AUDIT OF MEDICAL INPUT IN THE BLOOD TRANSFUSION SERVICES

Summary

The following recommendations are made for the institution of audit of medical input within UKBTS:-

1. External audit of medical functions within the RTC should be carried out by a team composed of the appropriate National Director or his nominee and consultant members of RTCs from RTCs outside the Division to which the audited centre belongs, and SNBTS. This audit would take place on an annual basis, and would cover a selection of the medical activities outlined in this report (sections 1.1.3 and 1.1.4).

2. Internal audit of medical input to the activities of the RTC should be carried out at regular meetings of senior medical staff, including representation of medical staff whose only involvement is in participation in donor sessions. This internal peer review could, with advantage, take one topic from the list set out in section 1.1.3 of this report, at each meeting.

3. Every teaching hospital and DGH should have a hospital transfusion committee, at which the local RTC should be represented either by a member of its consultant staff or by the hospital consultant haematologist, as appropriate. These committees would form the first line of external audit of the medical consultative service offered by the RTC.

4. Regional transfusion committees should be formed, chaired by the Regional Medical Officer or by a similarly independent medical officer, and with heavy representation of users from all appropriate clinical disciplines, including general practice. This committee will take a broader view of the service being offered, including medical involvement.

DRAFT

MEDICAL AUDIT OF BLOOD TRANSFUSION PRACTICE

Objective

The objective for medical audit of blood transfusion activities is to promote the safe and cost-effective supply of blood and products to patients in accordance with agreed guidelines and thereby ensure maximum therapeutic benefit.

The need for audit

The clinical use of blood and blood products should, in common with other medical activities, conform as closely as possible to accepted standards of good practice. Blood products are costly as indeed are some technical practices (e.g. usage of blood filters). The expenditure for blood products within the Welsh Region has shown steady growth over the last decade and currently approaches £5,000,000 annually. Safety and efficacy are particularly deserving of attention. The last decade has seen enormously highlighted awareness of transfusion risks - mishaps arising from sub-optimal practice are likely to be judged in an increasingly less sympathetic medicolegal climate. Containment of costs and safety aspects is likely to become increasingly difficult, not only are clinical pressures arising from the volume of work constantly increasing, but so also is the complexity of therapeutic problems - both factors bringing a correspondingly increased vulnerability to error. Audit of transfusion activities is therefore as deserving of attention as it is in other fields of medicine.

Hospital Transfusion Committees

Hospital Transfusion Committees have been promoted as an effective vehicle for discharging audit activities. Their composition should reflect the mix of disciplines most involved in transfusion. For example, the Consultant Haematologist would be expected to be the linchpin co-opting assistance from anaesthetic, obstetric, paediatric, surgical, nursing and laboratory scientific officer colleagues. It may, however, be more appropriate for the committee to be chaired by someone other than the Consultant Haematologist or RTC representative. The remit of such committees could include:

1) Educational aspects

Confirming that appropriate action is taken with regard to the following matters:

(a) Awareness of national guidelines for promotion of good transfusion practice.
(b) Development of local hospital guidelines.
(c) Transfusion policy induction procedure for new staff.
(d) Review of nursing procedures for administration of blood products.
(e) Promotion of important new information regarding transfusion matters.
(f) Ensuring that patients are adequately informed of matters that may concern them, e.g. availability, where applicable, of autologous transfusion options.

2) Audit and Review

(a) Review of trends of usage of blood products over time.
(b) Review of unexpectedly high patterns of usage.
(c) Assessment of transfusion practices in the light of previously agreed criteria for product usage.
(d) Review of compliance with blood ordering tariff systems.
(e) Review of blood product wastage rates.

3) Policy Development

Development and review of policies regarding:

(a) Emergencies, major incident casualties, usage of plasma expanders, group O negative blood under such circumstances etc.
(b) Inaccurately identified transfusion samples.
(c) Blood transfusion record keeping and documentation.

4) Safety of Transfusion

(a) Review and notification of transfusion complications (e.g. post transfusion infections etc).
(b) Establishment of review procedure to investigate serious transfusion mishaps.

5) Review of Proficiency Assessment Performance

(a) Consideration of transfusion laboratory proficiency assessment performance.
(b) Consideration of compliance with product specification and measurable indicators of service provided by Regional Transfusion Centre.

Hospital Transfusion Committees could have an overview function with regard to many of the above items encouraging particular clinical departments to review and question the appropriateness of their own transfusion practices by a peer group pressure

mechanism. There is good evidence to suppose that at least for certain blood products, a substantial proportion of usage does not accord with well founded clinical guidelines. Making inroads into such areas of dubious use would contribute greatly to safety and economy.

Regional Transfusion Committees

There are likely to be considerable difficulties in agreeing standards, identifying obtainable objectives and assessing progress in audit activities. Accordingly, there may well be benefit in encouraging local nominees from Hospital Transfusion Committees to participate in Regional Transfusion Committee meetings. These could be a funnel for channelling new ideas into the audit system and also enable participants to share experiences and assess their own local situation against a wider background. It might be appropriate for the chair at such meetings to be taken by someone outside the immediate hospital environment, for example a District Chief Administrative Medical Officer. Minutes of Hospital Transfusion Committees might usefully be available as agenda items.

Regional Transfusion Committees would also be well placed to audit the Regional Transfusion Service contribution, both in terms of consultant medical activities, as well as routine service provision.

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