'excessive time to transfuse' errors by Royal Cornwall Hospitals

**NHS Trust** 

NHS

# TRANSFUSION

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### **The Problem**

Nurse must take unit down within 4 hours of removal from temperature controlled storage:

- May not have started the transfusion
- Multiple tasks & patients
- No easy way to know when the unit must come down
- Transfusion stopped but still connected increases risk



### The Idea

- Increase shared awareness
- Change the patient experience
- Empower patients
- Engage other staff and visitors as 'Safety Partners'
- Improve hand-overs
- Digital solution → cost/ alarm fatigue/ limits engagement



### The Solution

- A visual prompt
- Tag to hang on drip stand
- Durable, wipeable, reusable
- Clearly display the time the unit needs to be taken down
- Dry-wipe panel
- Red blood drop shape and colour



### The feedback

"we can hand over exactly when the blood needs to come down and it's very obvious for everyone involved and we know that the patient will be kept safe when they get onto the ward"

**ED Staff Nurse** 

## Safety Critical

This transfusion must be taken down by:

"Did awareness of the take-down time of your transfusion help you to feel safe?"

"yes, definitely" 100% patients

### Steps taken from prototypes to implementation

Transfusion Practitioners came up with the idea because poor communication was identified as the root cause of most 'excessive time to transfuse' incidents and patient interactions were missed opportunities to keep patients safe.

- Innovation support and prototype design from the Trust
- Procedure/instructions were developed
- Quality control/testing/Infection control
- Staff engagement
- 5 weeks Prototype trial (c. 80 patients)
- Patient engagement
- Feedback questionnaires (staff and patients)
- Non-disclosure agreement & design registered
- Production and trust wide roll-out November 2022

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