Routine

BLOOD DONOR SESSIONS

The organisation and staffing of the donor sessions was last reviewed and changed by myself in 1970-72 and this introduced the fixed staff in teams, altered and standardised the session layout and established the pattern of the individual donor attendants caring for alternating bleed/rest beds. These changes coincided with the introduction of computer selection, calling and update of donor serological and management information. Since that time the situation has become much more complex and hazardous with a corresponding awareness of hepatitis, A.I.D.S. and other transmissible disease together with greatly increased complexity introduced by the multiplicity of the types of products and types of blood bags.

Meanwhile the staffing of each donor session has remained virtually static but the number of donors bled per session has increased and the duration of the individual sessions has been shortened. This has all led to a great increase in pressure on the staff, particularly on the medical officer who not only has to venesect the donors but must also be responsible for the selection or rejection of the donors and the aftercare of the donors, including the faints and the occasional convulsive attacks. The pressure has increased to the point at which to run a session of 120 or more donors safely further qualified and trained assistance is essential. I was aware of these trends four years ago and when Dr. Ala arrived, I hoped and anticipated that he would take his share of the burden, become aware of the problems and use his position to make the resources of staff etc. available.

Since that time the need to be highly selective of donors to avoid transmission of AIDS has become an urgent need. Instead of an increase in assistance and in staffing of this vital part of the service the situation has further deteriorated in the last three years. It is essential that more qualified nursing staff (S.R.N sisters and staff nurses) are allowed (see nursing officers)

MEDICAL OFFICERS ~~Doctors are allowed and every donor session of 120 donor attendances or above should have an S.R.N~~

As outlined in the preceeding section the medical problems of donor selection are now urgent and require both increased numbers of medical staff and more specialised training. The number of contracted sessions is now below the number required to cover the 34 weekly donor sessions and provide the reserve to cover leave sickness, answering of donor medical queries etc. It is worthy of note in this respect that N.W. Thames B.T.S. have one medical officer in addition to consultant staff to answer telephone questions put by donors. There is also an extensive postal correspondence with donors relating to donors who are on medication, have had operations, diagnoses of illness, fear of AIDS etc. which requires medical guidance. Although I do my best with these problems the available time and secretarial help is inadequate and most queries are dealt with by non-medical staff. In addition there are problems with the need to examine blood smears, counts, diagnosis of anaemic donors (approximately 15-20 per day) and to report on the results to their own doctors. For much of the time I am the only medical officer in the Vincent Drive premises and because I am not informed of the movements of Dr. Ala, and because Dr. Koster spends ~~most~~ much of his time at the BMH/QEH attending to their pheresis, I find it difficult to go out to outside sessions or to Cannon House.