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?
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

<table>
<thead>
<tr>
<th>Year</th>
<th>No of case reports</th>
<th>No of errors</th>
<th>% of total errors reported</th>
<th>When the errors occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-2002</td>
<td>120</td>
<td>157</td>
<td>28.4%</td>
<td>Not known</td>
</tr>
<tr>
<td>2003</td>
<td>155</td>
<td>183</td>
<td>31%</td>
<td>58% core, 41% not core</td>
</tr>
<tr>
<td>2004</td>
<td>180</td>
<td>194</td>
<td>NK</td>
<td>26% no response, 36% core, 38% not core</td>
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</tbody>
</table>
Errors that Continue to be Made

- Failure to provide the correct components for patients with special requirements, such as 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

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

- Stakeholders identified
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
Next steps

- Undertake survey of transfusion laboratories

- Workshop
  - regional representation
  - stakeholders
  - other interested groups
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