Implementation of BloodTrackTx® into Leeds Teaching Hospital NHS Trust

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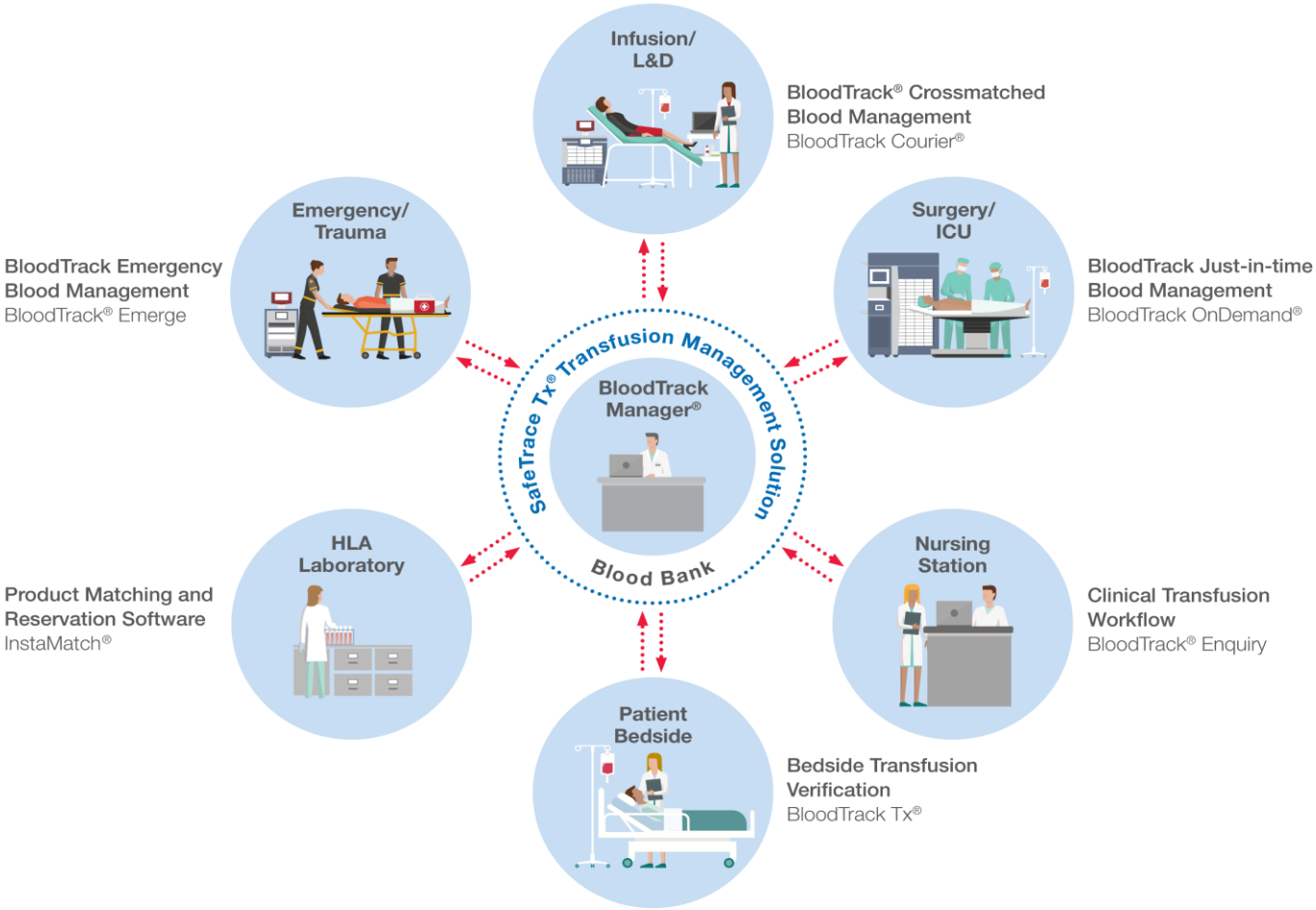
Where do I begin?

- Background
- Information Gathering
- Project Team
- Training Workstream
- Present Day

Electronic Blood Transfusion System

'Use of an electronic blood tracking system (such as BloodTrackTx®)is no longer an innovative approach to safe transfusion practice, it is the standard that all should aim for'

Ideal World in Leeds!



Background-
Leeds from 2005 to 2018

- ✓ In 2005 Leeds Transfusion lab and TP Team introduced Haemonetics BloodTrack Autofate to ensure traceability
- ✓ 2 business cases presented to introduce EBL to help promote but not seen as being the “right time” by the Trust
- ✓ 2018 MHRA inspection that highlighted that LTHT did not have an updated risks assessment for NOT introducing the 2 sample rule
- ✓ WBITs were highlighted during the MHRA inspection
- ✓ Clinical directors, senior management teams and MHRA wanted assurance that transfusion samples were taken and labelled safely across all 5 hospitals

Decision to introduce EBL -2018

'The use of secure bedside electronic patient identification systems reduces this risk; however, in the absence of such systems, it is highly recommended that a second sample is requested for confirmation of the ABO group of a first time Patient'

- ✓ Trust complied with National Guidance and ensured that patient safety was enforced
- ✓ Decided to build on the existing Haemonetics system and introduce/invest in
- ✓ BloodTrackTx®- sampling
- ✓ BloodTrack Administration
- ✓ Haemobanks

- ✓ However still had to call the Clinical Lead to ask if "are we getting this or what?"

Procurement

£1.4 million bought us

- 200 PDA's and Printers
- 19 Haemobanks across all 5 sites
- Training module on Bloodtrack
- Band 7 TP post to implement and maintain
- Videos to aid training
- 20 Wristband printers and cartridges
- More bought than any other hospital in the UK-

Information Gathering

- ✓ 2019- no restrictions to travelling!
- ✓ Other TPs- pick their brains
- ✓ Trips to other hospitals that had implemented a similar system

What did we want to know

- What did it look like
- How did it work
- Hints and tips to introduction
- What worked, what didn't
- Networking
- Nice food and sights!!!

Project Team

- ✓ Agreed very early on in the project to set up project teams
- ✓ Workstreams identified-IT, lab and training with expert leads
- ✓ Project lead- -not soon enough
- ✓ IT not involved in the business case and had covid to deal with
- ✓ TP's designated to Training Workstream
- ✓ Assurance board-Senior Pathology Management, lab staff, IT and associate director of operations for the trust, Communication team

Training and implementation-or so we thought

- ✓ Full Steam ahead-scoping and networking on 1 ICU
- ✓ Training plan-to implement sampling, admin and HB's in one go
- ✓ Base ourselves in ICU for 4 weeks
- ✓ They already had a part functioning Haemobank
- ✓ 12 hour days for the training team-capture days and nights
- ✓ Learn the process and reflect on what improvements can be made

Reflection- Background, Procurement and Project Team and initial Training

What went well?

Funding approved of 1.4 million
Band 7 TP for training lead
Equipment-configured by IT
Working HB in the lab to use for training
Working to strength-linked with CE's, Matrons and Medicss
Networking-did lots of this-they were keen to trial

What could we have done better?

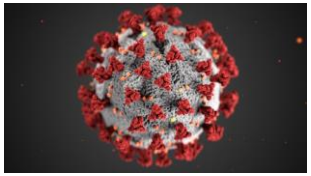
Widened our focus group- why did we not include our users
No discussion about what equipment we really needed
Did not appreciate that what works in one hospital may not work in another
Band 7- TP? Could money have gone to a project lead?
How do we record the training- new system-CHS 132
Did we appreciate the enormity of this

April 2020

Plans changed-

Introduce sampling only

Restriction to teaching-



Covid

Readdress all what we had planned

Training- Major Operation

- PPT on ESR platform-make friends not enemies
- Video
- Training Project team-met fortnightly
- Who needs to know- the whole trust!!
  - HONs
  - Matrons, Team leaders clinical areas
  - Clinical Educators
  - Medics
- Screen savers, bulletins, Start the week
- Scope each area-Eqt, times to train
- Extra staff on board

Given go ahead to train F2F

Covid experts on cleaning and PPE

Decide plan of action

Pilot

Then

areas at risk of 2 sample rule first then rest of Trust CSU by CSU

Pilot-area of high usage

Haematology day ward

2 weeks HTT presence

Evaluate then into the rest of the trust

Reflection on Pilot and scoping

What went Well

Staff receptive

scoping and being prepared
Picked it up quickly
Found it easy to use
F2F
Loved it-less rejections from the lab
Training tools

What Challenges were there

print label after ID of patient
NHS numbers faded
Covid restrictions-social distancing-access to areas,PPE
Team Leaders busy with Covid and lack of staff

And so it begins

Scope each area
Who needs the training? Where can we train? When best to train?
Areas where patients would have had one sample first
Pre-assessment, A&E, paediatrics, phlebotomists then the rest of the trust-CSU by CSU
6 weeks in each CSU

Start using as soon as trained

Whole trust trained in 6 months-2862 staff trained , 30 clinical educators and 101 trainers

TP-1.6 WTE
Extra help-1.2 WTE
Worked six am –six pm depending on need
Some weekends

Very tiring but equally satisfying when all areas using the Bloodtrack Tx system

How did it Go

What went well

Training ward team
Training trainers and CE's
Could move quickly between CSUs
Dedicated training team
Don't think we spread covid!!!

What were the challenges

Wristband printers
Wristbands for outpatients
Clinical areas busy
Training Doctors
Areas in Trust not identified –samples coming to lab
NHS numbers faded-zebra informed
ID badges-forget
medical students, bank staff and locums
label rolls and faulty equipment
Equipment going missing

Communication for all doctors to attend training
Drop in sessions twice weekly for all to attend
Audited written samples to highlight poor uptake –project board

Medical students-training in the Medical Hub
Bank staff- all told attend the drop in sessions
Locums –Training on induction to that CSU

Equipment checks two weekly in all areas and 6 weekly at peripheral sites
BloodTrack Tx is on the daily ward assurance check for all clinical areas
TP's available to action any problems

Problems identified

PAS numbers-wristband identical
Pre-printing labels
Equipment not being charged
Staff not getting the training –could still handwrite

Zero tolerance to handwritten samples-
Trust wanted to pilot this first to see if safe to do so

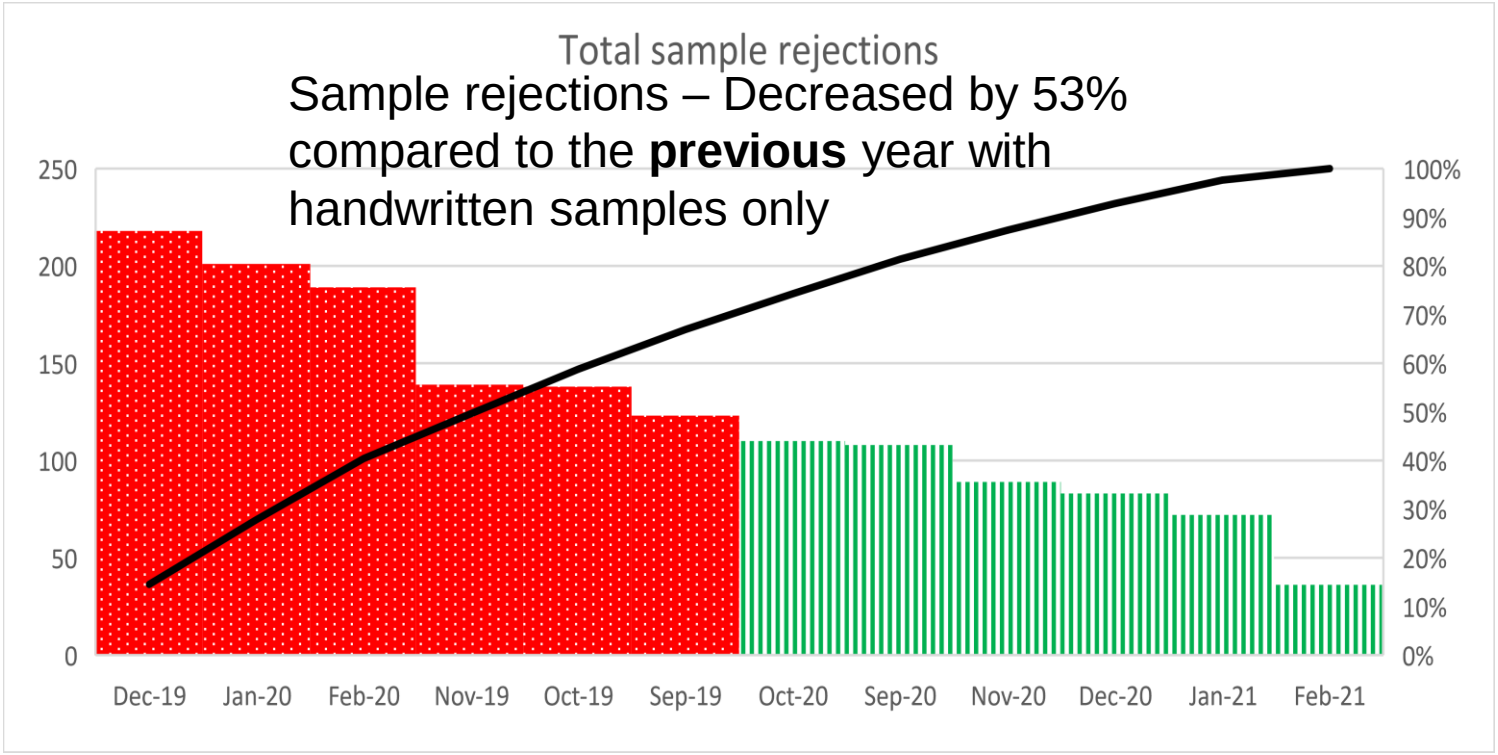
Sharing ID badges
Printing labels for others not trained
More work for those that were trained
Stopped the pilot as unsafe
Education and communication in ED
Bloodtrack Tx ED champions
Trust would not commit to zero tolerance and still haven't

Where are we now?

93% of Trust use Bloodtrack Tx
Audit written samples daily and follow up
Embedded new culture-lots of staff now don't know any difference
Reduction in rejected samples
Still not implemented 2 sample rule
Minimal problems in clinical area

Two recent WBITS with BloodTrack Tx-is it safe to implement one sample with EBT?
Should it be a two sample rule regardless?
We now train using evidence of bad practice

Quality improvement Projects-Kara Manning (BMS) and Stephanie Ferguson (TP) 2021



What do staff think of Bloodtrack Tx

"much quicker"

"user friendly"

"less rejections"

"I love it"

"why have we not had this before"

"saves time"

"Simple"

"Feel better protected"

References

-PHB Bolton –Maggs (ED)on behalf of the SHOT steering group, The 2017 Annual SHOT report (2018)

Transfusion Medicine|GUIDELINESGuidelines for pre-transfusion compatibility proceduresin blood transfusion laboratories*British Committee for Standards in HaematologyC. Milkins,1J. Berryman,2C. Cantwell,3C. Elliott,4R. Haggas,5J. Jones,6M. Rowley,3,7M. Williams8&N.Win