ISBT128 Clinical Implementation Issues

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ISBT128 Clinical Implementation Issues

- The current blood pack unit number contains 7 digits; the ISBT128 number contains 14 digits which will be more difficult to crosscheck prior to transfusion.
- Important that both managers and front line staff are aware of the change.
- Develop an implementation plan and include resource implications both personnel and budget issues, IT issues, time lines and training schedules.

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- Advise the hospital's transfusion committee,
- Advise the Director of Nursing,
- Inform specific medical staff who transfuse blood e.g. Emergency and Anaesthetic staff,
- Promote awareness for clinical staff and elicit suggestions on how the implementation should be managed in specific clinical areas in your hospital.

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- Seek advice on how best to read the 14 digit number regarding splitting up the number into sections.
- Emphasis in training that the 2 numbers are not the same.
- Inform staff that at present the plan is to have 2 numbers on the same label.
- If using scanning technology inform staff of the implications of the 2 barcodes on the same label.

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- IBTS hope to produce coloured printed posters of units of blood with the ISBT128 unit number circled. If your hospital is using ISBT128 you could include a simple message such as

  ‘Use this 14 digit number when compatibility checking this unit of blood’.

- To advertise the change over place this colour posters in clinical areas.

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Problem	2 numbers on one label could be confusing for staff……. which number should be checked?
Solution	Informed staff: but be aware that handling blood is not the clinical staff's central role, Emphasise at training that the unit number on the compatibility documentation/tag will guide what number should be checked.

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Problem	2 numbers on one label
Solution	Ideally separate the two numbers or deface the number the hospital is not using [identify where/when to do this]
Problem	Are there situations where both numbers/barcodes will be in use in the same hospital.
Problem	Are there situations where both numbers/barcodes will be in use in hospitals which transfer blood between them?

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Problem	2 barcodes on one label
Solution	Ideally separate the two barcodes or deface the barcode not in use in your hospital [identify where/when to do this]

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Problem	Barcode technology in use in storage situations will result in staff getting ‘wrong barcode scanned’ messages. This will occur during the change over period.
Solution	Inactivate the codabar barcode reader.
Problem	Train staff to recognise barcodes and also the error messages, acknowledge that this might be difficult due to the numbers of staff who collect blood. Lab staff be aware that there may be an increase in phone calls querying error messages.

ISBT128 Clinical Implementation Issues

Problem	Barcode technology in use in blood administration situations may result in staff getting ‘wrong barcode scanned’ messages.
Solution	Train staff to recognise barcodes and error messages. Defaced the codabar barcode, Inactivate the codabar barcode reader.

Discussion