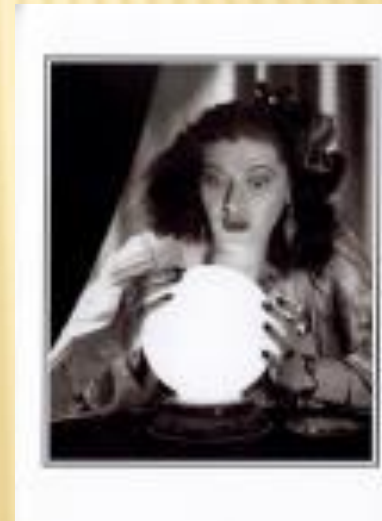


SHOT / IBMS LAB COLLABORATIVE

Recommended
Minimum Standards
for Hospital Blood
Transfusion
Laboratories

Where are we now?



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DATA COLLECTION Pre 2009

- ✘ 30-40% of wrong blood errors reported to SHOT originate in laboratory (consistent since 1996)
- ✘ Disproportionate number occur ‘outside core hours’
- ✘ To date, initiatives targeted at clinical areas e.g. Better Blood Transfusion HSC’s, SPN’s

ERROR RATE CONTRIBUTORY FACTORS

- ✘ 55% of staff possibly without formal transfusion qualification
- ✘ 6% labs had no staff with transfusion qualifications working on the day of the survey
- ✘ 20% of lead BMS staff are participating in non core hour service

ERROR RATE CONTRIBUTORY FACTORS

- ✘ Inadequate use of automated analysers
- ✘ Inadequate use of IT
- ✘ Under utilisation of a validated IT based EI system
- ✘ Insufficient emphasis put on training and competency

Collaborative recommendations based on survey data collected from a representative number of hospitals / workloads

1. Staffing – Levels and skill mix
2. Technology – Full use of automation
3. Training, competence, knowledge base

AIM

Reduce blood transfusion laboratory errors
by 50% by 30 September 2012

FACT

In 2009 8.7% of lab errors accounted for
'wrong blood' incidents
DOWN from 19.5% in 2008

IS IT ALL GOOD NEWS FROM 2009?

- ✘ Special requirements not met 67(41)
- ✘ Other laboratory errors 82(91)
- ✘ Lab errors account for
 - 53% of IBCT reports
 - 18% of all reports

() = 2008 figures

DO THIS YEARS ERRORS REFLECT THE CONCERNS ADDRESSED IN MINIMUM RECOMMENDATIONS?

- ✘ 27 errors due to poor serological knowledge or failure to recognise special needs of a specific patient group
- ✘ Lab based 'ABO grouping' errors remain stubbornly stable at 6 (2006-09) compared to mean of 20 (2003-05)
- ✘ Non BT staff involved in 30% 'wrong blood' incidents
- ✘ Non BT staff involved in 45% 'other pre trans' incidents

DO THIS YEARS ERRORS REFLECT THE CONCERNS ADDRESSED IN MINIMUM RECOMMENDATIONS?

- ✘ ‘Qualified’ staff overriding IT messages / flags
- ✘ Use of automation is still ‘limited’ e.g. not used overnight / weekends
- ✘ There continues to be a need for secure automation for the smaller lab

HOW HAVE THE RECOMMENDATIONS BEEN RECEIVED?

- ✘ Stimulated a lot of discussion! – competency assessment
- ✘ The setting of standards has been welcomed
- ✘ Future inspection against these standards has provoked much thought
- ✘ Qualification recommendations seen to enhance a ‘patient centred’, quality assured and safe NHS

ASSESS IMPLEMENTATION

- ✘ Have recommendations been considered by
 - Pathology management?
 - HTC?
- ✘ Has your lab developed a 24/7 capacity plan?
- ✘ Have you risk assessed manual procedures?
- ✘ Do your senior staff have the correct / appropriate qualifications?
- ✘ What approach has your lab taken with respect to enhancing transfusion knowledge for all lone workers?

KNOWLEDGE BASE

✘ IBMS Higher Specialist Diploma:	2008	9
	2009	12
✘ BBTS Spec Cert in Tr Sc Practice	2008	145
	2009	260
	2010	185*

* To June 18th (370 for full year)

CONCERNS or OPPORTUNITIES?

- ✘ Ageing workforce
- ✘ Lord Carter of Coles
- ✘ NetworkingNHS spending cuts
- ✘ Modernising scientific careers

Opportunities if managed properly.
TRAINING

- ✘ There will be a toolkit to aid assessment against the recommendations hosted by Transfusion science pages within IBMS website
- ✘ Advice on targeted CPD activities
- ✘ Re survey hospitals late 2010
- ✘ Update of recommendations to be published late 2010
 - + 'In post' supervisors/responsible for BT lab – demonstrate equivalence to IBMS HSD or accredited MSc in transfusion/transplantation
 - + 'In post' and to be a lone worker – demonstrate equivalence to BBTS Spec cert, IBMS SD.



The Future is Bright



Thank you