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
- Networking
- NHS 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