NW RTC Education and Training Group
‘Menu of transfusion training/minimum data set’ for different staff groups
June 2007

‘Menu of transfusion training/minimum data set’ for different staff groups

Background

The Health Service Circular HSC 2002/009 Better Blood Transfusion - Appropriate Use of Blood recommends that Trusts should ‘ensure that education and documented annual training on blood transfusion policies are administered to all health care staff involved in the process of blood transfusion and is included in the induction and orientation programmes for new staff.’

To support this initiative in the region and obtain a fuller picture of current practice, the Northwest Regional Transfusion Committees Education and Training Project Group conducted a survey in October 2006 to all hospitals in the region who had a Transfusion Practitioner (TP).

22 replies were received from 31 surveys giving a response rate of 71%.

A wide variety of practices were recorded from hospitals and the following conclusions were drawn:

- Transfusion training is more likely to be included in annual and mandatory sessions than on induction
- The average length of induction sessions tend to be shorter than annual mandatory sessions
- Junior doctors are the group most likely to have transfusion training on induction and Consultants and Medical students least likely
- Registered nurses were the group most likely to have transfusion training as annual and mandatory and Medical students least likely
- Only a small number of hospitals assessed competency at the time of this survey
- The commonest forms of competency assessment were via observation and quiz
- The TP is the most likely person to carry out transfusion training, but others are involved in some hospitals.
- A variety of other educational sessions are held in hospitals that include some degree of transfusion training
- The vast majority of hospitals (21/22) plan to, or are already using, e-learning for transfusion training

Following discussion at the NW RTC Education and Training group meeting in January 2007, it was decided it would be useful to look at what was the ‘minimum dataset/menu of transfusion training’ for the common staff groups, if only a short amount of time was available. A workshop was held at the regional TP meeting in March to develop this for the region.

NW RTC Education and Training Group

'Menu of transfusion training/minimum data set' for different staff groups

June 2007

Aim

- To provide guidance for TPs to use when developing training sessions on transfusion
- To standardise teaching and improve transfusion practice in the region

Objectives

- To determine *essential* information that should be included in the teaching sessions for the different staff groups if only a limited amount of time was available
- To determine *desirable* information that should be included in the teaching sessions for the different staff groups if time allowed

Results

The information gained from the TP workshop is summarised in the table below:

Staff Group	Essential information to include	Desirable Information to include
Non-qualified staff	• Recognition of their place in the transfusion chain • How to collect blood and transport it safely to the wards • Importance of patient identification • Need to know that blood is safe and that there are patient leaflets for the patient available (and where to get them). • Why ABO groups are so important	• Visit to the laboratory • The reason for performing observations (if applicable)
Scientists	• Blood safety and quality regulations 2005 • Blood components • Understanding of "special requirements • vCJD • SHOT • Examples of "real incidents", with emphasis on the impact on practice, plus feedback • Emphasis on the patient	• Transfusion times • Practical aspects of transfusing a patient • Appropriate use

NW RTC Education and Training Group

'Menu of transfusion training/minimum data set' for different staff groups

June 2007

Nurses/Midwives	• The importance of positive identification with all aspects of transfusion (sampling, collecting blood, administration) • Importance of good documentation and traceability • Risks/SHOT examples • The need sometimes for "special requirements" • Technical aspects of transfusion • What observations need to be performed and why • Transfusion reactions • What to do and who to contact if there are problems • Storage of blood • Time limits with transfusions of different components • Midwives: anti-D and transfusion rates for neonates	• E-learning • Blood groups • Penny Alison video • Devices used (pumps/blood warmers) • Visits to the laboratory • History of transfusion
Student Nurses	• Blood collection procedure • Transfusion times • SHOT/transfusion risks • The importance of patient identification • The need for traceability • Importance of the bedside check (mainly year 2) • The monitoring of transfusions – observations – signs and symptoms • Information about the individual components	• Basic blood group theory • Specific/local incidents • Information about preparing the patient for transfusion
Phlebotomists	• Importance of patient identification - "Wristband check" • The importance of sample labelling and not using addressograph labels • Checking the request form • Minimum data requirements for transfusion samples and forms	• SHOT • Examples of local incidents

NW RTC Education and Training Group

'Menu of transfusion training/minimum data set' for different staff groups

June 2007

Consultants	• Importance of positive patient identification • Prescription • Appropriate use • Guidelines/policies/MSBOS • Emergency blood stock management plan • Documentation in the patient's case notes • Traceability – storage – reasons why • Informed patient consent • Alternatives to transfusion available in the hospital	• Penny Alison video
Doctors and Medical Students	• Prescription • Appropriate use • Guidelines/policies/MBOS • Sample labelling • Positive patient identification • Components available to them • Practical scenarios • How to contact laboratory (specifically for induction) • Trusts documentation / traceability • Alternatives to transfusion available in the hospital • Transfusion times • Complications with transfusion	• Penny Alison video

For more information please contact:
Rebecca Gerrard, Transfusion Liaison Nurse
Tel: 0161 251 4328
Mobile: 07764 280 189
Email: rebecca.gerrard@nhsbt.nhs.uk