



Streamlining the Work Process of Handling Empty Blood Packets

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Background

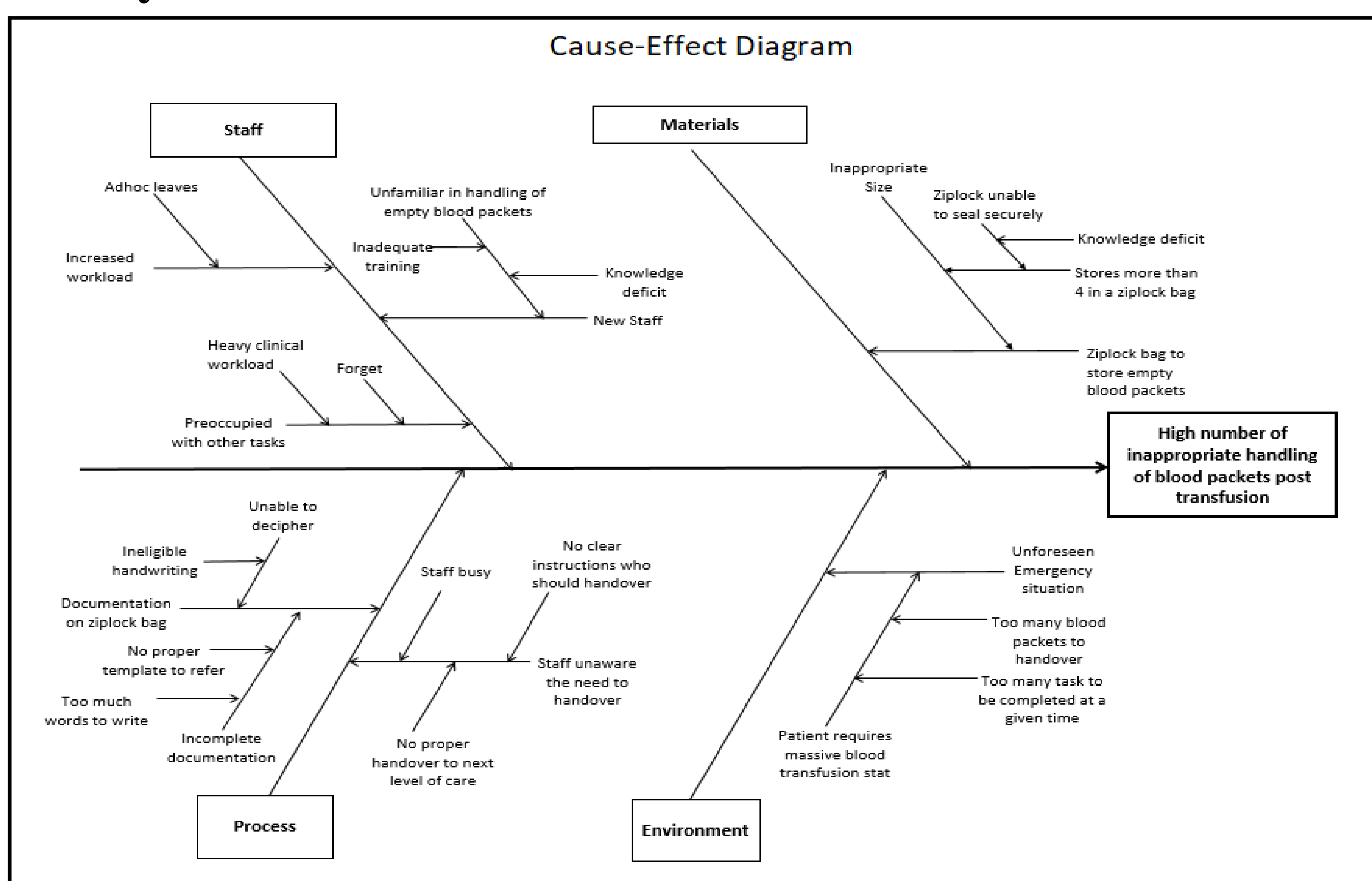
Blood transfusions are common in the Operating Theatre. It is important that all nurses understand the correct and safe way of handling empty blood packets. The empty blood packets are kept in ziplock bag and labeled. They will be handed over to the respective ward nurses and safe-keep for 24 hours in view of post transfusion reaction.

Statistics taken for a 12-week period showed, there were 26 occurrences related to the improper handling of empty blood packets.

Mission Statement

To reduce the number of occurrences related to improper handling of empty blood packets in Major Operating Theatre from 8 to 1 per month within 6 months.

Analysis



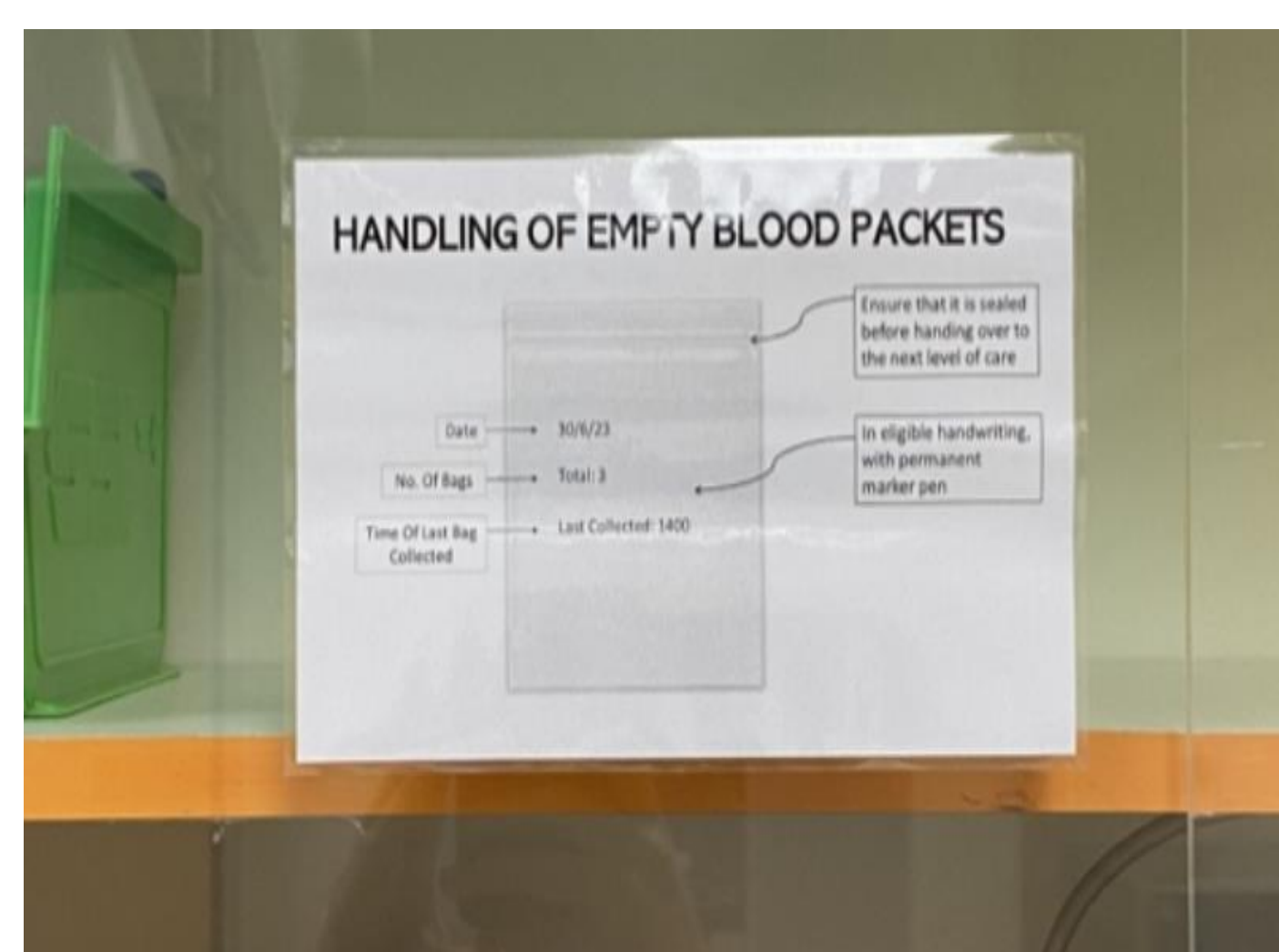
The final root causes were:

1. No proper template for reference.
2. Knowledge deficit.
3. No proper handover to next level of care.

Intervention

PDSA 1: Created a template for reference

These templates are placed in each Anaesthesia Room in MOT, PACU 1 and PACU 2 as a guide & reminder for the staff. All AU and PACU staffs were briefed during roll calls.



Reference Templates placed in all OT Anaesthesia Room & PACUs

PDSA 2: Improve knowledge on the appropriate use of different sizes of ziplock bags

Information on location and accessibility of ziplock bags shared during AU And PACU roll calls. New hired staff learn during MOT orientation and on-job training.



'L' & 'XL' ziplock bag

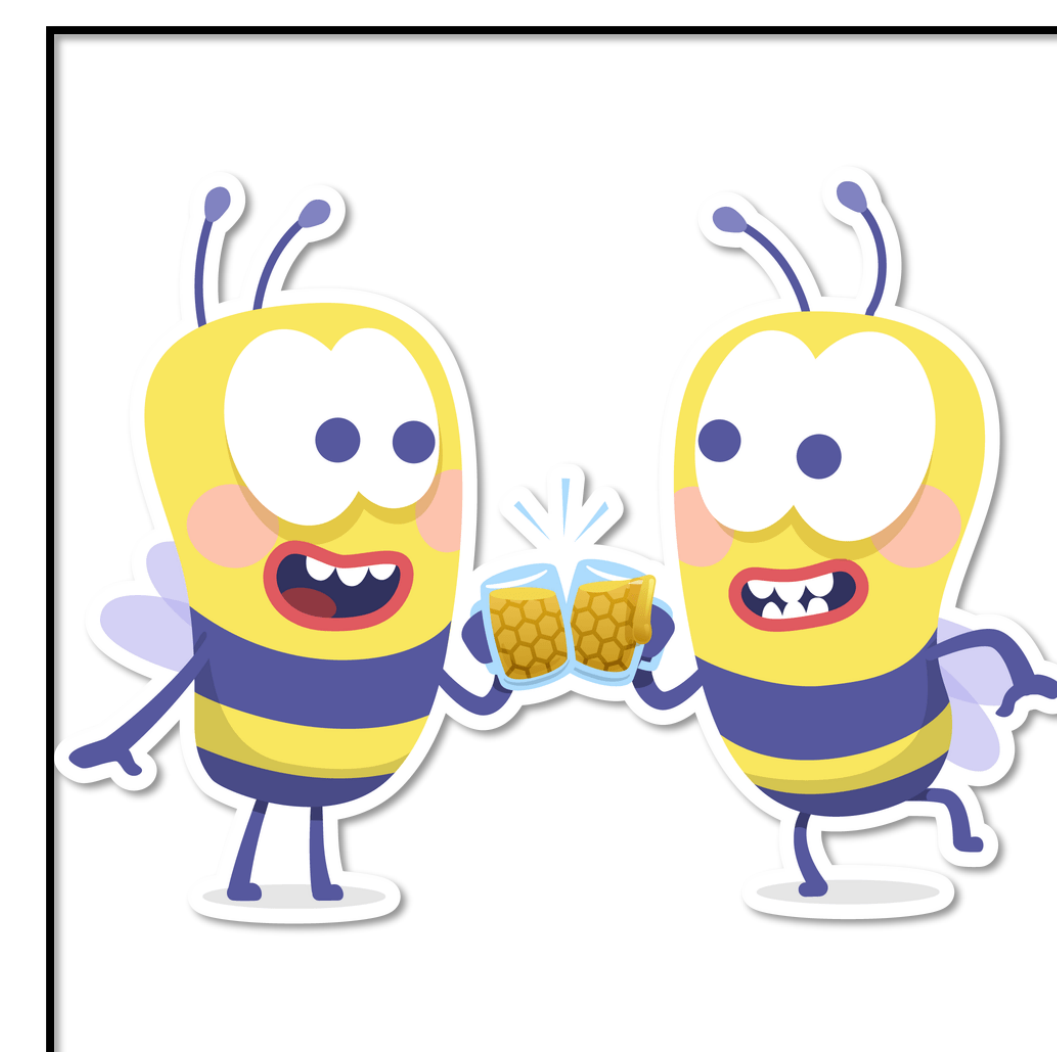


• Max of 4 empty blood packets in M size ziplock bag (PACUs and OT Anaesthesia Rooms)

• If more than 8 empty blood packets, to use size L or XL ziplock bag (Store D1)

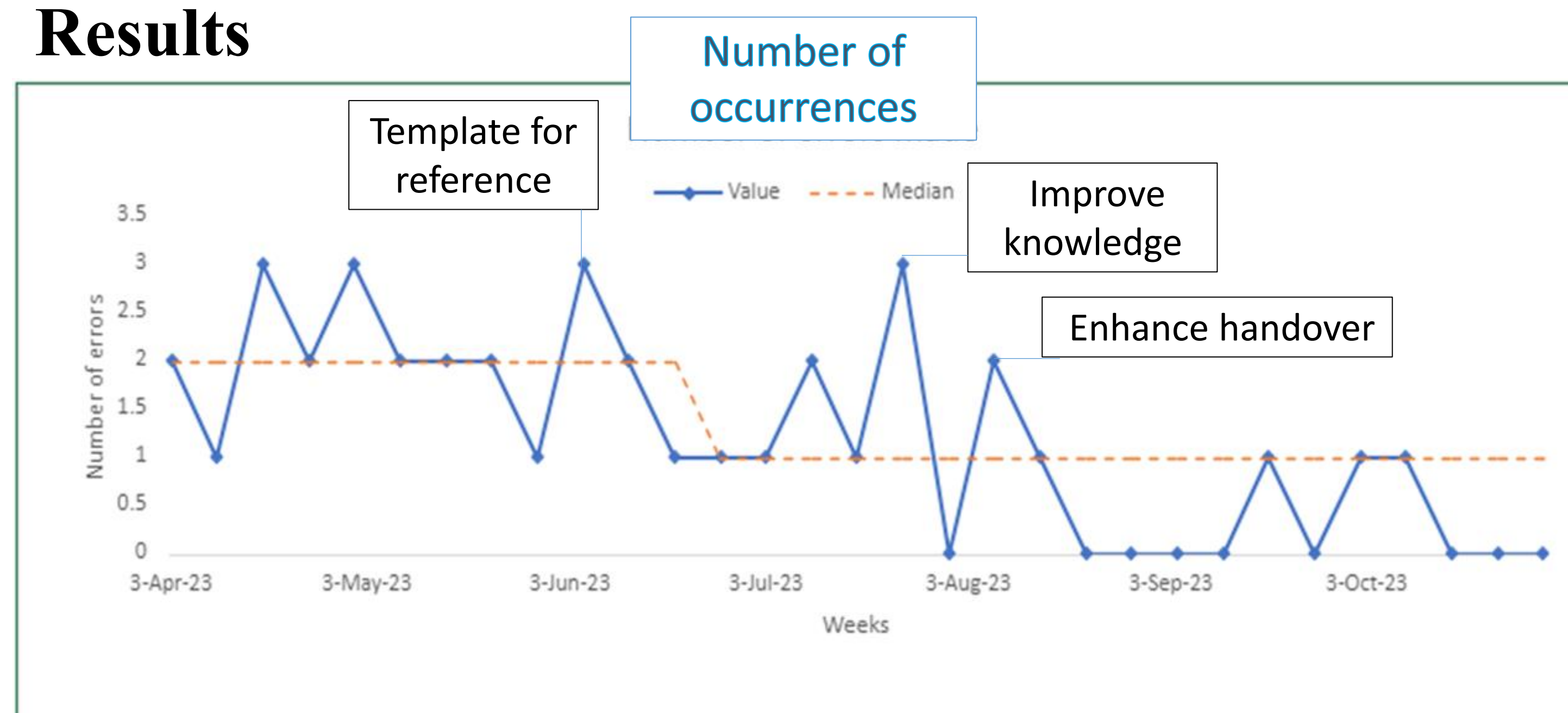
PDSA 3: Enhance handover practice to next level of care

During fast turnover of cases in OT, AU Nurse is unable to personally handover empty blood packets to PACU nurse. Circulating Nurse then helped to handover to PACU Nurse. Checking is done to ensure empty blood packets are properly labelled, sealed in appropriate size ziploc bags and no signs of leakage



Number of empty blood packet is documented in PACU Record Book under Property column for reference and ease of traceability

Results



We met our target of reducing the number of occurrences related to improper handling of empty blood packets to an average of one per month.

Intangible benefits include enhanced cooperation and good working relationship with all stakeholders in OT. It also helps to boost nurses' morale as stressful situation such as accidental exposure to blood due to leakage from inappropriate use of ziplock bags and poor sealing, are avoided.

Sustainability Plans

We continue to gather feedback from the nurses and carry out adhoc observation. Reminders are relayed to nurses via roll calls, staff monthly meeting and short message service.

The solutions implemented have become our standard practice.

Conclusion

The team further plans to reduce the number of occurrences related to improper handling of empty blood packets to zero. We have gathered feedback from other institutions' nurses, whereby they do not keep the empty blood packets for 24 hours. However, this may require time as it involves changing policy and require approval from the hospital senior management.