Implementation of Better Blood Transfusion 2 in a Hospital Trust

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Facts and Figures

• 6,500 staff
  – 1,000 doctors and dentists
  – 1,900 nurses
  – 920 support staff including 10 perfusionists

• Over 100 clinical areas
  – 1150 beds
  – 40 operating theatres
  – 1 helipad

• Local population – 605,000
  – Speaking 140 languages!
Transfusion activity 2002/03

- Group and screen samples 50,895
- Red cell units issued 52,373
- Red cell units used 28,548
- Platelets 5,423
- Fresh frozen plasma (FFP) 6,163
- Cryoprecipitate 1,963
Better Blood Transfusion

• Chief Medical Officers’ seminar July 1998
• HSC published December 1998
  – Category: Clinical Effectiveness

• Hospital Transfusion Committees (HTCs)
• Guidelines and protocols
• Participation in SHOT
• Alternatives to transfusion
Best way to improve hospital transfusion practice

- Increased education and training
- Appointment of a transfusion nurse
- Electronic bedside checking/patient ID
- Better attendance at HTCs
- Improved systems for data collection
- Consideration of alternatives

(responses from 186 hospitals)
**Better Blood Transfusion 2**

- Chief Medical Officers’ seminar October 2001 revisited Better Blood Transfusion
- HSC published July 2002
  - Subtitled: Appropriate Use of Blood
  - Category: Public Health
- Very clear objectives
  - Hospital Transfusion Teams (HTTs)
  - Transfusion Practitioners
Hospital Transfusion Team

- Hospital transfusion practitioner
- Lead consultant for transfusion
- Blood bank manager
- Information analyst
- Admin and clerical support!
Transfusion Practitioner

- Catalyst for change
- Primary function: to improve hospital based transfusion practice
  - education
  - audit
  - risk management
  - alternatives to transfusion
  - patient information
- Interface between laboratory & clinical areas
BBT is an integral part of NHS care

- Senior management and Board level commitment
- Appropriate membership and functioning of HTC and HTT
- Policies are in place, implemented and monitored
Improve the quality of service through audit and CPD
Education

- Annual documented training for all staff
- Qualified nurses and doctors at induction
- Pre and post basic nursing courses
- Clinical effectiveness half days
- Annual re-cert programme
- OSCE stations for nursing and medical students
- Workbook for updates
- Troubleshooting
Audit

- Staff knowledge
- Audit trail for all products
- Compliance with Trust policy
  - Multi-disciplinary
  - Feedback informs practice and education
- Blood Stocks Management Scheme
- Business case for data analyst
- Healthcare economics
Make blood transfusion safer

- Patient identification
- Investigate incidents & near misses
- Education - local incidents
- HTC - review policies/protocols
- Participate in SHOT
- CNST/CHI
- Look back exercises
- Litigation
Avoid unnecessary use of blood in clinical practice

- Inappropriate requests
- Maximum surgical blood order schedule (MSBOS)
- Pre-operative assessment
  - Preparing Patients for Surgery
Alternatives to transfusion

• No transfusion
  – nb iron deficiency anaemia
• Cell salvage
• Pre operative deposit
• Acute normovolaemic haemodilution
• Erythropoietin (EPO)
• Antifibrinolytics
Provide better information to patients and the public

- Verbal consent - benefits and risks
- Patient information leaflets
  - pre-admission
  - alternatives
  - in all clinical areas
  - handed out at teaching sessions