Sample collection and Blood Administration

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Objectives

- Reliability and acceptability in ITU
- Accurate positive patient identification
- Production of a complete transfusion history whilst on ITU

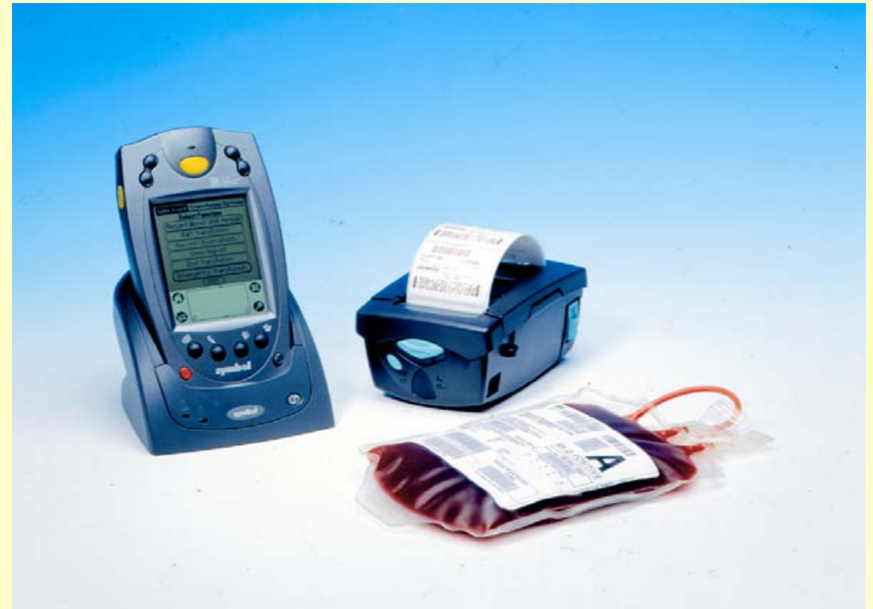
Methodology

- Equipment
  - Wrist band printer
    - Linked to PAS
    - Produces waterproof, smearproof and tear proof wristbands
  - 3 PDAs
  - 3 printers
    - Sample labels at the bedside

Safe Track Elements

- Portable data terminal
- Portable Printer

- Positive Patient ID using barcoded wristbands



Methodology

- Training
  - Issues with data capture led to a period of retraining

Results 01/01/03 - 30/06/03

- 457 patients admitted to ITU
- Blood Bank computer showed 110 patients (24%) had received a transfusion

Results 01/01/03 - 30/06/03

- Only 56 patients (12.3%) had any record of transfusion data in the Safetrack system. Many had multiple entries.
- 223 patient episodes on the system
- 29 training episodes on the system

Errors detected

- 69 episodes recorded mismatch of information.
  - Mis-spelling of names
  - Mis-matches in date of birth
- 1 wrong patient detected at the bedside

Monitoring of transfusion

- Recorded in 159/223 occasions
- 22 documented reactions
- 2 adverse reactions

- 26/223 recorded volume transfused

Discussion

- High non-compliance in using Safetrack system
  - Training/staffing issue in ITU
  - Only in patients where request made from ITU would the compatibility label have a PDF barcode printed
  - No PAS link with transfusion computer

PDF barcodes

Conclusion

- Mismatches are quickly identified at the bedside
- Using the device on an "ad hoc" basis is of little value in tracking blood transfusions and monitoring the safety of transfusion practice.
- Repeated training and evaluation is necessary and use needs to be mandatory.