Making a difference – Mapping the way forward
Hazard Analysis & Critical Control Points

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National Comparative Audit of Blood Transfusion
HACCP Audit

- This is a novel method, used before in a DH funded audit of HIV testing
- It is a form of adverse event screening
- It is based on the principles of Hazard Analysis & Critical Control Points

(HACCP)
Advantages

- Quickly identifies potential for error in performance
- Quickly involves key stakeholders
- Useful as a means of quality assurance
- Useful in Risk Assessment & Clinical Governance
How it works

1. See the process in action
2. Describe it on a flowchart
3. Agree process is described accurately
4. Agree potentials for error
5. Agree Critical Control Points
6. Agree action plan
Getting to today’s meeting
Describe it on a flowchart

A - Knowledge → B - Equipment → C - Practice → D - Management
Getting to today’s meeting
Describe it on a flowchart

A - Knowledge

B - Equipment

C - Practice

D - Management

A1 Where the meeting is

A2 Why I am going

A3 What I need to do to prepare
Getting to today’s meeting
Describe it on a flowchart

A - Knowledge
  A1. Where the meeting is
  A2. Why I am going
  A3. What I need to do to prepare

B - Equipment
  B1. Get a car
  B2. Get a map
  B3. Gather together the papers
  B4. Find a pen that works

C - Practice

D - Management

Getting to today’s meeting
Describe it on a flowchart

A - Knowledge

B - Equipment

C - Practice

D - Management

A1 Where the meeting is

B1 Get a car

C1 Drive the car competently

D1 Distribute handouts during the meeting

A2 Why I am going

B2 Get a map

C2 Drive the car safely

D2 Answer questions to clarify what people do not understand

A3 What I need to do to prepare

B3 Gather together the papers

C3 Read the map competently

B4 Find a pen that works

C4 Speak without hesitation
Getting to today’s meeting
Agree Hazards & Critical Control Points

A - Knowledge
  A1 Where the meeting is
  A2 Why I am going
  A3 What I need to do to prepare

B - Equipment
  B1 Get a car
  B2 Get a map
  B3 Gather together the papers
  B4 Find a pen that works

C - Practice
  C1 Drive the car competently
  C2 Drive the car safely
  C3 Read the map competently
  C4 Speak without hesitation

D - Management
  D1 Make notes during the meeting
  D2 Ask questions to clarify what I do not understand
6 Action plan

A1 - Write the venue in diary as soon as it is known
B1 - Book car 7 days before meeting
B3 - Buy map 7 / SatNav days before meeting
C2 - Practice driving car before setting off for meeting
C3 - Practice using a map Sat/Nav while driving
1. See the process

- Visit clinical areas and ask staff to show you what they do when someone needs a unit of blood for transfusion
- Write down each step, clarifying as necessary
2. Process flowchart

- **A. Identify patient to be transfused**
  - A1: Sister tells auxiliary patient details
  - A2: Auxiliary goes to blood bank

- **B. Collect unit from Blood Bank**
  - B1: Auxiliary finds blood record
  - B2: Auxiliary locates unit in fridge
  - B3: Take unit to ward

- **C. Pre-transfusion checking**
  - C1: Nurse checks blood prescribed
  - C2: Nurse checks patient notes
  - C3: Nurse checks wristband
3. Agree accuracy

- Feedback to all staff for comments, asking if there any steps in the process that have been omitted or misunderstood
4. Agree potentials for error

A. Identify patient to be transfused
   - Sister tell auxiliary patient details
   - Auxiliary goes to blood bank

B. Collect unit from Blood Bank
   - Auxiliary finds blood record
   - Auxiliary locates unit in fridge
   - Take unit to ward

C. Pre-transfusion checking
   - Nurse checks blood prescribed
   - Nurse checks patient notes
   - Nurse checks wristband
Critical Control Point

- A step in a process which, if it went wrong, would lead to an adverse, undesired event.
- It is critical to ensure it does not go wrong in order to prevent adverse events.
5. Agree Critical Control Points

A. Identify patient to be transfused
   A1. Sister tell auxiliary patient details
   A2. Auxiliary goes to blood bank

B. Collect unit from Blood Bank
   B1. Auxiliary finds blood record
   B2. Auxiliary locates unit in fridge
   B3. Take unit to ward

C. Pre-transfusion checking
   C1. Nurse checks blood prescribed
   C2. Nurse checks patient notes
   C3. Nurse checks wristband
Anecdotal evidence

• Ask staff to relate recent anecdotes if they can recall failures at the Critical Control Points

• Totalling the number of anecdotes per critical control point allows weighting for importance
6. Agree action plan

- **Critical Control Point C3** - Patient wristband is checked for correct ID before transfusion starts

- **Action**
  
  2 nurses to check

  *Transfusion nurse to random audit*
Blood collected

Y

Pre-transfusion checks

Z

Transfuse

Observe patient

AA

Y1 Staff member who is to collect blood is told the name of the patient

Y2 Staff member goes to blood bank, selects unit and dates and signs blood bank form.

Y3 Staff member takes unit to ward and leaves it on nursing station

Z1 2 nurses check that blood is prescribed & prescription is signed

Z2 Patient identity is checked against the patient copy of blood bank form

AA1 Baseline temperature taken

AA2 Giving set number recorded

AA3 Hourly temperature taken. Patient labelled if necessary asked to report symptoms

Error possible?

Y1 Could give staff wrong name

Y2 Could collect wrong unit

Z1 Could fail to check

Z2 Could fail to notice mismatch

AA1 Could fail to take baseline temperature

AA2 Could fail to record number

AA3 Could fail to take temperature / label patient