2008 Regional Road Show Birmingham

Feedback

Clinical/Laboratory Interface Workshop

1. How do clinicians order platelets in your hospital?

(a) Is it per patient?

- Most order per patient
- Only a couple stock platelets (a couple of comments that stocking platelets can lead to increased wastage. Also some clinicians don't allow ABO mismatch and problems with CMV negative and irradiated requirements. In Ireland they are looking at introducing pathogen inactivation of platelets resulting in 7 day platelets).
- Platelets can be ordered by any grade of doctor (junior to consultant).
- On the haematology units, the nurses often order. In some cases this leads to more timely requests.
- A couple of hospitals stated that requests for non-haematology patients are 'vetted' by the laboratory staff.

(b) Do you have an ordering cut off time – if not why is this?

- The majority stated that they do have a 'published' cut off time for ordering.
- However, in reality this is difficult to implement and in some cases is 'completely ignored'.
- Depends on time results are available in the clinical area / time they are reviewed by clinical staff.
- In many cases platelets are not ordered from the clinical area (e.g. haematology units) due to other workload pressures – medical staff have not been available earlier in the day. Also haematology day units are working longer hours.
- Needs a lead haematologist to 'champion' the system.
- There are no penalties to clinical staff if they are late ordering – has no significance to them.
- Also depends on distance from hospital to NBS.

2. What would you say has the biggest impact on platelet ordering patterns in your hospital?

- Individual clinician ordering.
- Availability of results / availability of clinician to review the results.
- On haematology units – pre ordering of platelets for known patients (e.g. Mon/Wed/Fri or 'Tuesday/Friday Club') – but sometimes patients don't need them. Also problems if patients have 'shared care' and have attended another hospital and had platelets there – lack of communication.
- One laboratory is looking at introducing 'laboratory ordering' of platelets. Full blood count results are often available at about 11am – so the laboratory will review these results, and where results meet a pre-agreed criteria, platelets will be ordered without clinician input.
- For surgical patients, the main problem is clinicians not planning platelet requirements and so not ordered in advance. Difficult for the laboratory to predict these.

3. What impact if any do you see on your red cell stock management from clinical ordering practices and patterns?

- Less of an impact than platelets.
- Timely availability of results / timely review of results are needed.
- All have an MSBOS – but not all clinicians follow it (or are aware of it) – this is applicable for all grades of doctor – junior to consultant.
- Poor surgical planning (e.g. taking patient to theatre with no 'Group & Save'). 'The laboratory is always last to know'.
- Some encourage laboratory staff to challenge clinicians – but not all laboratory staff have the confidence to do this. This also takes more time and resources are not always available.
- Clinician knowledge of antibodies / special requirements can lead to problems (e.g. neonates / paediatrics).
- Haematology patients – CMV negative requirements cause more problems (although the laboratory can often predict to some extent).

4. Have you tried changing the clinician's practice? If so what are the difficulties that you experienced?

- Difficult to access medical staff for training – especially seniors / consultants.
- Junior medical staff are often told what to do by seniors – the junior staff don't challenge.
- Historical practice.
- 'Generation gap'
- Poor representation on HTC.
- If laboratory staff are to challenge clinicians – needs knowledgeable confident laboratory staff.

5. If you have had some success what strategies did you employ to change practice that you are willing to share?

- A pro-active Transfusion Practitioner from a specialist background (theatres) who is confident to challenge theatre staff / surgeons / anaesthetists.
- Active confident haematologist – consultant to consultant challenges.
- Using audit data to highlight practice.
- Electronic issue.
- Timely pre-op assessment.
- Making MSBOS readily available in clinical areas (e.g. on front of request form).

6. What would be the most useful tool to help you try to change clinician's ordering practice?

- Audit and education – someone with the time to do it.

7. Do you think your use of O Neg is appropriate?

Not discussed.

8. How can you cut back on your use of O Neg?

- Attendees kept a variable number of flyers (one to 'numerous').
- Those with fewer flyers stated that they have limited issue fridges (only one issue fridge – no satellites) and restricted access (flyers are kept in the laboratory).
- Some have numerous fridges across hospital sites – often due to hospital layout, but also due to clinician insistence (e.g. theatres only one floor above transfusion laboratory, but clinicians insist keeping fridge with flyers in theatre).
- An often previous experience makes this a very emotive subject.
- Some stated that distance from the NBS may have an impact – time taken for an alternative to be available, so O Neg used instead.
- Electronic issue – perhaps issue on an historical blood group.
- One stated that O Neg use may have increased slightly due to changes in laboratory technology – no manual techniques used so group specific is slower.

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

- Should O Pos be used instead of O Neg (some are doing this in certain circumstances).
- Those present generally agreed that only a small number of fridges / flyers are generally needed, but the clinicians often do not agree with this. This instant availability may lead to inappropriate use and bad practice (too easy to grab the flyers).

10. Generate some ideas that you think might help to change your inventory management practice.

- Bonded fridge / stock.
- Share stock – some hospitals are doing this, but generally only within same Trust – increased problems if outside Trust due to MHRA / cold chain requirements.
- If blood is transferred with a patient but not used – some hospitals are reluctant to take in as stock (due to MHRA / cold chain requirements). Regional policies for the transfer of blood exist, but no national policy – therefore reluctant to take blood into stock if outside the region.
- Sale or return group B units

Replenishment and Blood Ordering Workshops

1. What would your ideal way of ordering be for regular orders?

- Need consistent number of routine deliveries across the country in order to answer this effectively. Ranges currently from 1 – 2 at the moment. All would like 2 deliveries with a Saturday routine option.
- Web based for standard products
- Prefer to talk to local people with whom a rapport has been established.

2. What would your ideal way of ordering be for urgent requests?

- Prefer telephone / fax ordering
- Would need phone call for urgent requests
- Often requires discussion/negotiation over the phone
- Rapport with local centre

3. What are your views on ‘on line’ ordering?

(a) What types of orders would it be suitable for?

- On line ordering is ok as long as technology supports it. Not all hospitals have access. Would need to be web based not email as systems can fail.
- Would need confirmation of order.
- Back up system essential.
- Would want controls on the system to prompt typing errors.

(b) What types of orders would it be unsuitable for?

- Non-standard, out of hours, urgent.

(c) Would you like a confirmation receipt?

- Yes, confirmation of all orders required

(d) You may need enhancements to your laboratory software, how easy would this be?

- Finance would be an issue for some hospitals
- PCs not always available in the lab/limited number
- May not be able to access out of hours

4. How would you feel about the NBS issue managers being able to look at your stock levels to ascertain your ordering needs?

- Don't like the idea of Issue Manager looking at stock. They will not be aware of de-reserved stock to come back or requests for minor groups in the pipeline.
- Some of the larger hospitals were ok with this but would want confirmation of what was being sent.
- Would it be for red cells only or for frozen and platelets? Happy for frozen but only one hospital would be happy for platelets to be ordered this way.

5. If you don't agree with this approach what are your reasons?

- Hospitals best placed to manage their own stock
- Understanding of what's out there, what's coming back etc

6. What would you think of using a national call centre for ordering and queries?

- No not a good idea – web based would be better as presumably this would be managed by local centre with local stock information.
- One hospital (a large user) was happy with this concept
- Would it be off-shore?

7. Why would you not like the idea of a call centre?

- Like local contact.
- Must have this for urgent requests
- Would call centre staff have knowledge of local stock levels?
- Local Issue Centre knows ordering pattern and will prompt if no routine request received.
- Consensus was a "feeling of unease about this" rather than a bad business decision.

8. What are the reasons for the ad hoc orders that you make?

- Mainly for platelets but also irradiated products, phenotyped units, frozen products.
- Not enough routine deliveries Monday to Friday and Weekends.

9. Can you think of changes that you could make that would reduce the number of ad hoc orders?

- One hospital thought 7 day platelets had had an effect on their ad hocs. Another could not demonstrate any effect.
- Change routine delivery times to ensure platelet orders are in.
- 24 hour de-reservation could decrease ad hocs but cannot do Sat / Sun and MHRA may have a problem with doing it on weekdays only.
- Inter hospital transfer could reduce ad hocs, but only within same Trust or finance becomes a problem.
- Private hospital setting up agreement with an NHS hospital
- Educate medical staff – batch orders together
- Use own transport to collect from NBS
- Devolve blood budget.
- Need to adhere to guidelines for platelet requests and refer to a Medic if outside the guidelines – this can reduce ad hocs

10. If ad hoc deliveries are driven by platelets would you consider holding a stock of platelets, even if it was just one dose?

- One hospital commented that recent poster showed this did not work
- Some sites too small to justify holding platelet stocks, those large enough do hold stock
- Keeping stock platelets – lots of discussion on this, some have tried and it was not cost effective. Large Trusts keep a stock but still order as ad hoc.
- NBS can't always fulfil stock orders
- Got to off set risk of stock platelets against cost of ad hoc delivery

11. The replenishment model may mean that you would have to increase your red cell stock level. How would you feel about this?

- More stock, more wastage as highlighted by BSMS graphs
- Do not want to keep more stock
- If NHSBT did use or credit for Group B's, they would not sit at NHSBT getting older and be short dated when issued.
- Not a huge amount of support for this.

12. Do you think the replenishment model would be suitable for all hospitals?

- Needs to reflect real time hospital data to be effective.
- A few would consider the replenishment model if they were guaranteed two deliveries per day. The first could be replenished, the second the hospital would put the order in.
- Need for more science behind the stock levels – this has been assisted by the BSMS.

13. Vendor managed inventory might be considered by the NBS? How do you feel about this?

- Need more information on this.
- How would MHRA react to bonded stock?
- Who would own stock?
- Who would be in charge?
- How would the Finance be managed?
- Who would have responsibility for the fridge – use and supply?
- Hospitals would consider being a pilot to see if this could work.