

Supporting Good Laboratory Practice

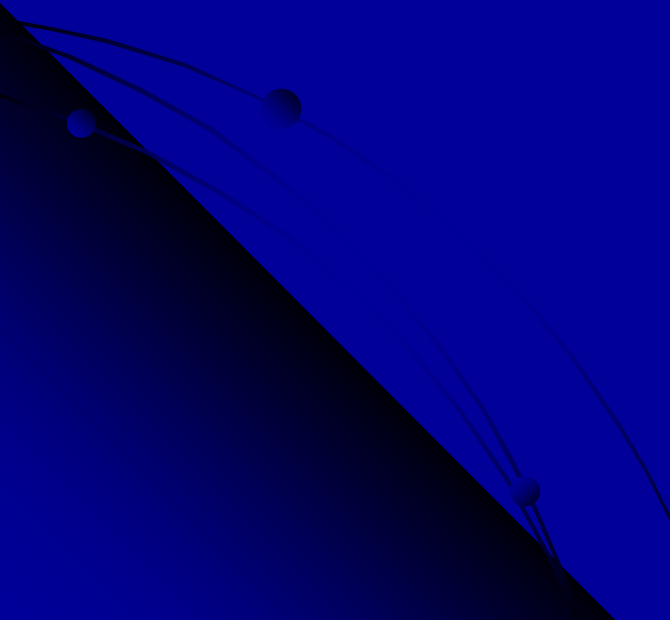
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Laboratory Initiative

Led by IBMS in conjunction with
SHOT and other stakeholders

**What is the
rationale for this
initiative?**



Our Area of EXPERTISE!

- Laboratory errors are a cause for concern and in some cases reflect poor standards of practice
- The same standards MUST apply to pre-transfusion testing in and outside of laboratory core hours and these should be consistent with current guidelines
- In this years report 37/87 (42.5%) 'wrong blood' reports the originating error occurred in the hospital transfusion laboratory.


Laboratory Errors

Year	No of case reports	No of errors	% of total errors reported	When the errors occurred
2001-2002	120	157	28.4%	Not known
2003	155	183	31%	58% core 41% not core
2004	180	194	NK	26% no response 36% core 38% not core

Errors that Continue to be Made

- Failure to provide the correct components for patients with special requirements ie irradiation, CMV negative, methylene blue FFP
- Transposition of compatibility labels

The issues

- Working Time Directive
 - 24 hour service
 - Career structure
 - Regulations and requirements
 - Competency frameworks
- 

Professional Lead

- Stakeholders identified

- BBTS
- NEQAS
- BSH
- BCSH
- MHRA
- CPA
- HPC
- RC Path
- NBTC or equivalent

Blue Sky Thinking



Areas of consideration

- Lone working
- Training
- Staff numbers
- Skill mix
- Quality
- Continuity of service – senior staff not always present
- Maintenance of competency

- Not cut and dried



- Not all encompassing

- You may have better ideas/suggestions



Thoughts (1)

- No laboratory must be staffed during core hours with fewer than two qualified persons – defined as HPC registered with BBTS Certificate (or equivalent)
- If routine transfusion occurs outside of core hours, senior staff member must be present

Thoughts (2)

- Senior staff member present at all times during core hours – defined as HPC registered, FIBMS (or equivalent) and Diploma of Extended Practice in Clinical Transfusion (or equivalent)
- Out of hours transfusion requests to be dealt with person qualified to BBTS Certificate level (or equivalent)

Thoughts (3)

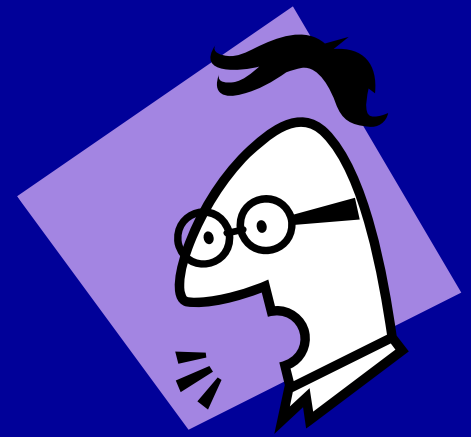
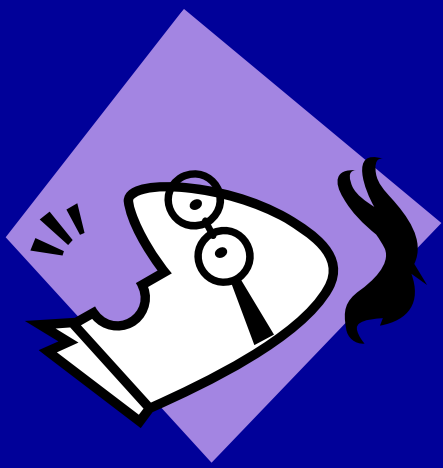
- Routine transfusion must not be undertaken if only one person is staffing all out of hours requests
- All staff to undertake a minimum period of update training over a two-year registration cycle – defined as one day per year of formal external training

Thoughts (4)

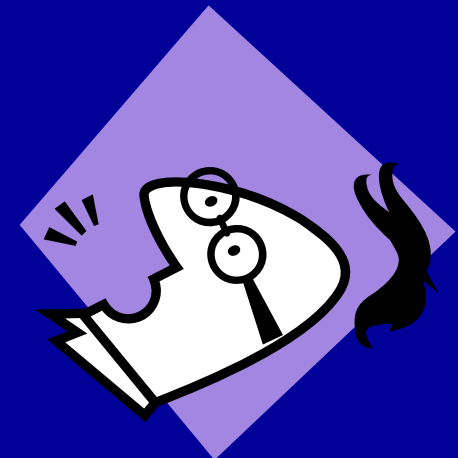
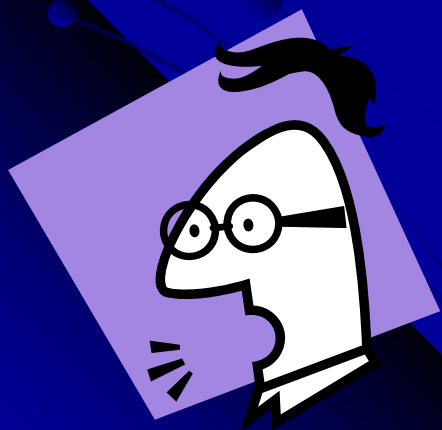
- External training courses need to be defined and developed
- Senior staff to undertake external training and have 'peer' assessment of their competencies
- Define core hours

Thoughts (5)

- Persons who instruct non-laboratory staff in transfusion must have a recognised teaching/assessment qualification – defined as IBMS certificate
- Competency assessment for non laboratory staff to be developed and designed – all work to common standard ? based on NOS



- not possible
- not sustainable
- not, not, not !!!



Next steps

- Undertake survey of transfusion laboratories
 - Workshop
 - regional representation
 - stakeholders
 - other interested groups
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Workshop discussions

- Staffing levels actual/desired
- Skill mix
- Evidence of good practice/competency
- How to become a biomedical scientist consultant

**It will be up to you, as
members of the
profession, to work
together and take this
initiative forward**