

Implementation of

Single Person Checking of Blood

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In conjunction with Multi-Disciplinary Trust Teams

Background

British Committee for Standards in Haematology (BCSH) first recommended single person checking back in 1999.

All Scotland Trusts, some English and Welsh Trusts introduced a single staff pre-administration check in light of evidence that a single checker taking full accountability was as safe or a safer practice. It was found that Trusts who had implemented single checker DID NOT report more incidents in pre administration check.

The current process was leading to delays in transfusion while causing interruptions that compromise patient safety.

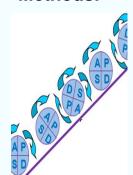
The principle objective of this project was to establish single person administration of blood components into practice within the Belfast Health and Social Care Trust (BHSCT).

The project began with a pilot in the Acute Oncology Haematology Unit (AOHU) and the Haemophilia centre in June 2019 for 8 weeks.

AIM

To improve patient safety, and the efficient use of staff time, in transfusion pre-administration checking by changing from a two person check to a single person check in BHSCT by September 2020.

Methods:



Cycle 1: Prequestionnaire & observations.

Cycle 2: SOP drafted & tested.

Cycle 3: SOP adapted & tested.

Cycle 4: Post- questionnaire & observations undertaken.

Cycle 5: Project results presented to Nursing Executive Team resulting in full support to scale and spread Trust-wide.

Cycle 6: Implementation plan developed and rolled out Trust-wide via Divisional Nurses.

Process Measures

- Reduction in staff time preforming pre-administration check
- Reduction in delays to start of transfusion due to need for second checker
- Reduction in incidents of interrupting staff

Outcome Measures

 Use of single transfusion preadministration checker

Balancing Measures

- staff being more confident in doing a transfusion pre-administration check on their own
- incidents in pre-administration checks

Driver Diagram

Aim

To improve patient safety, and the efficient use of staff time, in transfusion preadministration checking by changing from a two person check to a single person check in BHSCT by September 2020

Primary Drivers

Ensure a safer transfusion preadministration check system

Improve the patient experience by ensuring a more fluid transfusion pre-administration system

Improve Staff confidence in single transfusion preadministration checking Secondary Drivers

To reduce the time taken to do preadministration checks

Prevent delays in setting up transfusion due to need for second checker

Determine staff concerns and provide evidence of a safer system Tests of Change

Trust protocol and documentation to allow for single pre-administration check

Monitor timings in a single checker process

staff feedback to monitor confidence

Reduction in transfusion delays due to the need for a second checker

Staff Comments Pre-Pilot:

"Think it is safer with double checker"

"Always been taught to double check"

"Risk of an allergic reaction, IV drugs have two checkers"

"I would prefer a second checker for peace of mind"

Results & Outcome

After 3 months of pilot results indicated:

- 100% staff felt confident performing single person check.
- 83% staff who responded in AOHU feel pre administration check was more thorough being a single person checker.
- 100% of staff who responded in AOHU noticed a reduction in distractions due to not being asked to double check blood components.
- 83% staff in AOHU who responded felt it improved the patient experience due to it being faster and more timely allowing the patient to return home.

Overall staffs concerns faded and confidence grew in using single person checker with none of the pilot areas wanting to revert to double checking post pilot. Full implementation was rolled out across Belfast Trust in November 2020 (currently excluding paediatrics and neonates).

Staff Comments Post-Pilot:

"double checking was time consuming"
"safer one person checking"

"I don't want to revert to double checking, this has been a much more streamlined process"

Key Learning:

Implementing this project was difficult in terms of cultural change, however in working with staff to understand the need for change and how the outcome could benefit both staff and patient the realisation for the need began to take momentum. Communication to eliminate concern and reassure that this change had the patient at the center was crucial in implementing a safer patient protocol.

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