NSQHS Standard 7 Blood and Blood Products

Facility audit tool

Hospital and Health Service:	Facility:	Audit Date/Period:

Facility audit tool: collects facility level data and collates the ward/unit level responses.

Notes:
- *Each facility needs to determine those audit questions that are applicable to their facility / health service circumstances for review*
- *Some questions and responses may not be applicable (eg. at a ward/unit level) and can be adapted to suit individual requirements*
- *The measurement plan details each audit question and the action/criteria it aligns to in the standard*

Facility Questions		Response
1.0	Is there evidence that the facility (or at service level) has policies, procedures and/or protocols on blood and blood products that adhere to national guidelines?	☐ Yes ☐ No
1.1	If yes: Is there evidence that they include: • safe and appropriate prescription, administration and management of blood and blood products?	☐ Yes ☐ No
	• pre-transfusion and sampling practices such as specimen collection?	☐ Yes ☐ No
	• processes that relate to laboratory-hospital interface?	☐ Yes ☐ No
	• consent procedures?	☐ Yes ☐ No
	• tools for transfusion that are available?	☐ Yes ☐ No
	• storage and transportation of blood and blood products?	☐ Yes ☐ No
1.2	If yes to 1.0: Is there evidence of a Massive Transfusion Protocol (MTP) in place for areas such as Emergency/Theatre?	☐ Yes ☐ No
1.3	If yes to 1.2: Is there evidence of clear documentation to support implementation and cessation of a Massive Transfusion Protocol?	☐ Yes ☐ No
1.4	If yes to 1.0: Is there an Emergency Donor Panel (EDP) policy in place?	☐ Yes ☐ No
1.5	If yes to 1.0: Is there evidence that: • they are accessible to the clinical workforce, managers and the senior executive?	☐ Yes ☐ No
	• there are processes for the implementation and distribution throughout the facility?	☐ Yes ☐ No
	• they define the audit process to be undertaken to assess against them?	☐ Yes ☐ No
	• they reference the consultation processes or collaborative group/s involved in their development?	☐ Yes ☐ No
	• they detail the date they became effective?	☐ Yes ☐ No

Facility Questions		Response
	• they specify the date of the next revision?	☐ Yes ☐ No
	• they reference the source documents (if applicable) particularly where they are represented as best practice?	☐ Yes ☐ No
1.6	If yes to 1.0: Outline the policy owner and file location of the documents and any other comments.	
2.0	Is there evidence that the facility (or at service level) provides orientation and ongoing training for the clinical workforce relating to blood and blood products management (in line with the policies, procedures and/or protocols)?	☐ Yes ☐ No
2.1	If yes: Is there evidence that: • staff attendance at the education/training sessions is recorded?	☐ Yes ☐ No
	• the competency-based training needs of staff are evaluated?	☐ Yes ☐ No
	• staff feedback reports of the sessions are evaluated and incorporated into the next revision?	☐ Yes ☐ No
2.2	If yes to 2.0: Is there evidence that the facility (or at service level) mandates the BloodSafe eLearning Australia transfusion training program for all staff involved in transfusion protocols?	☐ Yes ☐ No
2.3	If yes to 2.2: Is there evidence that staff are required to complete all BloodSafe eLearning modules on a yearly basis?	☐ Yes ☐ No
2.4	If yes to 2.0: Provide comments on the education provided and when.	
3.0	Is there evidence that the facility (or at service level) has a committee such as a blood management committee or blood transfusion advisory committee that oversees blood and blood products management?	☐ Yes ☐ No
3.1	If yes: Is there evidence of: • Terms of Reference?	☐ Yes ☐ No
	• strategic plans that relate to blood and blood products?	☐ Yes ☐ No
	• risk register or log that includes actions to address identified risks?	☐ Yes ☐ No
	• documentation on consultation processes in the development and review of policies, procedures and protocols?	☐ Yes ☐ No
	• a clinicians' checklist for prescribing blood components to ensure blood products are only released for transfusion when guidelines have been satisfied?	☐ Yes ☐ No
	• documentation such as request forms or blood administration forms for ordering or administering blood components that adhere to national guidelines?	☐ Yes ☐ No
	• audit of the use of forms and tools for prescription, request and administration of blood products?	☐ Yes ☐ No
	• reports on transfusions provided to clinical units, senior executive and relevant committees?	☐ Yes ☐ No
	• reports of vetting of transfusion requests?	☐ Yes ☐ No
	• reports of adverse blood and blood product incidents?	☐ Yes ☐ No

Facility Questions		Response
	• observational audit clinical guidelines accessible to the clinical workforce?	☐ Yes ☐ No
	• quality improvement plans that outline designated responsibilities and timeframes for completion of improvement actions?	☐ Yes ☐ No
	• use of a standardised transfusion 'prescription' which incorporates requests and clinical information (such as haemoglobin level) to support appropriate assessments?	☐ Yes ☐ No
3.2	If yes to 3.0: Outline details of the committee/s, when they meet, who the members are etc. and any other comments.	
4.0	Is there evidence that the facility (or at service level) undertakes risk assessments of: • systems for blood and blood products?	☐ Yes ☐ No
	• processes for addressing pathology laboratory documentation that identifies patient safety risks from the use of blood and blood products?	☐ Yes ☐ No
4.1	If yes to 4.0: Is there evidence of a consistently applied scale to rate risks?	☐ Yes ☐ No
4.2	If yes to 4.0: Is there evidence the risks are reviewed on a regular basis?	☐ Yes ☐ No
4.3	If yes to 4.0: Provide details on the risk assessments undertaken.	
4.4	Is there evidence that the facility (or at service level) has: • audit of compliance with policies, procedures and/or protocols on blood and blood product systems?	☐ Yes ☐ No
4.5	If yes: Provide details on how, when etc. performed.	
5.0	Is there evidence that the facility (or at service level) supports prescription of blood products with patient-specific special requirements such as Irradiated, Washed, Phenotyped, CMV Negative?	☐ Yes ☐ No
5.1	Is there evidence that transfusions are undertaken during routine shifts (ie. between 07:00 - 22:00 when staffing levels are at full capacity), unless urgent?	☐ Yes ☐ No
6.0	Is there evidence that the facility (or at service level) has a system for reporting, investigating and analysing incidents relating to use of blood and blood products?	☐ Yes ☐ No
6.1	If yes: Is there evidence of: • a register of reported incidents, adverse events and near misses related to transfusion of blood or blood components that includes actions to address identified risks?	☐ Yes ☐ No
	• records of healthcare blood product adverse events?	☐ Yes ☐ No
	• use of an incident reporting management system that documents analysis and review of incidents, adverse events and near misses relating to use of blood and blood products e.g. PRIME?	☐ Yes ☐ No

Facility Questions		Response
	• agenda papers, meetings minutes and/or reports that demonstrate the routine review of incidents relating to blood and blood product use and trends in incidents?	☐ Yes ☐ No
	• root cause analysis of breaches of policies, procedures or protocols resulting in a serious breach or sentinel event?	☐ Yes ☐ No
	• audit of patient clinical records that demonstrate reporting and investigation of incidents relating to use of blood and blood products?	☐ Yes ☐ No
6.2	If yes: Provide comments to support any of the above.	
7.0	Is there evidence that the facility (or at service level) has evaluation and feedback processes relating to use of blood and blood products?	☐ Yes ☐ No
7.1	If yes: Is there evidence of: • regular reporting and evaluation of performance measures?	☐ Yes ☐ No
	• information relating to use of blood and blood products presented to the senior executive and/or relevant committees?	☐ Yes ☐ No
	• an annual report describing trends in incidents related to the use of blood and blood products?	☐ Yes ☐ No
	• peer review processes for transfusion practice such as quality assurance meetings?	☐ Yes ☐ No
7.2	If yes to an annual report: Is the data presented in the report meaningful and relevant?	☐ Yes ☐ No
7.3	If yes to 7.0: Outline the processes, where the reports are filed and where/who/how often they are reported to.	
8.0	Is there evidence that the facility (or at service level) participates in relevant haemovigilance activities?	☐ Yes ☐ No
8.1	If yes: Is there evidence of: • Schedules of haemovigilance reporting?	☐ Yes ☐ No
	• Reports of haemovigilance monitoring, such as Queensland incidents in Transfusion (QiiT) to national collation agencies such as National Blood Authority?	☐ Yes ☐ No
8.2	If yes to 8.0: Provide comments or details on when these have been undertaken, by whom etc.	
9.0	Is there evidence that the facility (or at service level) regularly reviews the receipt, storage, collection and transport of blood and blood products?	☐ Yes ☐ No
9.1	If yes: Is there evidence of: • delegation documentation for access to the secure blood fridge?	☐ Yes ☐ No

Facility Questions		Response
	• review of access to secure blood fridge where 24 hour on-site pathology service is not available? (N/A where a 24 hour service is available)	☐Yes ☐No ☐N/A
	• a register of current blood components?	☐ Yes ☐ No
	• audit of documentation accompanying blood components?	☐ Yes ☐ No
	• maintenance records and performance testing of refrigerators and freezers used for storing blood and blood products?	☐ Yes ☐ No
	• delegation documentation for responding to storage alarms and taking corrective action?	☐ Yes ☐ No
	• position descriptions, staff duty statements, employment contracts or policies, procedures and/or protocols specify blood related delegations?	☐ Yes ☐ No
	• observational audits of the use of checking processes for labels and dates when blood or blood products are handled?	☐ Yes ☐ No
	• records of disposal rates of blood products?	☐ Yes ☐ No
9.2	If yes: Provide comments to support any of the above.	
10.0	Is there evidence that the facility (or at service level) regularly monitors blood and blood product wastage?	☐ Yes ☐ No
10.1	If yes: Is there evidence of: • reconciled reports from pathology laboratories completed by relevant clinical teams?	☐ Yes ☐ No
	• audit of compliance of usage and disposal of blood and blood products against policy?	☐ Yes ☐ No
10.2	If yes: Provide comments to support any of the above.	
11.0	Is there evidence that the facility (or at service level) has patient information relating to blood and blood products, including risks, benefits and alternatives available to patients?	☐ Yes ☐ No
11.1	If yes: Which patient information is available?	
	• Blood and blood products transfusion consent	☐ Yes ☐ No
	• Blood who needs it? A consumer brochure	☐ Yes ☐ No
	• Blood transfusion - questions to ask your doctor	☐ Yes ☐ No
	• Blood components: a guide for patients	☐ Yes ☐ No
	• Blood transfusion - answers to some common questions for you and your family	☐ Yes ☐ No
	• Information for patients needing irradiated blood	☐ Yes ☐ No
	• Other (specify) _____	☐ Yes ☐ No
11.2	If yes to 11.0: Is there evidence: • the workforce is aware of the information material/s?	☐ Yes ☐ No

Facility Questions		Response
	• of processes in place for routinely distributing the material?	☐ Yes ☐ No
	• that the needs of culturally and linguistically diverse patients are taken into consideration?	☐ Yes ☐ No
	• the communication strategies are evaluated and modified accordingly?	☐ Yes ☐ No

Collation of ward/unit data (This section is only needed to be used if the data was collected at the ward/unit level. Enables whole of facility reporting)		Count of No. of wards who meet criteria	Count of Total No. of wards audited	Calculate the %
	(as per measurement plan)	Numerator (N)	Denominator (D)	(N/D*100)
12.0	What is the number of wards/units that undertake quality improvement activities to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products? (BBP_Ward_Q1.0)			
12.1	Collate information on the improvement activities undertaken and the wards/units who implemented the activities.(BBP_Ward_Q1.1)			

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on PSQIS_Comms@health.qld.gov.au for feedback or comments.