The Whittington Hospital NHS
NHS Trust

Transfusion Practitioner Annual report 2007

Main objective is promotion of appropriate use of blood and maintenance of safe standard practice

TASK	STAFF GROUP	PROGRESS	FUTHER ACTION REQUIRED	EXPECTED OUTCOMES
Blood transfusion training: - ♦ Requesting, collection, transportation and administration of blood and blood components. ♦ Indications for transfusion. ♦ Paediatric and neonatal transfusion. ♦ Blood transfusion awareness campaign	♦ Nurses/Midwives ♦ Medical staff ♦ Porters/HCA ♦ Lab staff	♦ A rolling programme of blood transfusion training has been maintained mostly aiming at nurses/midwives through mandatory and IV study day. ♦ Weekly organise training sessions for clinical areas such as ED, NICU, IFOR and ITU that includes both nursing and medical staff. ♦ Porters/HCA competency training and assessment ♦ Participating in FY1 & FY2 Trust induction programme. ♦ Total of **654** qualified nurses/midwives and supportive staff plus **47** junior and **15** senior medical staff have been trained from May 2006 to May 2007. This shows marked improvement in transfusion practice.	♦ To revise and extend the current training provision to include all medical staff and registered Bank staff involve in transfusion practice. ♦ To introduce E-learning assessment and competency Modules for all staff involve in transfusion process. ♦ Ensure policies are updated to reflect the current changes. ♦ Identify transfusion 'Champion' who will be a qualified registered nurse/midwife to cascade transfusion training in their clinical areas.	♦ By May 2008, 50% of our clinical and supportive staff will be assessed and competent in blood transfusion practices. ♦ Learn about safe transfusion practice. ♦ Improve Patient care. ♦ Reduce Risk. ♦ Our clinical staff to become safer practitioners. ♦ Complied with the NPSA recommendations.

Serious Hazard of transfusion (SHOT): - ♦ Annual report. ♦ Lessons for Clinical Staff. ♦Near miss events ♦Serious Adverse Events ♦Serious Adverse Reaction	♦ Nurses/Midwives ♦ Medical Staff ♦ Porters/HCA ♦ Lab staff	♦ Presentation of the cumulative data of SHOT annual report to all staff involve in transfusion process shows a significant improvement, reflecting an increased awareness of transfusion issues throughout the Trust. ♦The number of reported transfusion incidents within the clinical areas has significantly dropped.	♦ To create an awareness or alert poster from the SHOT report for distribution and display in clinical areas. ♦ It is essential that transfusion safety be maintained through risk management strategies.	♦ Increase level of awareness on transfusion issues amongst our staff ♦Minimised blood transfusion incidents.
Audit ♦ Use of blood in primary, elective, unilateral hip replacement ♦ Red cell use in Medical patients ♦ Clinical use of platelet ♦ Blood & blood components traceability	♦Medical staff ♦Nursing/Midwives	♦ Majority of audit work performed is for 'National Comparative Audit'. ♦ The comparative results stimulate the need for improvement in the areas that we poorly perform. ♦ The traceability audit is to monitor our compliance on 'Blood Quality & Safety Regulation' 2005. ♦ This time our blood traceability compliance is **97%,** 3% lower than recommended by MHRA	♦ To educate all prescribers on the audit results. ♦ To ensure written recommendation are in place ♦ Introduction of blood transfusion record. ♦ To consider using appropriate point of care testing	♦ Appropriate use of blood and blood products. ♦ To complied fully with the 'Blood Quality & Safety Regulation' 2005.

Documentation ♦New Compatibility/report form	♦ Nurses/Midwives ♦ Medical staff ♦ Porters/HCA ♦Laboratory staff	♦ With the new launch of Pathology IT system for blood transfusion on 14th/5/2007, a new documentation was introduced for blood group & antibody report and cross-match and compatibility report with sticker label. ♦ The new cross-match and compatibility report has cause some confusion and concern for clinical staff. ♦ Efforts are being put to adjust the layout of the information on the new form and I am devoting more time in clinical area to clarify any issue.	♦ As soon as the new Pathology IT system is well established and mastered by our transfusion lab staff, other improvement should be made to the compatibility/report form. ♦Continuous awareness through training sessions and face-to-face meetings with clinical staff.	♦ All clinical staff will be well familiar with the new form.
Use of Red Blood Cell ♦ 2006/2007	♦ Medical staff ♦ Nurses/Midwives ♦ Porters/HCA ♦ Laboratory staff	♦ Total------------9592 ♦ Transfused----9448 ♦ Wasted------------94 ♦ Expired------------42 ♦ Discarded----------8 ♦Transferred---------0	♦ Training and education on clinical indications for the use of red blood cell. ♦ Blood policy/guideline ♦Transfusion record to prompt and record good clinical practice.	♦ To reduce inappropriate or unnecessary transfusions ♦ To minimise wastage
Blood Products Wasted	♦ Medical staff ♦ Nurses/Midwives	♦ **Platelets**---------247 Wasted------------14	♦ Training and education on clinical indications ♦ Carefully challenge	♦ To see more reduction in an inappropriate

♦ 2006/2007	♦Porters/HCA ♦ Laboratory staff	♦ **FFP** --------------612 Wasted------------44 ♦ **Cryo-ppt**---------111 Wasted--------------2 ♦ **HAS**---------------245 Wasted--------------3 ♦ **Anti-D**------------1207 Wasted---------------3	inappropriate requests for blood products. ♦ Some request needs further clarification by our Haematologist before ordering and releasing blood products.	request and to minimise wastage.

CONCLUSIONS

This report indicates some more improvement from previous report and it demonstrate continuous effort and commitment to improve blood transfusion practices throughout the Trust. Many clinical areas are taken the issues of blood transfusion very serious and as such there have been fewer incidents during this period, in fact there was an increased number of near miss incidents detected on the wards as a results of good final patient identity check carried out by our nurses/midwives in clinical areas.

With the current training provision, majority of our medical staff that prescribe blood were unable to receive the required blood transfusion training. It is felt that this essential training should be recognise by each Medical Education Supervisor and to ensure that junior doctors under their supervision participate in the new transfusion-training programme.

It is hope that all the key stakeholders within the Trust will give their full support and cooperation for a successful implementation of the proposed training programme.

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June 2007