



Service Priorities and Programmes
Electronic Presentations

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Enhancement on Better Workflow and Safe Practice of Blood Taking in Primary Health Care Setting -- East Kowloon General Outpatient Clinic

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Introduction

Multiple factors contribute to the unsafe practice of blood taking such as multi-tasking, distraction, insufficient education and training of staff. In order to minimize the risks in patient identification, specimen labeling or specimen loss, a well-designed clinical setting and smooth workflow should be established.

Objectives

Safe practice for better health care: streamline the workflow of blood taking to deliver the right specimens to the right place for right investigations. Ultimately, patients could receive care timely and safely

Methodology

1. Meeting with management and administration team, discussion among different ranks including nurses, PCAs and OpA at 1Q2016.
2. Problems identified :
 - a) distraction to staff for handling blood taking and collection of other specimen simultaneously.
 - b) the crowded setting may induce needle stick injury
3. Modifications implemented :
 - a) Re-design the floor plan of treatment rooms and nurse stations on 2 Q Jan 2016.
 - b) Designated patient Care Assistant (PCA) collects specimens other than blood specimen while the phlebotomists and nurses take blood specimens only.
 - c) OpA helps to triage the patients for taking blood test and hand in other specimen separately.
 - d) Double checking system is introduced:
 - (i) Phlebotomist and PCA independently check the total number of blood specimens collected which should be equal to that of investigation reminders prescribed.
 - (ii) Nurse and PCA independently check the total number of all blood and others specimens before sending out.
 - e) PCA traced reports at the afternoon session on the specimen receiving day or the following morning session.
4. All the related records should be kept for 1 year.
5. Nurse in charge audit the blood taking procedure on July 2016. And clinic management team had also visited the clinic for monitoring the improvement work.

Result

Patients and staff feedback for the better workflow implemented. And the risk of patient identification, specimen labelling or specimen loss were greatly reduced. Incidents decreased from 3 in 2015 to 0 in 2016. Even though the daily quota of blood taking increased from 45 to 70 from 2016 - 2017, just one incident on wrong specimen labelling.

Safe practice is an important enabler of change in blood taking. A systematic review of each service interface finds necessary changes of clinical setting and workflow. Moreover, the team effort is a key of success.