

Workshop – Putting Patient Blood Management into Action – Thursday 18 June 2015

On Thursday 18th June 2015, the West Midlands Regional Transfusion Committee (WM RTC) held a workshop entitled 'Putting Patient Blood Management (PBM) Into Action'.

Andrea Harris (NHSBT PBM Regional Lead) reported on the results of a WM RTC PBM Survey (attached).



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Andrea also provided details of recently produced PBM resources, including:

- Resources from NHSBT (<http://hospital.blood.co.uk/patient-services/patient-blood-management/>) including Single Unit Transfusion resources and Hospital PBM group terms of Reference
- AABB: Building a Better PBM Program Business Case (www.aabb.org/pbm)
- Australia PBM Guidelines (<http://blood.gov.au/patient-blood-management-pbm>)

Janine Beddow and Bethia Summers then provided an overview of PBM activity at University Hospital Coventry and Warwickshire (attached).



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Following this, the attendees were split into four workshop groups, each looking at a specific PBM activity:

- How can we increase PBM 'buy-in' across Trusts
- Pre-operative assessment
- Laboratory Staff Empowerment
- IV iron (focussing on post-operative / medicine)

Feedback from each workshop is summarised below:

How can we increase PBM 'buy-in' across Trusts

Support – is needed from the top – but monitored by whom?

Money talks ! – Audit results should be presented at Board level and to Consultants – clinician buy-in.
Impact of budget (whether or not budget is devolved)

Safety – Blood transfusions are generally very safe. Worst case scenario of 'wrong blood' has only ~10% mortality, although ABO incompatible transfusion is a 'never Event'. A serious incident at one Trust is likely to raise awareness.

Education – use of posters / charts / policies / use of hospital intranets
Transfusion dosage charts indicating how much to transfuse depending on patient weight and required rise in Hb.
Contact staff in a timely manner when investigating incidents (e.g. wastage or possible inappropriate use)

Healthy Competition – Reports with ward / speciality / consultant data
Avoid 'League of Shame'
Focus on 'Best of' – improve best to be better

Need to engage with GP's – use of iron supplements / appropriate treatment of anaemia
Public health – what is best for patients

Laboratory Staff Empowerment

What's required	Barriers
<ul style="list-style-type: none">• Clear indications for component use• Policy supported by Consultants / Senior Medical support (Medical and Clinical Directors) – concordance between clinical and laboratory practices• Consultant Haematologists need to support Laboratory Staff• Clinical Education for Laboratory Staff• Keep laboratory staff abreast of changes / initiatives in clinical practice• Real-time communications• Electronic Issue	<ul style="list-style-type: none">• Lack of support from (some) Consultant Haematologists• Lack of support from (some) Medical and Clinical Directors• Apathy• It is easier to provide blood components when requested rather than to question• Lack of knowledge / time for education activities• Lack of confidence• Culture – need to break down cultural practices (may put doctors out of their comfort zone).

Pre-operative Assessment

What are the current limitations?

- Pre-operative assessment is a fragmented service
- Commissioning
- When patients are referred back to primary care – variable outcomes
- Timeframe targets for surgery. Patients are put on the waiting list for surgery before they have been fully prepared and optimised.
- Waiting list officers not understanding the issues
- 'Anaemia' is currently a 'tick box' for pre-operative assessment
- Lack of understanding that the lower the Hb pre-operatively, the increased risk of mortality and length of stay

What is needed?

- Pre-operative assessment needs to 'own' the waiting lists
- As patients are referred to pre-operative assessment, patients need to have appropriate blood tests taken (including FBC, B12, folate, serum iron, transferrin, ferritin)
- Appropriate referrals back to GPs for appropriate treatments and investigations – the pre-operative waiting list clock is stopped during this time (but allows for Cancer / Urgent Fast Track).
- Patients only listed for surgery once fully pre-optimised

IV iron (focussing on post-op / medicine)

Need to be able to clearly identify patients

- Simple algorithms (1 sheet)
- Education, Education, Education !
- Audit

Challenge practices

- But by who? - Suggest employing a PBM practitioner (paid for by saving blood!)

Find out who is using iron, and who could use iron?

- Audit
- Share practice and experiences (at Trust level and at RTC)

Custom and Practice

- Need to increase awareness, patient empowerment, education, audit
- Need to address 'fears' of IV iron - education

Consider Oral Vs Intravenous (IV) iron

- Oral iron is cheaper but need to monitor compliance and manage side effects
- IV iron improves compliance, but problems gaining pharmacy agreement and resources / logistics for administering. Some IV iron preparations are more expensive, but faster to administer, single dose transfusions (and so actually more cost effective)

Money aspects:

- Need to consider the 'real' or 'full' cost of blood
- Audit