Why is clinical audit important in Transfusion?

It allows standards of practice to be reviewed and the effectiveness of treatment monitored e.g. the usage of platelets within the Trust.

Local practice can be benchmarked against national guidelines and practice.

It can result in changes to practice. When changes to practice are implemented these can be evaluated.

Results can be evaluated and feedback given to staff.

Results of the audits can be used in the educational setting to further develop awareness and good practice.

Examples of completed Audits linked to the work of the Hospital Transfusion Committee

Use of Signed Addressograph labels for Blood Transfusion Samples and Requests

Department of Haematology- Local audit - signed addressograph versus handwritten labelling.

The use of addressograph labels is not recommended in British Committee of Standards of Haematology (BCSH) guidelines. However, at central we accept the use of SIGNED addressograph labels for blood trans supplies and requests. All requests between 14/10/03 and 14/2/03 were included in this 5th audit.

• Samples were checked for labelling errors as is normal practice.

2056 samples were received by the laboratory during this period.

• The use of addressograph labels accounted for 2233 (67%) of requests.

• A total of 54 samples (1.6%) were recorded with errors, 3 of these samples had multiple errors.

Sample origin and label type

The samples received during this period were divided into seven groups and label types as shown in chart 1 below.

Chart 1

Breakdown of sample origin and label type

- The single most common error was the omission of the signature from the sample, this error occurred more frequently with handwritten labels, differing from previous audits which showed a 50/50 split between the two label types.

- Other errors occurred less frequently and mainly on handwritten labels.

- All labels, which contained multiple errors were handwritten.

- Samples which contained errors were not accepted for analysis.

Conclusions

1. Of the 3356 requests received 54(1.6%) contained errors.

2. 67% of samples were received with signed addressograph labels.

3. Only 20% of errors were received on signed addressograph labels.

4. Main error was the omission of the signature on both label types.

5. Multiple errors were only found on handwritten labels.

6. All departments are predominately using signed addressograph labels.

7. The majority of errors were from MRI wards.

Dates of audits.

- March 2000. Errors 73/2000 requests (4%)

- December 2000. Errors 73/2000 requests (4%)

- November 2001. Errors 60/3582 requests (1.6%)

- May 2002. Errors 72/1988 requests (1.8%)

- January 2003. Errors 54/2935 requests (1.6%)

The overall findings of this continuing audit show that as part of the Transfusion Process each must adhere to the Trust Blood Transfusion Policy when collecting samples. This is regardless of whether signed addressograph labels or handwritten labels are used.

The percentage of errors has decreased since the initial audit commenced in March 2000 from 4% to 1.6% in January 2003. However errors still occur and staff must be vigilant in following the checks in the policy. The results of the audit are reported to the Hospital Transfusion Committee.

If an error occurs at the blood sample collection stage of the transfusion process, serious consequences could occur, for example and ABO incompatible transfusion. Therefore following the protocols of the policy is essential to maintain patient safety.

National Comparative Audit of Blood Transfusion 2003

Introduction

The audit is, in part, a repeat of an audit performed by the Royal College of Physicians in 1995 and is based on guidance issued by the British Committee for Standards in Haematology (BCSH) 1999.

The standard criteria in the audit were taken from the BCSH guidelines. The Trust Blood Transfusion Policy Version 3.0 incorporates guidance provided by the BCSH.

Objectives

The aim of participation in the audit was to compare performance at Manchester Royal Infirmary against the Standard, for Blood Transfusion Practice.

The audit involved the collection of information on current and post questionnaires were used.

The aim was to evaluate the effectiveness of training sessions pre and post questionnaires were used.

The audit is, in part, a repeat of an audit performed by the National Blood Service auditors selection areas of users to be audited.

Standard 1 - Identified all in-patients were name-bands, 6 had age rather than date of birth. The Day Case area did not use name-bands. 10 out of the 12 patients in this area audited knew their hospital number and this was used in the checking procedure.

Standard 2 - 39 out of 40 signed either the Summary or IV Fluid Prescription Sheet.

Standard 3 – Dates and times of transfusions are adequately recorded (start and end of transfusion times).

Standard 4 – The rationale for transfusing blood is recorded in medical notes.

Results of the audits can be evaluated and feedback given to staff.

When changes to practice are implemented these can be evaluated.

Results can be evaluated and feedback given to staff.

Results of the audits can be used in the educational setting to further develop awareness and good practice.

Conclusions

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If an error occurs at the blood sample collection stage of the transfusion process, serious consequences could occur, for example and ABO incompatible transfusion. Therefore following the protocols of the policy is essential to maintain patient safety.

Future planned actions from the audit will be to evaluate other transfusion documentation. This is linked in with a recent completed audit on red cell usage in adult medical patients.

Transfusion Awareness Questionnaire

The aim was to evaluate the effectiveness of training sessions pre and post questionnaires were used.

A simple question was used to look at pre and post transfusion awareness after attendance at one of the Transfusion Awareness training sessions.

Results Summary

Initially 50 post questionnaires were sent out to staff who had attended training within the last six months, however only 13 were returned. It was then decided that the questionnaires would be given out at the beginning and the end of each session. In total, 45 post questionnaires and 35 pre questionnaires have been used for the audit.

There was an overall improvement in the answers to the post questionnaires with greater understanding of the use of blood and blood components.

It was interesting to see that very few staff had any formal sessions on transfusion awareness. The results of the above related only to nursing staff, but on correlating the results received from medical students it was very similar.

It shows that there is a place for education as a tool in developing staff awareness especially in relation to minimising risk and promoting good practice.