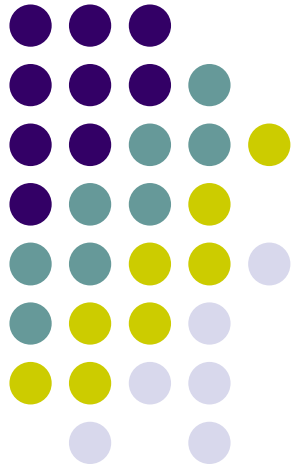
British Blood Transfusion Society
TRANSFUSION PRACTITIONER GROUP

Transfusion Practitioners
The litmus testers of safety?

Wendy McSporran
Transfusion Practitioner
On behalf of the BBTS TP Group



The TP Role – what makes a good litmus tester?

Steven Covey's strategy for effective people

- 7 Habits of Highly Effective People
- Habit 5 – Seek to understand before being understood

The joy at being told this was an actual tool for work!

State the problem					
	WHY ?				
		WHY ?			
			WHY ?		
				WHY ?	
					WHY ?
Root Cause					

The TP and litmus testing the data

National Comparative Audit of Blood Transfusion

NHS Blood and Transplant

National Comparative Audit of Blood Transfusion

25 audits of transfusion practice
2016 NCA haematology audit, 6109 episode of transfusion audited.

The number of SHOT reports 2009 – 2016
27,490

The TP often has a unique role
The global perspective

Trust processes for document ratification

Clinical culture

Audits – hospital, Regional, National

Transfusion care & prescribing

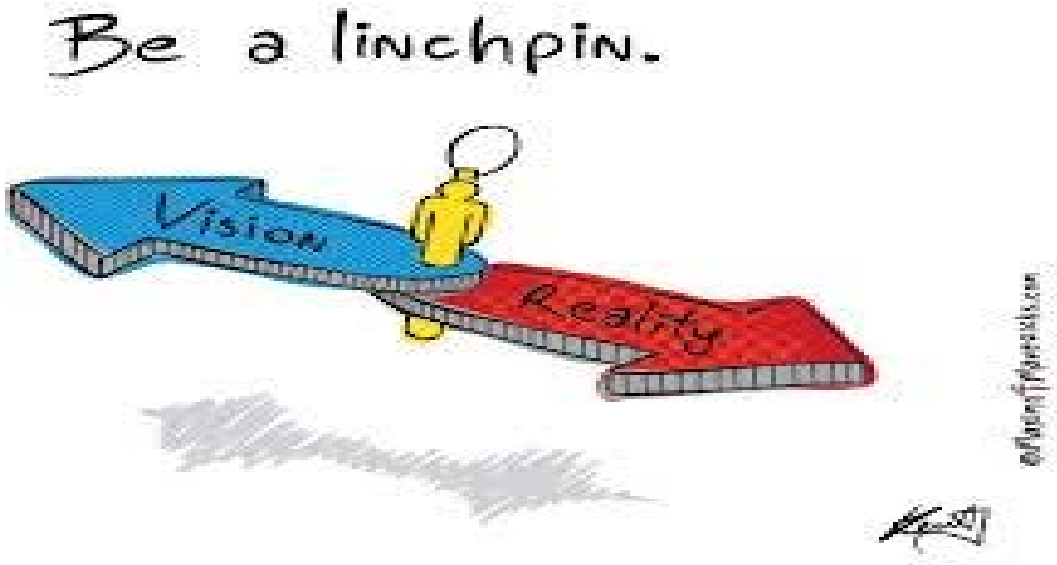
Questions in education sessions

Incident investigation

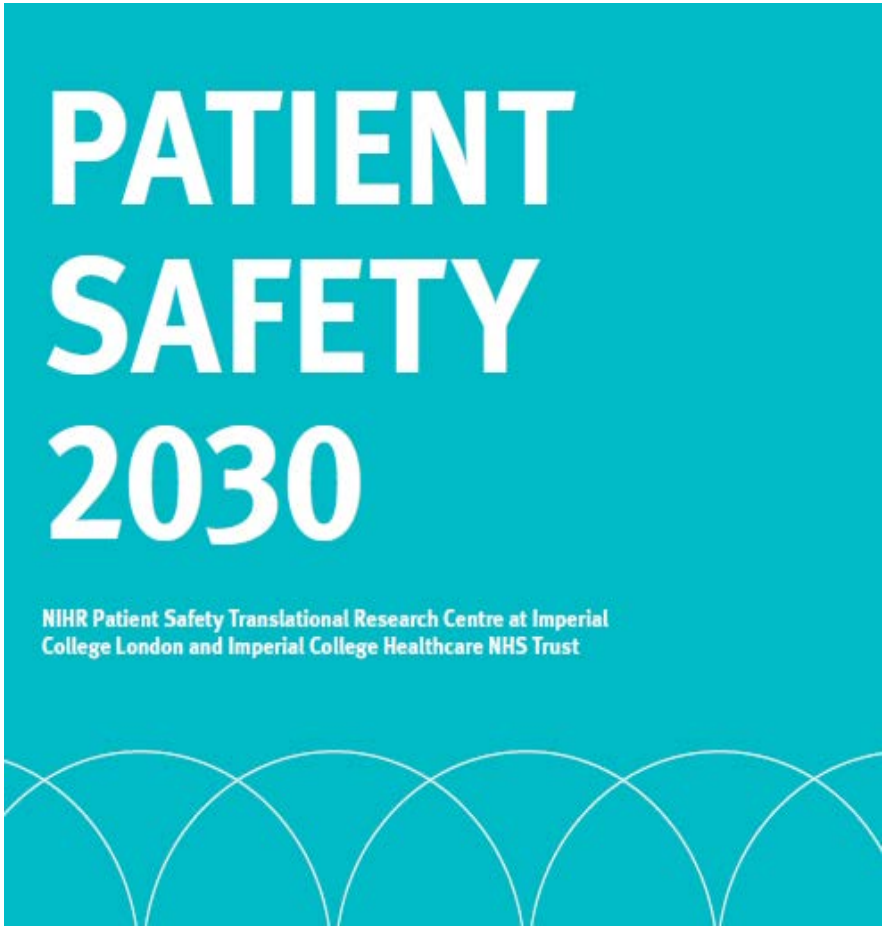
Attending trust wide meetings

TP value

- Difficult to pin down exact contribution to safety!

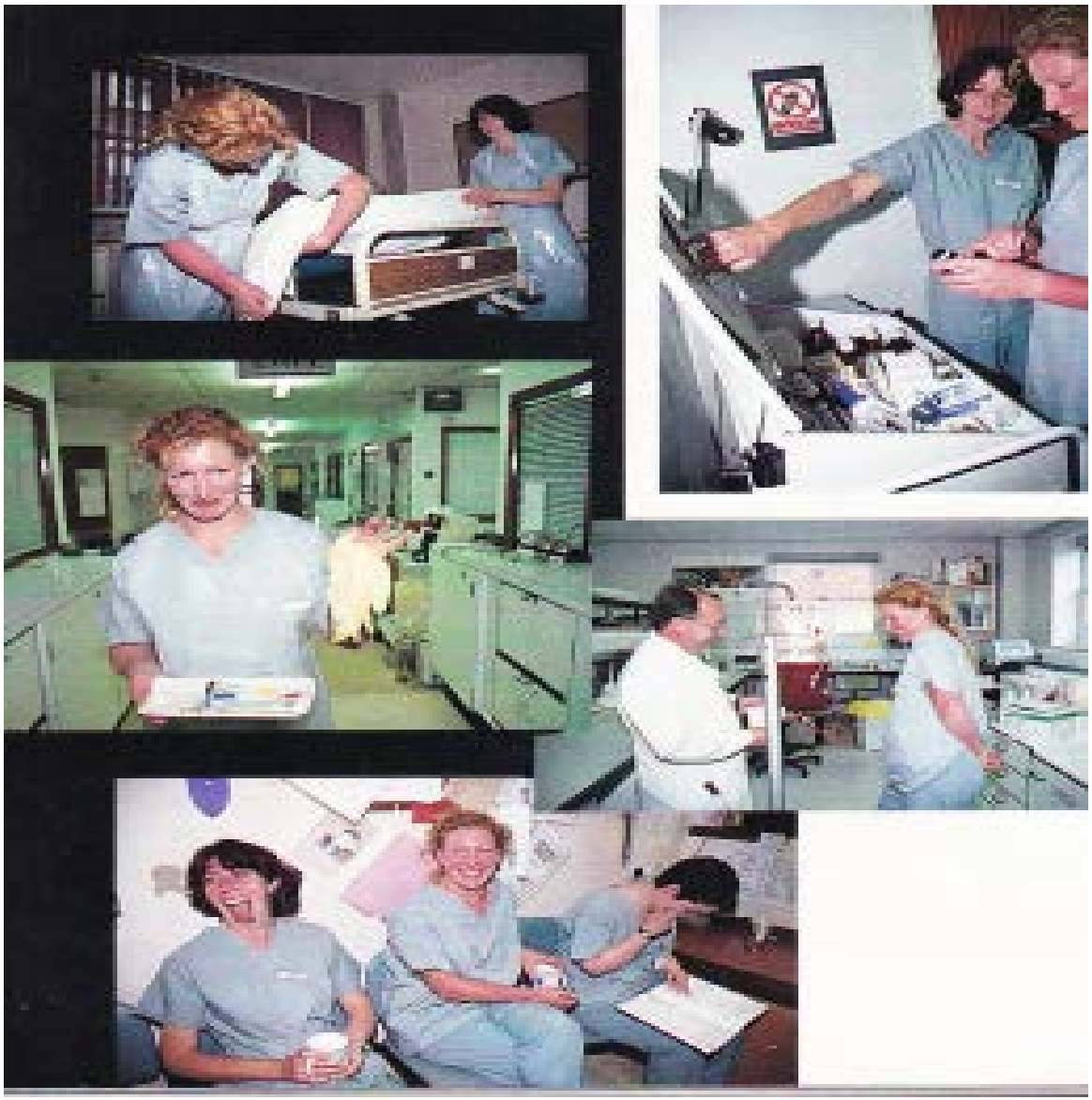


Safety Research - 4 pillars of safety



- Systems approach
- Culture counts
- Patients as true partners
- Bias towards action

Culture pre TP - 1998



Black Box Thinking
Matthew Syed

Litmus Test

- a decisively indicative test.
- "effectiveness in these areas is often a good litmus test of overall quality“ (Google dictionary)

- Is safety in transfusion a good indicator of overall safety in an organisation?
- BBTS group asked TP’s/HP’s for their case examples of transfusion impacting on other aspects of safety…….

That pesky WBIT Identification…..Fundamental to correct care and treatment.

Changed procedure for allocating hospital numbers in cases of multiple sibling births

Changes to the procedure for initial registration & attaching identification band

Influencing procedures for patients attending different departments & before discharge medication

Developing flow charts ‘who am I?’ and campaigns for Positive patient identification

Validation procedures developed for patients who could not ID themselves

Fluid & IV management

- General fluid overload not being actively managed, identified tools required to identify at risk patients regardless of transfusion involvement
- Identified issues with IV pumps and devices – too easy to accidently programme incorrectly
- Staff not aware of how to reconstitute PCC – not the only drug that comes in that type of vial!

Monitoring & Documentation of care

- Patients vital signs / observations not completed, impact found in deteriorating patients
- Share care issues also impacting on other care and treatment, medication, repeat testing/imaging, delays in treatment

Classification: Official

NHS Improvement

Patient Safety Alert

Resources to support safer care of the deteriorating patient (adults and children)

12 July 2016

Alert reference number: NHS/PSA/RE/2016/005

Alert stage: Two - Resources

Patients of all ages are known to suffer harm if deterioration in their condition is not detected or acted upon in a timely or effective manner. This is a clinical issue contributing to death and severe harm.

Research has shown that 26% of preventable deaths were related to failures in clinical monitoring. These included failure to set up systems, failure to respond to deterioration and failure to act on test results (Hogan et al, 2012).[1] In 2015 around 7% of patient safety incidents reported to the National Reporting and Learning System (NRLS) as death or severe harm were related to a failure to recognise or act on deterioration.

Many acute hospitals have developed programmes to improve the recognition and response to deterioration. These have included Early Warning Scores (EWS), initiatives and technology for improving the accuracy of taking and recording observations, and the timely escalation of care. However, it is those organisations and teams that have placed the EWS within a **whole safe system of care** that are producing better outcomes for patients.

This resource alert is supported by the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Physicians (RCP). We have brought

Actions

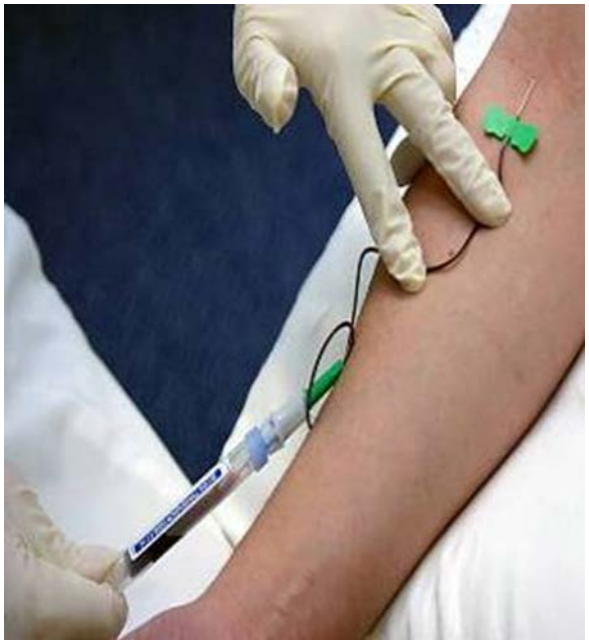
Who: All organisations* providing NHS-funded care

When: To begin as soon as possible and to be completed by 31 January 2017

1. Identify a senior clinical leader in the organisation to take forward the response to this alert.
2. Using these resources, assess whether any areas of your organisation's overall system of recognising and responding to the deteriorating adult

Unnecessary testing

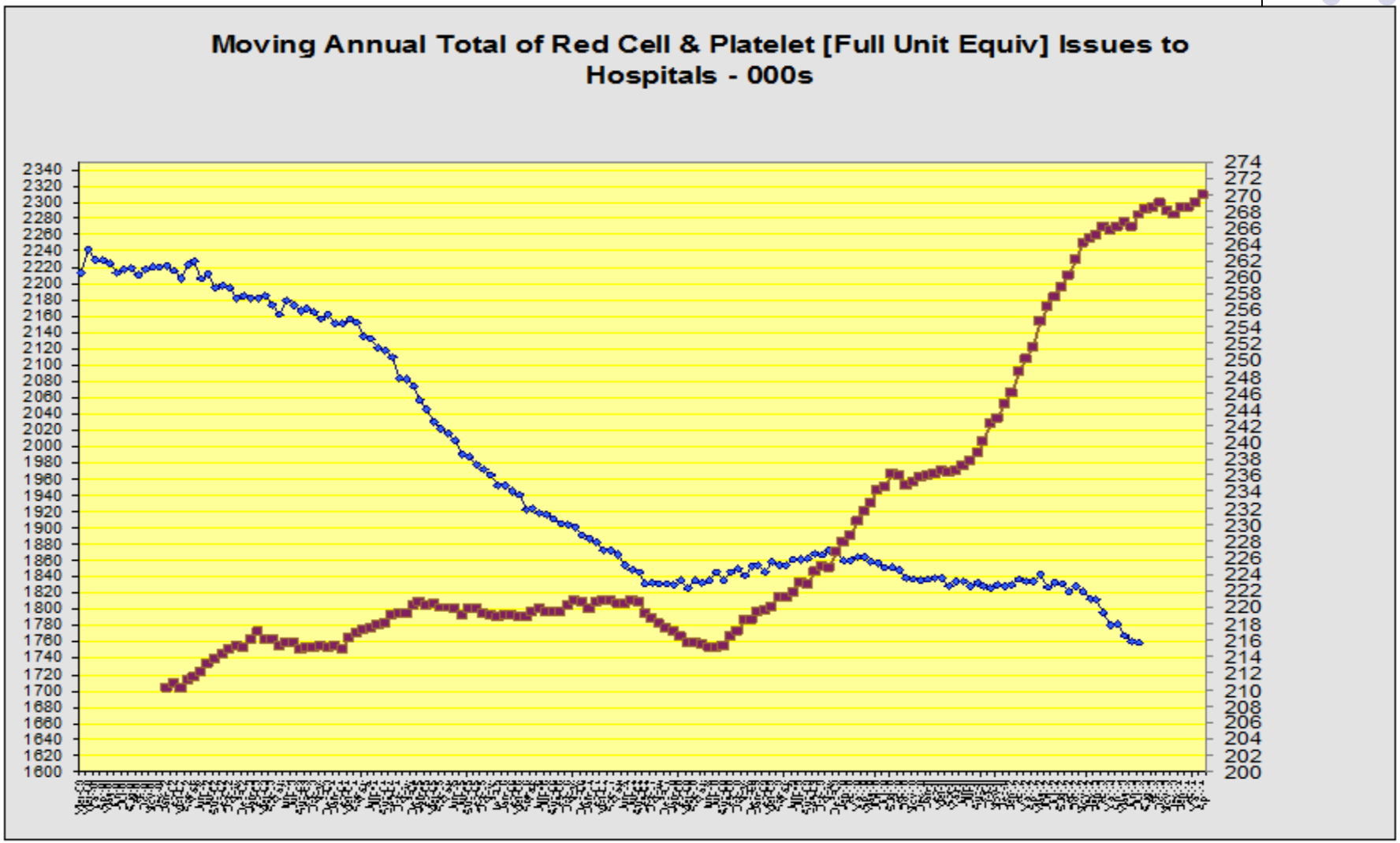
Protocols developed to limit phlebotomy frequency and volume



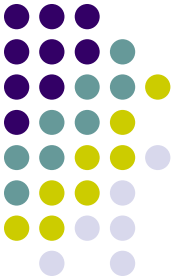
Culture of ‘routine samples’ questioned

Examination of other unnecessary tests and procedures

TP Contribution?



National Reporting & Learning System – Datix database



- January to December 2016
- 1,879,822 reports up 7% from 2015

- ‘Patient accident’(17%)
- ‘Implementation of care and ongoing monitoring/review’ (13%)
- ‘Medication’ incidents (11%)

- 0.5% severe harm or death

Going forward with transfusion safety….

- The evidence points to learning most by trial and error, implementing and evaluating
- Transfusion reports of what went well
- Further examination of:-
- Check sample – is adding a time frame more effective than not?
- The most effective way to implement the bedside checklist?

TP usually has detail of how decisions are made, risks and culture to help influence safety actions for their hospitals.

And what is the most effective way to capture peoples attention to promote safety?

Conclusion

The dedicated transfusion / haemovigilence practitioner role for ensuring patient safety for transfusion influences the overall safety culture and has a direct impact on other patient care.

Thank you

With much thanks to all the practitioners who took the time to submit cases