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Transfusion Training Programme for Nurses to Ensure Safe Type & Screen (T&S) Procedure in Cardiothoracic Surgery

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Introduction

A specially-designed training program on T&S procedure was developed for nurses in CTSD in QMH because nurses are the main personnel to carry out the procedure. The programme covers the standard procedure for patient identification and blood collection for new comers and highlights the risks associated with the procedures & the ways to mitigate those risks by video show for refreshers. Each new comer shall complete the Practical Skill Workshop under the assessment by the trainers to make sure all the steps are correctly taken & the 2D-barcode equipment is properly used. Trained nurses are endorsed by the QMH Blood Transfusion Subcommittee before practicing in clinical setting

Objectives

To review the training programme and to study its outcome, since its implementation from September 2008, to December 2012.

Methodology

Training records were reviewed. The number of T&S requests performed by CTSD was retrieved from the Blood Bank Laboratory Information System. Incidents related to transfusion request were retrieved from the HKWC haemovigilance database. Incidence data related to CTSD was benchmarked with that related to QMH T&S requests.

<u>Result</u>

Result: A total of 88 nurses had been trained under the training programme, with refresher training carried out for 52 nurses. The number of incidents related to transfusion request was small, ranging from 3 to 5 incidents each year, with a mean incidence of 0.338% (0.222% - 0.694%). All incidents were minor ones with no case of wrong patient identification. The incidence was, however, higher when comparing with the mean incidence of transfusion request in QMH, 0.194% (0.126% - 0.248%) during the same study period. The number of T&S requests increased (432 samples in 2008; 2189 in 2012), which also contributed an increasing percentage of T&S in QMH (1.15% in 2008; 6.51% in 2012). Despite these increased figures, the percentage to

CTSD's transfusion incidents was decreased from 0.93% in 2008 to 0.27% in 2012 Conclusion Although the absolute number of incidents related to transfusion request carried out by CTSD nurses was low, the incidence of which was relatively high when compared with QMH haemovigilance data, suggesting room for improvement and emphasizing the importance of continuous training programme This study also illustrated the effectiveness of training as shown by the decreasing incidence of transfusion incidents despite an increase in requests during the study period.