Wristband Audit at Cornwall Community Hospital

Judy Kyte, Patient Safety Coordinator, Cornwall Community Hospital and Dr. Elianna Saidenberg, Hematologist, The Ottawa Hospital

When the Transfusion Committee at Cornwall Community Hospital (CCH) recognized that a current transfusion practice, initially put into place to protect patient safety, actually posed significant risk, we undertook to make some changes.

The task: to discontinue use of a separate blood ID band and ensure only the patient ID wristband is used for identifying patients needing transfusion therapy. The blood bracelet had a long history at CCH and there was significant resistance to its discontinuation. We had to prove to naysayers that this change would indeed be a safe one. One concerned party indicated that compliance with wristband use was suboptimal and therefore not an appropriate method of identifying patients. An audit was therefore designed to determine the hospital's compliance with accurate ID wristbands.

During the summer of 2011, a total of 180 patients were audited in the Emergency Department, CCU, Day Surgery, PACU as well as all in- patient units. Some high risk, high turn-over areas were audited on more than one day.

Patients were considered correctly identified if they were wearing their ID band on their arm or ankle and if the information was legible and correct.

Our results showed that 88% of patients reviewed were correctly identified. The results were presented to the Transfusion Committee, Nursing Leadership and Nursing Advisory Committee. Gaps have been identified and individual departments will develop plans to improve their compliance. Follow up audits will be done to ensure that the improvements made are sustained.

A small bump in the road presented itself when it was discovered that the blood bracelet system also included stickers that were used as compatibility labels on the components. New stickers were found and purchased and we are thrilled to report that as of November 2011 the blood bracelet system is a historical artifact at the Cornwall Community Hospital. It is our first major undertaking to improve transfusion safety, but it won't be our last!

CASE STUDY: "Point of Care" Blood Banking

Setting: Ms. Smith*,an 85 year old female from the local nursing home is found to have decreased levels of consciousness and is brought into the emergency room of Hospital A. Her Hgb measures 70g/L which is decreased from 110g/L when last checked 3 weeks ago. Her ECG shows signs of cardiac ischemia. At the same time the Ontario Provincial Police (OPP) reports to the ER that a nearby motor vehicle accident has occurred and that more information will follow. *(*name has been changed)*

Background information: Hospital A is a small rural hospital with 6 beds, an ER, limited point of care testing, is not accredited by Ontario Laboratory Accreditation, and is affiliated with a nearby long term care facility. It maintains an emergency stock of 2 units of O RhD Neg RBCs and stores crossmatched RBCs for patients that have been supplied by hospital B. Hospital B is a community hospital supporting Hospital A's transfusion needs. They receive specimens for compatibility testing and prepare and ship crossmatched RBCs as well as provide the emergency stock of 2 units of O RhD Neg RBCs.

Description of event: The ER physician deems a transfusion is necessary for Ms. Smith but is reluctant to use the group O trauma stock due to the recent OPP report. There are 2 units of group A RhD Neg RBCs available in the ER fridge, crossmatched for a young woman who gave birth two nights previously.

CASE STUDY: "Point of Care" Blood Banking *continued*

Ms. Smith's chart result, faxed from the nursing home indicates that she is group A RhD Pos, antibody screen negative. The ER physician orders the two units of group A RhD Neg RBCs be transfused to Ms. Smith. During the first unit Ms. Smith's temperature increases from 36.5 to 39.6°C accompanied by rigors and hypotension. The transfusion is stopped and the medical director from the blood bank at Hospital B is consulted. Ms. Smith is then transferred to Hospital B for further investigation. Upon arrival, she has low grade DIC and acute renal failure.
Laboratory findings reveal that Ms. Smith is actually group O RhD Pos with a previously detected anti-Jka still reacting in her plasma. The DAT is negative at the time of testing. The implicated unit is found to be crossmatch incompatible by immediate spin.

Conclusion: It is determined that the nursing home accidently faxed the results for a different patient, also named Smith, to the ER at Hospital A, resulting in the erroneous assignment of her blood group. Ms. Smith was placed on chronic dialysis and her family was informed of the error.

Question to Ponder: In the absence of a licensed laboratory at hospital A, which facility should be held responsible for ensuring that appropriate transfusion policies are in place at hospital A?

Please refer to our website www.transfusionontario.org February 29, 2012 for a posting of a discussion paper on this case study. Compare your answers to the question posed.

Upcoming Educational Events Calendar

Event	Where	When
Annual ORBCoN/CBS Spring Symposium	Toronto, ON	March 23-24, 2012
Annual Videoconference Symposium	Sudbury/OTN	April 18, 2012
CSTM Annual General Meeting and Expo	Halifax	May 24 -27, 2012
LABCON 2012	Gatineau	June 2-4, 2012

For a complete list of upcoming events please visit www.transfusionontario.org

Quote

Our greatest glory is not in never falling
but rising every time we fall.
~ Confucius

Contact Us

transfusionontario@ottawahospital.on.ca **www.transfusionontario.org**

Central ORBCoN Office	Northern and Eastern ORBCoN Office	Southwest ORBCoN Office
416.480.6100 ext. 89433	613.798.5555 ext. 19741	905.525.9140 ext. 22915