



Service Priorities and Programmes Electronic Presentations

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Blood Sampling Audit in Intensive Care Unit

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Introduction

Owing to the frequent feedback of blood samples with missing identified labels reported by laboratory, an audit to evaluate the compliance of ICU nurses in blood sampling process was conducted.

Objectives

(1) To study ICU nurses' compliance on blood sampling process; (2) to arouse staff awareness in blood sampling procedure and handling; (3) to recommend strategies for continuous surveillance.

Methodology

The study was carried out from 9th to 13th May 2016 in PYNEH ICU, all ICU Nursing Officers and Advanced Practice Nurses were invited as auditors in the study. Random samplings by means of lot draw of patient's bed numbers. The audit information was delivered to all ICU nurses via emails and posted on notice board beforehand. Once the bed numbers were drawn out randomly as the study groups, the case nurses were notified and they were required to approach auditors for blood sampling audit during blood taking. All 9 standard criteria on the checklist were expected to go through during each audit. In addition, 2 of the 9 items were critically important which were denoted with a "*" included (1) stick label on the specimen bottle; (2) after taking blood specimen, check again patient's name, HKID number on wristband, blood specimen prescription job sheet & dedicated specimen bottle. Focus on these critical items, 100% compliance was expected.

Result

Result

28 audits were recruited during the study period. Among all, 4 could not pass all 9 standard criteria in which at least one critical item was not passed. Only 85.7% compliance rate achieved in critical item *(2). Staff were reinforced for the importance of checking patient's names, Identity numbers versus blood sampling job sheets and stuck the appropriate labels on correct specimen bottles before sending out. Besides, a few staff were found on the wrong sequence of blood taking bottles incidentally.

Conclusion

ICU nurses were competent in blood sampling process resulting in 97-98% compliance rate. However, there is no doubt that it's easy to get wrong when staff were distracted or in emergency. Self-devised reminder cards were posted up in ward area to enhance staff's alertness. Furthermore, extra attention should be paid during blood sampling process so as to minimize incomplete checking of specimens leading to possible delayed laboratory result interpretation and hence violate patient's safety.