Myth 2

‘Doctors know more than us about blood transfusion’

Depends…

- Basic transfusion education in medical school and as FY1/2s
- Pick up practice on wards…good and bad
  - Non-haem consultants can be ‘out of date’
  - Trainee doctors reluctant to challenge consultant’s authority – this is where you can help...

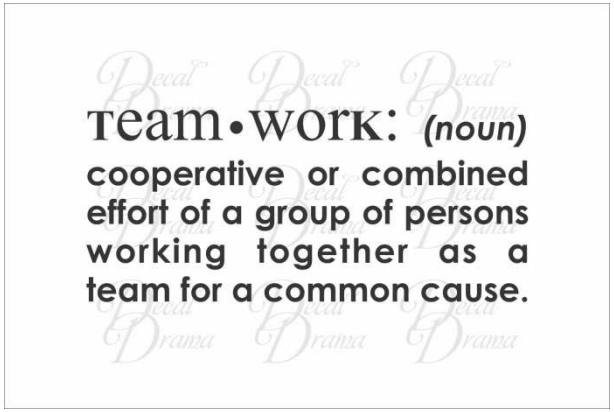
- Laboratory staff complete lengthy training and education in blood transfusion science
- Annual competencies, CPD programme, NEQAS
- Knowledge extensive in certain areas *but lacking in clinical relevance*
  - Can offer valuable support and education
  - Can direct to guidelines, haematology advice

Myth 2

‘Doctors know more than us about blood transfusion’

Collaboration

- Working together is the key
- We know stuff, they know stuff – not the same stuff, but important stuff!
- Stronger as a team with a common goal – best practice for best patient outcome



Myth 3

‘I don’t have the authority to challenge’

Facts

- Know your rights *and* responsibilities
  - **BMS:**
    - HCPC registration – must take responsibility for own actions
  - **Medical staff:**
    - GMC and medical liability insurance - as above, but with extra cover
- Be aware of your place in the clinical pathway – does the buck stop with you?

- *Doctors make the difficult decisions and take ultimate responsibility for the patient in their care*
- *You will be held responsible for any avoidable delay in provision which results in patient harm*

So what does that mean?

THIS IS IMPORTANT

- You have the authority to ***challenge*** a request, but…
- You do NOT have the authority to ***refuse*** it

- It’s important they know you aren’t saying ‘No’, you are just seeking advice
- So…if you get a request that doesn't ‘fit’ the guidelines…

Establish clinical urgency immediately

Patient has life-threatening bleeding/trauma/arrest?

YES

- Start processing request
- *(bleeding - suggest they declare Major Haemorrhage?)*
- Recommend they discuss with haematologist ASAP
- Take name and number and contact on-call haem medic yourself!

NO

- Refer them to relevant Trust guidelines
- Tell them this request must be reviewed by the Transfusion Team and explain how it doesn't meet Trust guidelines
- Ask for their contact details and aim for a prompt response

Myth 3

‘I don’t have the authority to challenge’

SHOT Bites No 8 Massive haemorrhage - delays

SERIOUS HAZARDS OF TRANSFUSION

Email: shot@nhsbt.nhs.uk **Telephone:** 0161 423 4208 **Website:** www.shotuk.org

Background:

- 'Delay in appropriate transfusion contributes to death and morbidity in sick patients and is often caused by poor communication between clinicians and laboratory staff' (Key Message in the 2015 Annual SHOT Report).
- The number of reports of delays causing harm has increased each year (2010-2015).
- There were 94 cases of delays in the 2015 Annual SHOT Report; some patients suffered cardiac arrest. Many delays, 67%, were emergency or urgent requests. There were 6 deaths in which delay contributed and 5 cases of major morbidity, 2 in major obstetric haemorrhages.

Common Reasons:

Communication Failure contributed in 25% of delays reported (SHOT 2015-16):

Key Messages:

Desire to follow good transfusion practice in some areas, if taken out of context, may risk patient death or morbidity due to delays in transfusion in MH scenarios.

Examples include:

- avoidance of unnecessary use of O D- at all
- giving 2 units of O D- only and no more permitted while a patient's sample is tested for ABO group, or a 2nd group check is awaited, or a discrepancy in patient identification means that a repeat sample is needed
- withholding any blood as the antibody screen is positive but antibody identification is not yet known
- avoiding wastage

In all these scenarios, there are safety concerns, but if clinical harm to patients from withholding blood outweighs these, then emergency blood is essential and should be offered
(e.g.: O D-, O D+, group specific, or ABO full Rh & K matched, depending on the scenario).

- Treat all MH calls as emergencies until proven otherwise

To achieve this?

- Guidelines must be pragmatic and comprehensive, well evidenced – NICE, BCSH
- Accessible to lab staff & medical staff
- Medical staff must know the lab staff will challenge requests
  - Medical induction/teaching
  - Governance meetings etc.
- Good education for medical staff
- Changes hospital perception of labs
  - Will start asking labs for advice
  - Supportive service
- AfC banding

What if things get heated?

- Empathise – you do not have the patient in front of you
- It takes two…try not to get sucked in
- Always be polite and calm, constructive and helpful
- This is where robust guidelines help
- Take their name and contact number
- Document *everything*

PASS IT ON TO A HAEMATOLOGIST

REMEMBER: no-one has the right to be rude or abusive

- there is a **patient** at the end of this – it's not about you
- We're all on the same side – common goal

Essentials for an empowered blood transfusion lab?

- ✓ Educated, competent, supported and motivated team of BMSs
- ✓ Enthusiastic blood transfusion manager and TT
- ✓ Clear guidelines for use of all components
- ✓ Supportive haematology medical team

Thanks!

Any questions?