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.