Service Priorities and Programmes

Electronic Presentations

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B.E.S.T' After Implementation of IPMOE

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Introduction

In-Patient Medication Order Entry (IPMOE) had been implemented in 2016. As the paper Medication Administration Record (MAR) was no longer been used, the practice of blood transfusion administration & documentation had been changed accordingly. A transfusion Box was designed to Enhance Safe Transfusion. (B.E.S.T)

Objectives

1) To assess the nurses' compliance in this change of documentation practice for blood transfusion after the launching of IPMOE in Department of Medicine &
2) To assess the effectiveness of a simple innovative to facilitate the adherence to the transfusion guideline.

Methodology

1. To determine the non-complied items of the staff in performing blood transfusion documentation, a preliminary retrospective audit was held on 45 samples, retrieved via CDARS, of in-patients who received blood transfusion in Department of Medicine from 1 Dec, 2016 to 30, Dec 2016.
2. Compliance in '15 min vital sign taking' & 'entries in the post blood transfusion record sheet' were found to have room for improvement.
3. A plastic container grouping with i) timer, ii) transfusion chop & iii) newly designed clip reminder is prepared to enhance nurses' compliance.
4. A post evaluation audit was conducted on 348 samples during Apr-May, 2017.

Result

After implementation of blood transfusion kit, there were improvements in compliance in both criteria of '15 min vital sign taking' which increased from 81% to 99%; & 'complete of transfusion record' which was 81% from 51%. The Major missing items in transfusion record were 'Finished time' & 'Reaction'.
Blood product administration was carried out in 98.8% by two nurses, 100% with verifying by 2D barcode technology.
Obtain consent & Pre-transfusion nursing observation & record were performed in 100%. All documentation in IPS was well use of standardized transfusion chop

together.
2 episodes of adverse reaction developed after commencing the blood units. All the cases were early-detected and documented in patients' IPS with appropriated treatment. 10 % of the audit samples perform inappropriate vital sign charting on patients' IPS instead of observation chart.
The post audit result shows markedly improvement with non-complied items, with a continual comparative trend. Further promotion on proper vital sign charting on observation chart and periodically booster audit on blood transfusion may be considered.