

Poster Review and Prize Award 2011

Mike Murphy

Number and type of abstracts

**7 submitted and were all accepted
(14 in 2010 and 15 in 2009)**

Main topics:-

- 3 audits**
- 2 surveys**
- 1 education**
- 1 haemovigilance**

5 from England, 1 from Scotland, 1 from ?

**You may not have got Olympics tickets,
but there is a winner in this audience...**



Audit of FFP use and wastage

- **383 units FFP ordered for 58 patients in 4 months**
- **Most common indications: massive transfusion (31%) and liver disease (28%)**
- **41 units wasted**
Bleeding stopped (7); 'order was inappropriate' (6); 'communication error' (4); patient missed appointment for prophylaxis (4); change in clinical condition (4); unknown (8)

Recommendations:

Requests should be approved by a haematologist; better documentation of reasons for transfusion and reasons for wastage; better education of clinical staff about indications for the use of FFP and practical issues such as its shelf-life

Audit of massive transfusion

- Audit of all patients receiving ≥ 10 units of blood in one hospital in 12 months
- 95 patients
- 46 (48%) patients died, mostly within 7 days
- The 46 patients used 723 units of red cells, 132 FFP, 40 platelets, 15 cryo, 4 rFVIIa, and 5 PCC
- The ratio of units of red cells:FFP was 6.3:1
- The ratio of units of red cells:plts was 4.5:1

Conclusions

Massive transfusion was associated with a high mortality. Blood component support appeared to be inadequate and there was concern about the whole process of transfusion support for massive transfusion.

Cryoprecipitate transfusion: appropriate and necessary?

- **3 region audit of each episode of use of cryoprecipitate over 3 months in 2010**
- **31 hospitals provided data on 451 episodes**
 - **Commonest scenarios were cardiac surgery, trauma in adults, critical care in children and neonatal use**
 - **84% of episodes were associated with haemorrhage in adults compared to 53% in children and 37% in neonates**
 - **pre-treatment fibrinogen was measured in 77% and was higher when haemorrhage was the indication compared to prophylaxis**

Conclusions

The study identified the main clinical indications for the use of cryoprecipitate but did not attempt to address whether usage was appropriate

Use of anti-D: a survey of midwives in north west England and north Wales

- **A survey of midwives knowledge of the use of anti-D was undertaken in response to increasing SHOT reports of anti-D errors**
- **207 responses**
 - 30% not aware of reasons for routine antenatal anti-D
 - 10% identified a reason to use anti-D in RhD positive women
 - Many seemed to be unaware of the need for additional anti-D for large FMH
 - 60% 'favoured' further training (even many who thought they had adequate knowledge)

Conclusions

The survey highlights gaps in the knowledge of midwives about anti-D. New modules on Learn Blood Transfusion and the use of other learning resources can be used to address these deficiencies and reduce the number of errors in anti-D administration.

Can one head be better than two?

(Single nurse administration of blood components)

- 1999 BCSH guidelines on blood administration recommended single nurse pre-transfusion bedside checking but this has not been implemented**
- After 2 wrong blood incidents with 2 nurse checking, this hospital piloted single nurse checking but first asked staff to complete a survey**
- Additional training in safe practice was provided to willing volunteers**
- Staff liked the change, it saved time, and it is planned to extend it throughout the hospital**

Education and training

- **Negative feedback from junior doctors about transfusion training**
- **Is this due to repetition of basic transfusion safety procedures?**
- **New teaching plan**
 - 5th year: basic transfusion practice
 - End of training 'shadowing' period: transfusion documentation, practical issues
 - 1st year as doctors: case studies and group discussion
- **Delivered to 271 junior doctors in 2 hospitals**
- **Feedback was very positive**

Haemovigilance

Summary of 5 years of reporting to SABRE

- Reports of SAEs and SARs have increased each year from 2005 to 2010
- 6 deaths in 2010: TRALI, TACO, anaphylaxis
- Only one SAR was an ABO incompatible tx
- The majority of SARs were anaphylaxis or hypersensitivity
- Most SAEs were due to incorrect handling or storage, missing special requirements or sample labelling errors

Conclusions:

- Still scope for improving transfusion practice
- From 2011, an annual report will be provided for users

SERIOUS HAZARDS OF TRANSFUSION

SHOT



Can one head be better than two?

(Single nurse administration of blood components)

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