Regional Road Shows 2008
Summary Feedback
Ordering and Replenishment Workshops

1. Web based ordering

- The general consensus was for the introduction of web based ordering. Considered to be suitable for routine orders only – request for a feedback system to ensure the order had
  - Been received
  - Created
  - Filled
  - Despatched
- A phone call of fax would be first preference for non standard orders e.g. irradiated, phenotyped units, HLA and urgent orders
- Not all hospitals have easily available internet access which may pose a problem for universal web based ordering. Some PCs with internet access are not available out of hours. Some Trusts may need to upgrade IT systems and/or PCs.
- A few hospitals represented would prefer to continue with faxing their orders

2. NBS issue managers ability to view hospital stock levels to ascertain ordering requirements

- NBS would not be able to see units in the reserved fridge or in satellite fridges, these are taken into consideration by the hospital laboratory when placing an order
- Some hospitals like to “top up” an order, this would not be available
- There was a feeling of lack of understanding by NBS staff of the situation hospitals face regarding the requirement for blood
- Clear unambiguous guidelines would be required
- Some larger hospitals did not have a problem with this concept

3. National Call Centre for blood ordering and enquiries

- A unanimous no.
- Not a good idea
- Where would it be?
- Another variable
- There would be no local knowledge – the working relationship with the local centre is considered to be very important

4. Reasons for Ad *hoc* ordering

- Mainly for platelets and phenotyped red cells
- Not enough routine deliveries

- For HLA matched platelets

5. How could hospitals reduce the number of *ad hocs?*

- Encouraging medical staff to batch orders
- Batching orders in the laboratory
- Adherence to hospital guidelines for platelet requests
- Having back up from a “strong” haematology consultant
- Educate medical staff re. cut off times for platelet orders
- Stock rotation between hospitals
- Implementing a devolved budget – clincians then take responsibility
- Two routine deliveries a day for all hospitals
- Audit of *ad hoc* requests
- Acknowledgement that hospital life has changed and patients may arrive at any time, it only takes one patient to generate an *ad hoc* request
- Use of an “ice cream style” blood delivery van that held additional units especially platelets

6. Would your hospital consider holding a stock of platelets?

- It depends on platelet usage – larger users could hold a stock, no justification for smaller users
- One hospital reported that stockholding of platelets reduced their *ad hocs* by 70 – 80% and did not increase wastage
- Some hospitals wanted to hold a stock but could not get them
- Some hospitals reported restrictions on availability
- Stock holding is a good idea provided the platelets have an appropriate shelf life

7. How would you feel about the use of a replenishment model?

- More stock leads to increased wastage as demonstrated by the BSMS
- Red cell usage is very variable
- Would still need *ad hoc* deliveries
- Hospital wastage would be likely to increase
- Hospitals did not want to hold more stock
- The NBS would have to change its issue practice and issue units with a variable shelf life
- Little support for it

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Clinical/Laboratory Interface Workshops

8. Platelet ordering by Clinicians

- Usually ordered on an individual patient basis
- Nurses often order for haematology ward patients
- Platelet orders are accepted once approved by the consultant Haematologist
- Some hospitals had special early phlebotomy rounds for haematology patients, these ensured that the sample arrived in the laboratory by e.g. 8.30, the results were back by e.g.10.30 and the platelets ordered by midday so that they could come on the afternoon delivery
- Some hospitals reported saving up the orders and making a bulk order with the blood centre

9. Platelet ordering cut off times

- Many hospitals have a published order cut off time
- Many hospitals reported that a cut off time is difficult to implement as medical staff ignore it
- Hospitals reported that haematology consultants are often worse than other clinicians for ignoring cut off times
- The system fails when new registrars start

10. What is the biggest impact on platelet ordering patterns?

Positive

- Early availability of results and availability of clinician to view the results
- Strong lead from Haematology consultant
- Vetting of platelet requests by Haematology consultant
- Educating junior laboratory staff to batch orders rather than send each one as they come in
- Having a devolved blood budget

Negative

- Individual clinician ordering
- Pre-ordering of platelets in haematology clinics and then finding the patients don't need them
- Surgeons not planning platelet requirements
- Unpredictability
- Apparent lack of understanding of the process by clinicians
- Plans falling down at weekends and bank holidays

11. The impact on red cell stock management from clinical ordering practices and patterns

Positive

- Having laboratory staff who are confident and experienced enough to challenge clinicians
- Training laboratory staff in protocols etc.
- Electronic issue

Negative

- MSBOS not followed
- Poor surgical planning – often the laboratory is the last to know of a requirement

12. Changing clinicians practice

- Difficult to access medical staff for training purposes
- Junior medical staff are told what to do by senior staff who are often unaware of the protocols
- There is historical poor practice which is difficult to change
- Poor representation on the hospital transfusion committee
- Need more knowledgeable, confident laboratory staff
- Some hospitals felt they were banging their head against a brick wall; no one will listen

13. Strategies employed in hospitals that have managed to change practice

- Pro-active transfusion practitioner who is confident to challenge surgeons and anaesthetists
- An active confident lead haematologist for blood transfusion
- Using audit to highlight practice
- Holding a minimal stock of platelets where these can be used as required
- Sharing stock around the Trust
- Inviting clinicians into the laboratory
- Get "buy in" for transfusion policies at Trust level – easier to do if you can demonstrate savings
- Data collected and presented to appropriate directorates on over-ordering, inappropriate use, under usage etc.
- Quality reports presented to directorates to encourage changes in practice
- Introduction of electronic issue
- Communication works when appropriate language and style is employed for particular groups

14. What is the most useful tool to change clinical practice?

- Audit and education
- Data feedback to clinicians
- Devolved budget
- A clinical champion e.g. transfusion committee chair of consultant haematologist
- Strong lead consultant haematologist
- A pro-active hospital transfusion committee

15. Reducing the use of O Neg

- Only holding O Neg flying squad units in the laboratory blood fridge and not satellite fridges
- Too many fridges with O Neg flying squad units – often due to clinical insistance
- Educating clinicians on the appropriate use of O Neg
- Audit the use of O Neg flying squad and feedback to clinicians
- Some hospitals queried the figure of 8.5% as the % in the general population

16. Is it appropriate to reduce the requirement for O Neg in emergencies?

- O Pos should be used in appropriate circumstances rather than O Neg
- Flying squad O Neg should only be available in a limited number of fridges. Clinicians often do not agree with this. Instant availability is more likely to lead to inappropriate use and bad practice

17. Generate ideas that would help to change inventory management practice

- Sharing stock has really helped to reduce wastage
- Consider offering group B on a sale or return basis
- Personal approach with clinicians is very effective
- Consultant haematologist support is vital
- Use an algorithm/protocol this really empowers the BMS to challenge and builds a consistent message with clinicians
- Highlight the moral/ethical issue of wasted resources
- Employ a transfusion practitioner as a communication channel, and chaser. Can follow up inappropriate use, wastage out of temperature control, give feedback and educate
- Concept of flexibility in NBS deliveries – i.e. could deliver to Crewe/Macclesfield from Birmingham rather than Manchester
- Mandatory training for clinicians
- More active stock management by senior BMS staff – the use of better laboratory guidelines on selection of blood for crossmatching for particular patients