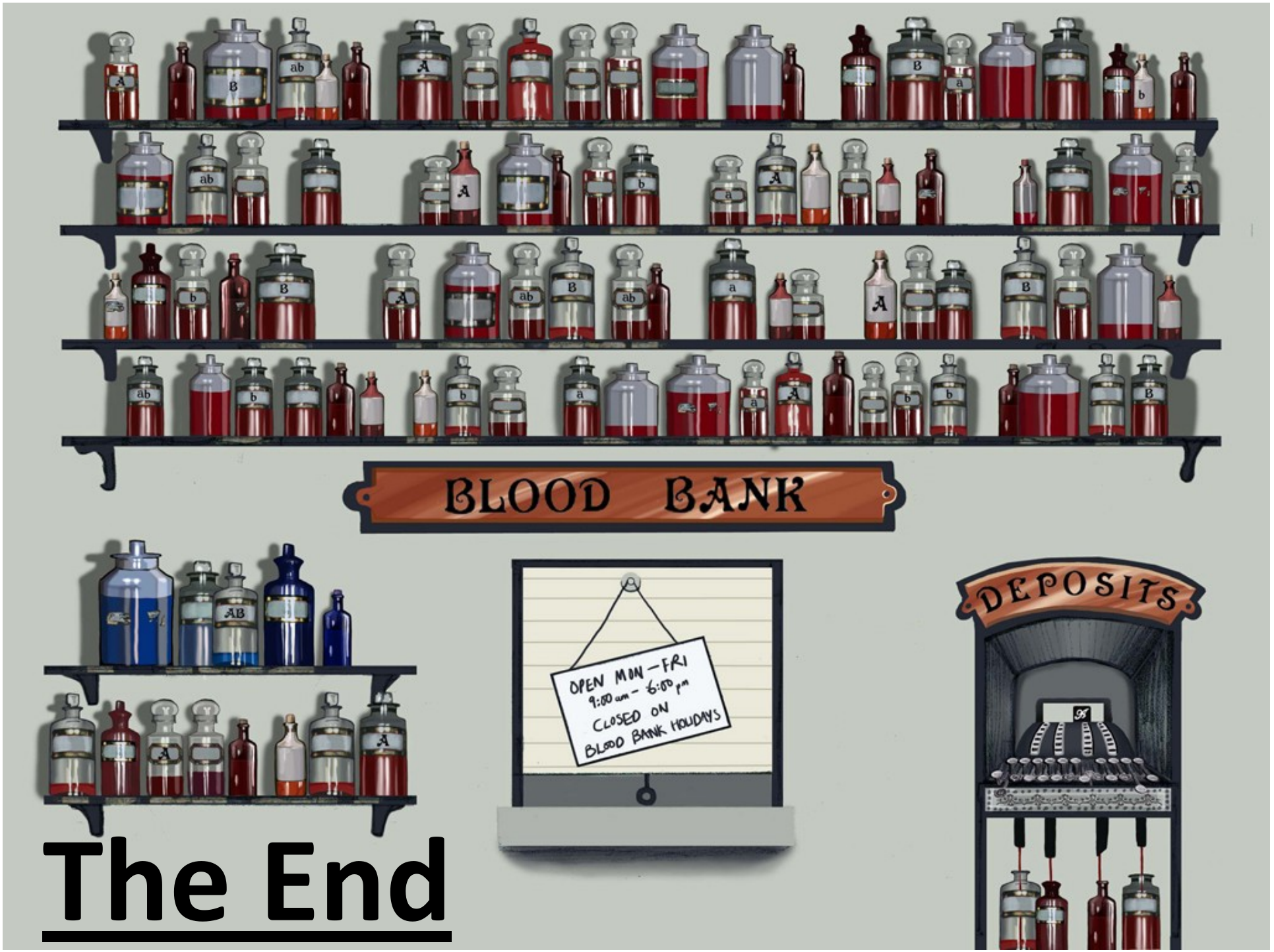
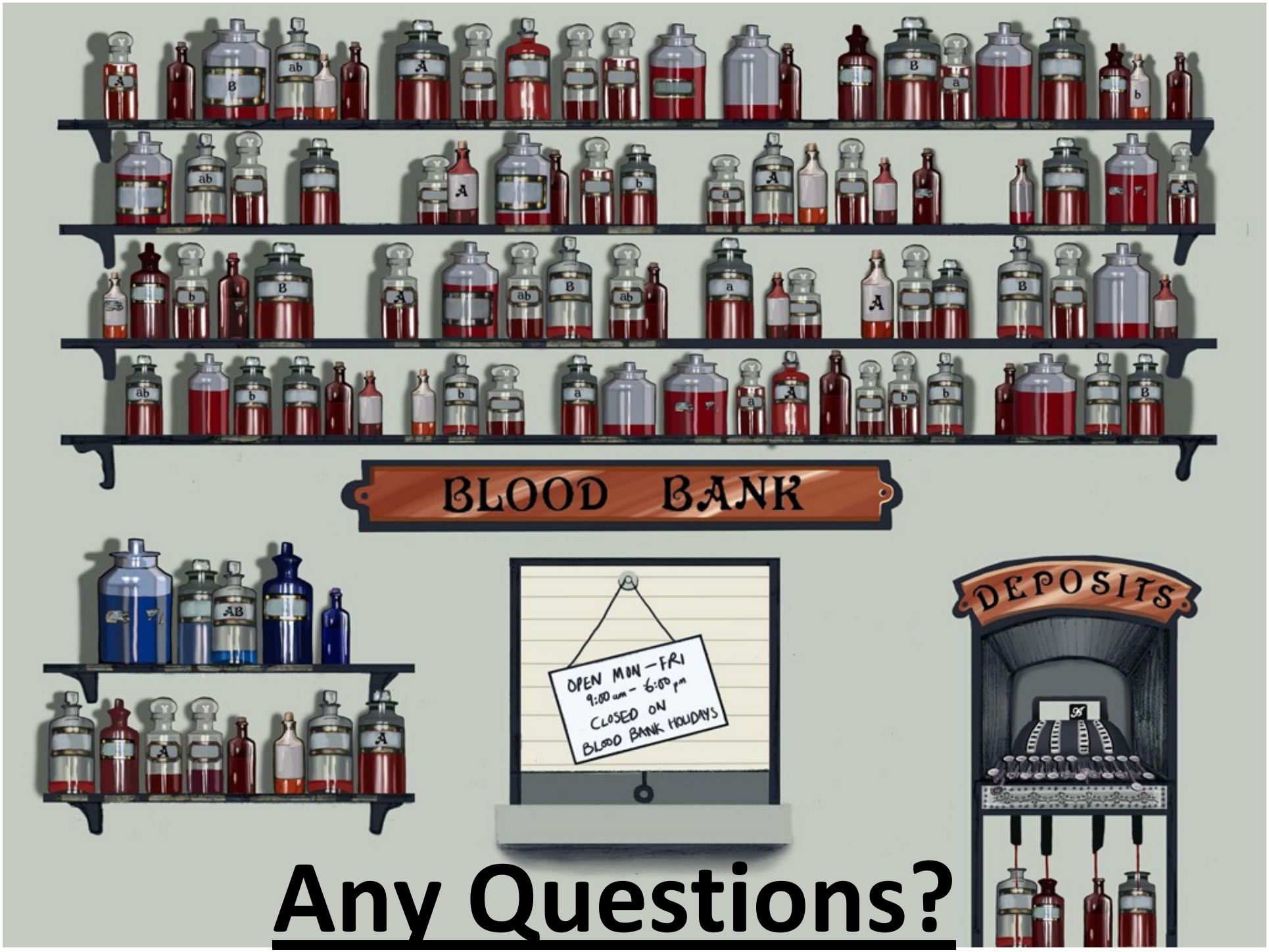
- Move to 1 person checks.
- Remove the pink compatibility form.
- 'Do you know who I am' campaign




BLOOD BANK
OPEN MON – FRI
9:00 am – 5:00 pm
CLOSED ON
BLOOD BANK HOLIDAYS
DEPOSITS

The End



Any Questions?

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