

Anwen Davies

Patient Blood Management Practitioner, NHSBT

South East Coast RTC

4th October 2019



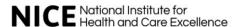
Background







- NICE Blood Transfusion Quality Standard QS138 published December 2016,
- 4 Quality Statements (QS) describing high-quality care in priority areas for improvement
- Are we compliant? As a hospital? As a region?
- Gap Analysis needed, easy for the region to use
- Online audit tool developed by SEC Transfusion
 Practitioner group in collaboration with NHS Blood and Transplant in July 2018
- Tool endorsed by NICE September 2018





QS138 Tool Guidance Notes



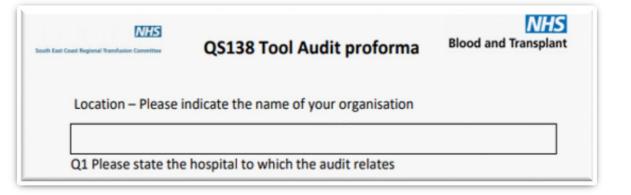
audit tool available bere:

This document provides additional guidance to the online audit tool available here: NICE Quality Standards Audit Tool Blood Transfusion

Information to note:

The QS138 Tool:

- Guidance Notes



-An Audit proforma

National Institute for Health and Care Excellence (NICE) Quality Standard
Transfusion - QS 138

This NICE guideline offers best practice advice on the care of adults, children and young people who need a blood transfusion. A copy of the quality standard is available for download at:

www.nice.org.uk/guidance/qs138

This online audit has been developed by the NHSBT Patient Blood Management Team to support hospitals to audit their practice against this standard.

This has been developed based on feedback during piloting with the South East Coast RTC Region.

- A Snap Survey





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R

E

What our Tool audits....



QS1 Iron Supplementation

> QS1a: Iron given before surgery where needed

> QS1b: Iron given after surgery where needed **EXCLUDED**

QS2 Tranexamic Acid (TXA)

QS2: TXA given to adult surgical patients where moderate bleeding anticipated QS3 Re-assessment

after Transfusion

QS3a: Clinical re-assessment

QS3b: Haemoglobin re-checked QS4
Patient
Information

QS4a: Patients who may receive blood EXCLUDED

QS4b: Patients who have received blood are given verbal and written information



So....Where are we so far in South East Coast?.....

3 Audit cycles:

August 2018 November 2018 May 2019





Data received from 13 sites

Number of patients audited:

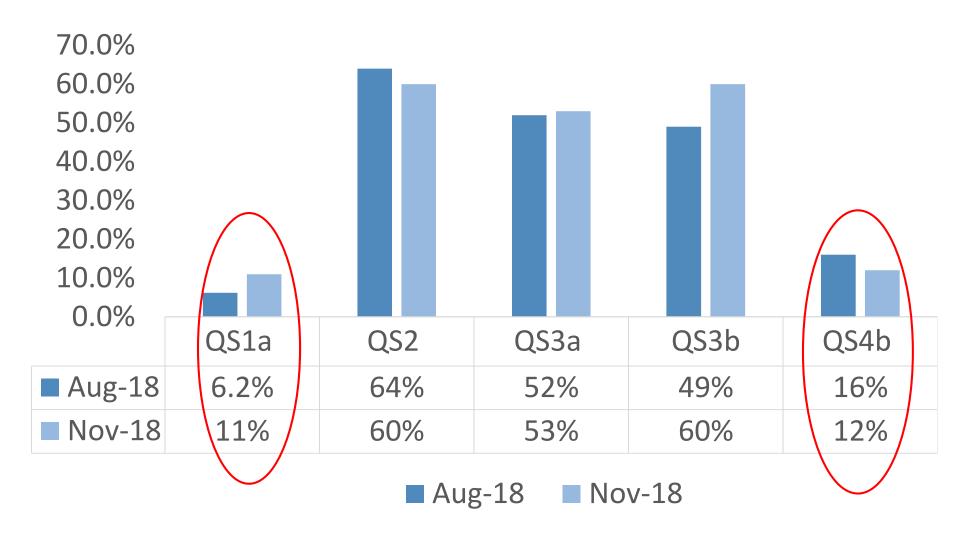
QS1a 143

QS3 **225**

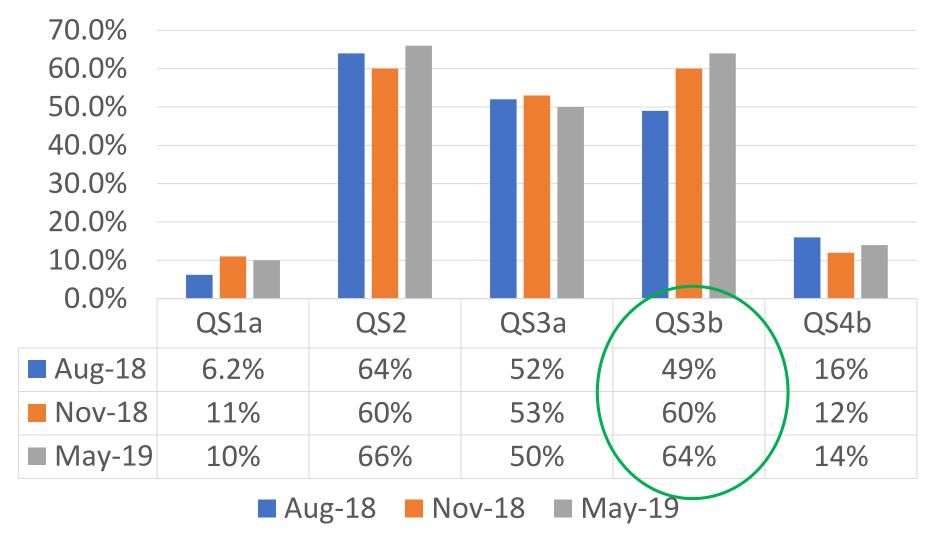
QS2 **227**

QS4b 249

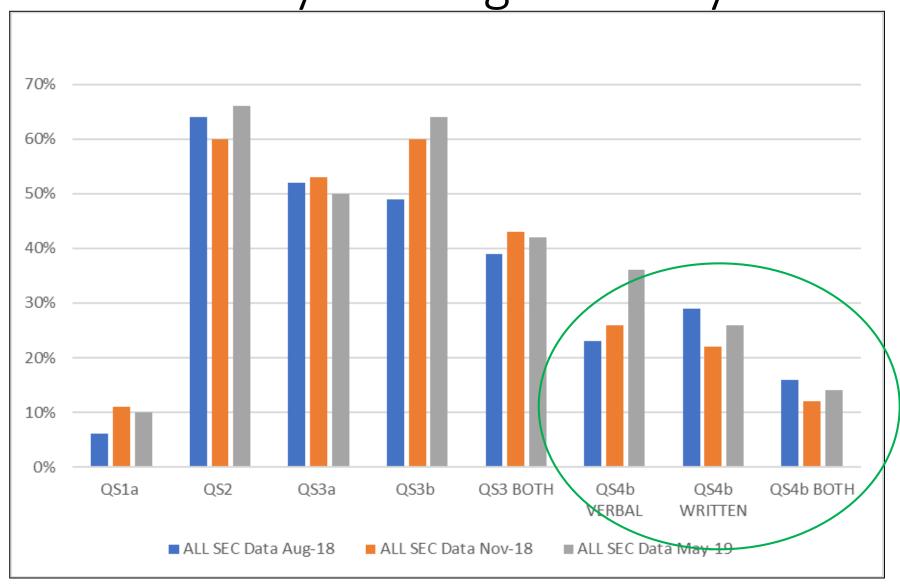
Aug v Nov 2018 % Compliance ALL SEC



ALL SEC Data % Compliance 3 Audit Cycles Aug 18 - May 2019



ALL SEC Data % Compliance 3 Audit Cycles Aug 18 - May 2019



So where are we now?

Gap analysis is not as simple as we first thought



- As a region our relative strengths lie with appropriate use of TxA and red cells
- There is room for improvement around consent



 The results for QS1a indicate poor compliance but further work needs to be done to capture the right audit population



Consent for blood transfusion with the consequence of the consequence	Blood and Transplant	RECORD OF DECISION TO TRANSFUSE				
Consent for blood transfusion Consent for blood transfusion	Blood area	Fathert's name:	90		tierth; ay	r. number
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Guidance. • Explain the risks and learneding growing but it is a special production of the production	Consent for	It for children or ad it as an approximat explaned the risks	uts with low body seight w ion for a 70-80kg patient. § I benefits and alternatives	th no active to be assess you winters into	r patient after processor provinces	to row of Flogs, per unit, ir each unit transfused.
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Description *	Guidance:					Total
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	and should carly seem (seems)	3//	Designation States MD	rx Sq	pan.	2 mx



Does the patient have a diagnosis of 'heart failure' congestive cardiac failure (CCF), severe aortic stenosis, or moderate to severe left ventricular dysfunction? Is the patient on a regular diuretic? Does the patient have severe anaemia?



Does the patient have respiratory symptoms of undiagnosed cause



Is the fluid balance clinically significantly Is the patient on concomitant fluids (or has been in the past 24 hours)? Is there any peripheral oedema?

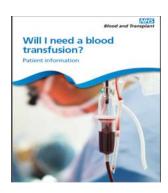
Does the patient have hypoalbuminaemia? Does the patient have significant renal

If 'yes' to any of these question



- Review the need for transfusion (do the benefits outweigh the risks)?
- Can the transfusion be safely deferred until the issue can be
- investigated, treated or resolved?
- Consider body weight dosing for red cells (especially if low body weight) Transfuse one unit (red cells) and
- review symptoms of anaemia Measure the fluid balance
- Consider giving a prophylactic
- Monitor the vital signs closely including oxygen saturation





https://hospital.blood.co .uk/patientservices/patient-bloodmanagement/consentfor-transfusion/



National Blood Transfusion Committee

Indications for the use of **Blood Components in Adults**

This guidance is based on the NBTC Indication Codes for Transfusion (June 2016).

Red cell concentrates

Dose - if no bleeding and anaemia reversible, use the minimum number of units to achieve a target Hb. Assume an increment of 10g/L per unit for a 70kg adult.

- R1 Acute Bleeding Once normovolaemia achieved, frequent measurement of Hb (including by near patient testing) should be used - see suggested thresholds below.
- R2 Hb ≤70g/L if stable acute anaemia. Use a target Hb of 70-90g/L. Follow local protocols for post cardiac surgery, traumatic brain injury, acute cerebral ischaemia.
- R3 Hb ≤80g/L if cardiovascular disease Use a target Hb of 80-100a/L.
- R4 Chronic transfusion dependent anaemia Maintain an Hb which prevents symptoms. Suggest an initial threshold of 80g/L then adjust as required. Haemoglobinopathy patients require individualised Hb thresholds.
- R5 Radiotherapy Limited data for maintaining Hb of 110g/L.
- R6 Exchange transfusion.

Audit resources already available

Moving forward....



Continue auditing twice per year



Feedback results to appropriate clinical teams



Share results at regional leve



Learn from each other



Formulate action plans



Share resources and ideas



Develop new resources?



