Breaking the Walls of Blood Transfusions to Form a Patient Safety Bridge

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Objective

To review Lehigh Valley Hospital – Hazleton's success in implementation of the "Transfusion Administration Record", also known as "TAR", an electronic method of administering blood products in the hospital setting via bedside barcode scanning.

Organizational Facts

- Lehigh Valley Health Network's mission is to heal, comfort and care for the people of our community by providing advanced and compassionate health care of superior quality and value, supported by education and clinical research
- Lehigh Valley Hospital-Hazleton has more than 100 highly trained and well-respected physicians that serve over 100,000 people throughout the Greater Hazleton area

Collaboration for TAR

- Past practices of blood administration needed revision to promote the highest quality of patient safety in the acute care setting
- New ideas for administration needed to be presented and discussed between departments
- Brain storm with Laboratory, Blood Bank, Informatics, and Nursing Administration for ideas
- "Transfusion Administration Record" (TAR) module offered within hospitals current EHR vendor

Rollout/ Implementation

- Contacted EHR vendor to inform them of possible implementation and receive correct timelines for rollout
- Multidisciplinary team meeting to discuss roles for departments for testing: Lab directors, Clinical Informatics, Registration.
- Rollout plan was based upon best practices that promoted patient safety.
- Once module was delivered, testing/building proceeded between blood bank super users and informatics nurses.
- Mandatory one hour training classes scheduled for all end users including staff nurses and nursing supervisors. Classes offered for every shift, 55 total classes for 350 end users. End users signed competency sheet upon class completion.
- Go-live hospital wide; close monitoring of all blood administration. Mandatory requirement that staff goes through process with informatics nurse for first time administration to patients
- 24 hour Informatics support offered for first two weeks of implementation

Lessons Learned

- With any new feature introduced, there is always kickback from staff. We encouraged to the end users this practice is more safe than our current practice, and produces a safer outcome for the patient
- Although the process is tedious, the risk for error is greatly minimized.
- Pre transfusion and post transfusion vital signs are captured outside of the transfusion model. Nurses often find difficulty in remembering to document these vital signs. Issue brought to vendor's attention, facility is awaiting update to correct these issues.

Performance Improvement

- All electronic blood administrations are reviewed on a daily basis for any discrepancies
- Informatics department has blood product orders printed to office for additional review in EMR.
- Any issues that arise, informatics remains available for staff resource
- Any deviation in practice is closely observed and corrected by the staff responsible.
- Nursing administration, nurse managers, and staff nurses involved are made aware if an error in documentation occurred. Staff nurses are responsible for correcting errors.
- Staff nurses are allowed to attend additional education classes if needed that are offered during hospital orientation

Moving Forward

- Recently launched TAR within our outpatient Oncology center
- New updates available with module to ease documentation of vital signs