

Frequently asked questions about individual health service reports

For the *Statewide comparative audit of blood transfusion, Victoria 2005: An audit of blood transfusion policy, procedures and administration practices*

The original audit forms relevant to each frequently asked question are available in Appendix 1 of the report.

1. How are the risk assessments derived in the section ‘Your health service report: Protocol risk assessment’?

- There are two protocol risk assessments: aggregate and cumulative risks.
- Questions not answered on the form were scored as the equivalent of a NO reply for this purpose of the risk assessment.

1a. AGGREGATE RISK

There are five risk categories in Table 1: Aggregate risk

Risk in Patient Identification Policy (Max Value 5)	Risk in identification of blood sample (Max Value 1)	Risk in Identification of Unconscious (Max Value 1)	Risk in Identification of Unknown Patients (Max Value 1)	Risk in Post Transfusion Observation (Max Value 4)
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- **Risk in patient identification policy**
A risk of 1 (for each policy element) was scored for each NO answer for questions relating to a written policy stating that wristbands should be worn in transfusion by all patients and unless a specified alternative method is used; that there is a policy statement on how the identity of the patient is verified prior to transfusion and that for conscious patients it includes both checking the wristband and asking patients to state their forename, surname and date of birth.
- **Risk in identification of blood sample**
A risk was scored if there was no written policy statement on the labelling of blood samples for blood grouping and cross matching.
- **Risk in identification of unconscious patients**
A risk was scored if there was no policy statement on how to identify unconscious patients including checking the wristband for forename, surname, date of birth and hospital number.
- **Risk in identification of unknown patients**
A risk was scored if there was no policy stating that wristbands should be worn during transfusion by all patients unless a specified alternative method is used (that is, where an emergency number has been allocated to an unknown patient in the emergency department).

- **Risk in post-transfusion observations**

A risk of up to 4 was scored where there was no policy statement that post-transfusion observations should be made for pulse, temperature, blood pressure and respirations.

1b. CUMULATIVE RISK

There are three risk categories in Table 2: Cumulative risk

Each of the three categories was allocated 33 per cent of the cumulative risk. The three cumulative risk categories were derived from the aggregate risk scores.

Patient Identification Policy Risk	Product Identification Policy Risk	Undetected adverse events policy risk
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- **Patient identification policy risk**

A score was recorded if there is a risk in aggregate patient identification policy, identification of unconscious patients and identification of unknown patients.

- **Product identification policy risk**

A score was recorded if there is a risk of identification of the blood sample.

- **Undetected adverse events policy risk**

A score was recorded if there was a risk in post-transfusion observations.

2. **How are the risk assessments derived in the section ‘Your health service report: Practice risk assessment’, for the risk categories:**

- **‘Patients not recorded as conscious’?**
- **‘Incomplete documentation in adverse transfusion reaction’?**

Both the number and percentage of transfusion episodes reported in the audit for your health service were recorded on this report.

Patients not recorded as conscious

A transfusion episode was considered a risk if a patient was recorded as not conscious AND:

- there was one or more of the following wristband elements missing: surname, forename, date of birth, hospital identification number and gender AND/OR
- they were having a transfusion in a secluded area AND/OR
- transfusion documentation was incomplete. NOTE 1: this includes that the date of the transfusion was recorded on the compatibility report or the prescription sheet, the time of commencement of the unit was recorded on the observations documentation, the stop time of the unit was recorded and that there was a clear statement in the medical notes giving the reason for the transfusion.

Incomplete documentation in adverse transfusion reaction

A transfusion episode was considered a risk if there were inconsistent replies provided for the three questions on adverse transfusion events (8a, 8b and 8c) AND

- the patient was being transfused in a secluded area AND/OR
- the patient was unconscious AND/OR
- documentation was incomplete (see Note 1 in the above section) AND/OR
- pre- and post-transfusion observations were incomplete.

Rationale for this algorithm: accurate and complete documentation is important for the timely detection of adverse events. Unconscious patients transfused and/or patients transfused in a secluded area are at higher risk of a delay in detection of a transfusion adverse event and this places greater importance on accurate and complete documentation.