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
Can one head be better than two?
(Single nurse administration of blood components)

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