Improving blood culture documentation on ICU
A quality improvement project

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Sepsis is a common problem encountered on ICU.
Treatment planning involves taking blood cultures to target appropriate treatment

Following an incident where cultures in a septic patient were recorded as being sent, but never received by the microbiology lab, we set about looking at how this could happen

Concepts of safety II centre around learning about and improving safety from when processes go right

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How do we imagine blood cultures are recorded?

- Sepsis suspected
- Request made for blood cultures on electronic patient record
- Blood cultures taken as part of the ‘sepsis 6’ pathway
- Barcode sticker attached to bottle which starts electronic tagging of cultures from taking to results being available

How are blood cultures actually recorded?

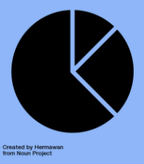
- Sepsis suspected
- Blood cultures taken as part of ‘sepsis 6’ pathway
- Blood cultures recorded as taken in patient notes

So whats going on?

Recording blood cultures in this manner is a governance risk and impacts patient safety

How many blood cultures are recorded as we imagine
Why do we not record blood cultures in the way we imagine?
How can we change things to align with expected practice?
Why have we ended up in this position?

We found from an initial audit of all blood cultures taken on ICU in May 2022 (N=135)



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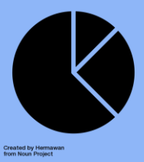

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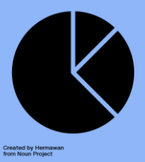

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73% of blood cultures received by microbiology recorded as taken in the notes

10% of blood cultures recorded as taken were never received by microbiology

0% were recorded in the imagined way

How do you change practice?

Barriers:
Access to computers
Working printers

Perceived time constraints
Perceived labour intensive process of logging request on computer

Knowing HOW to do the right thing

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What was within our gift to change?

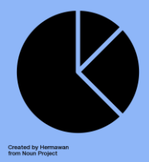
Teaching and training others about the right process

Using positive language to reinforce doing the right thing

Spending time with colleagues within the MDT, during high impact periods e.g. The ward round, team reviews, safety huddles we showed the whole team the expected process

We **celebrated people using the right process** by reminding them that they were having a positive impact on patient safety, and saying thank you

Re-audit October 2022 N= 144



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100% of blood cultures recorded using expected process

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0% of blood cultures were lost

Comment:

Using a positive approach plays a part in improving practice.

Positivity in the workplace is an easy strategy to use for quality improvement

Positive messaging is enjoyable to use