

# 2008 Bedside Transfusion Re-audit

## Headlines

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# Number of cases audited

- 9037 transfusions audited
- Data came from 264 hospitals / Trusts in England, Scotland & Wales
- Good participation this time from independent sector, including treatment centres and a PCT

# Key findings

- Some patients transfused without wristbands
- Information is missing or mismatched on identification
- Pre, intra and post-transfusion obs not done
- **Same old messages!!**

# Wearing ID for the transfusion

- 8798 of 9037 (97%) patients had a form of ID. 236 did not. 3 replies left blank.
- Form of ID worn
  - ID band = 8685
  - Photo ID = 24
  - ID badge = 11

# So who's not wearing ID?

- Of the 236 patients not wearing ID
  - 76 (32%) were day cases
  - 160 (68%) were inpatients in a wide range of specialities

So why not?

# Reasons for inpatients not wearing ID

- 23 not put on by nursing staff
- 49 taken off by staff and not replaced
- 18 taken off by patient and not replaced
- 2 carried, not worn, by patient
- 14 Don't know
- 11 other
- (43 not stated)

Patients limbs grossly oedematous

Patient details had fallen out of the wrist band

identity band on bedside table

Identification attached to babies cot due to skin rash it cannot be worn (skin rash not related to transfusion)

Patient was complaining (last week) that it was annoying her wrist

Wristband on patient is broken, patient details have fallen out of cover

Oedematous limbs

No visible patient name, date of birth or hospital number - all information missing, possibly worn off through washing/bathing.

All written identification seems to have been washed off

Wristband found in cot, ? had been cut off by a member of staff for line insertion and not replaced

Geriatric Patient

# Completeness of information

- Last name on ID = 8775 (99.7%)
- First name on ID = (99.4%)
- DOB on ID = (98.5%)
- NHS number on ID = (20.7%)
- Hospital number on ID = (76.1%)
- Other number on ID = (0.01%)
- 4 completely blank!!

# Mismatched information

- Some evidence of
  - DOB wrong
  - ID numbers mismatching or incomplete
  - Names not matching patient statement

# Pre-transfusion Observations

- Taken up to 60 minutes before unit started
  - BP = 8099 (89.6%)
  - Pulse = 8081 (89.4%)
  - Temp = 8022 (88.7%)

887(9.8%) patients with no recorded pre-transfusion obs

# Observations taken at 15 mins

- Pulse = 2824 (31.2%)
- Temp = 2760 (30.5%)

Range is 1 minute to over one hour after unit started transfusing

# Post-transfusion Observations

- Taken up to 60 minutes after unit finished
  - BP = 5638 (62%)
  - Pulse = 5648 (62%)
  - Temp = 5577 (62%)

No post-transfusion obs = 530 (5.8%)

Don't know = 269 patients (2.9%)

Blank = 2545 patients (28.1%)

# Questions

- Is it ever acceptable to transfuse a patient who is not wearing a form of ID?
- Why are some data items missing from ID?
- Is taking observations important? If so, why is it not done?
- How do we translate these findings into risk?
- What can we do to improve practice?

- **Project team:** Dr. Hari Boralessa, David Dalton, Dr. Dora Foukaneli, John Grant-Casey, Tanya Hawkins, Derek Lowe, Allan Morrison, Prof. Mike Murphy, Dr. Craig Taylor, Denise Watson, and Katharine Young
- Hospital staff who collected the audit data