2008 Regional Road Show Colindale

Feedback

Clinical/Laboratory Interface Workshops

1. How do clinicians order platelets in your hospital?

(a) Is it per patient?

- Always on individual patient basis. Haematology/oncology worst offenders

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

- Most labs find it impossible to enforce ordering cut off time.

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

- Can make some strategic demands on ordering of platelets for inpatients, but due to the unpredictability of outpatients requirements it is almost impossible to outline any restrictions on ordering patterns except may be consider all ordering to be done at the end of a clinic rather than at each patient interaction.
- Haematology Oncology patients the hardest to get sorted as although FBC results may be on the system early, ward rounds and treatment decisions are made much later and thus it is impossible to tie into routine delivery times.
- Need more dialogue with NBS regarding delivery times.
- A lot depends on the distance from the blood centre.
- Difficulties around unpredictability in Paediatric ICU.
- Patients expectations to have treatment now rather than later.
- Difficult to get physicians to order in appropriate time frame.
- Holding stock vs. potential wastage.
- Apparent lack of understanding of process by clinicians.
- Antagonism/reluctance to ‘listen to’ BMS.
- Clinical need.

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

- Lack of planning for pre-ops, timeliness of 'Group & Save', positive antibody screen.
- Inappropriate transfusion, timing (Out of hours), justification (Iron def).
- Special requirements, Antibodies, CMV, Irradiated, Paeds/neonates.

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

- There are training issues.
  - with clinical staff unawareness of availability surrounding platelets (they think they are in the lab at all times).

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

- To consider having a minimal stock of platelets whereby these can be utilised/ manipulated as required making less ad hoc deliveries perhaps.
- To consider 1 unit A neg CMV neg irradiated platelets as stock.
  - This supports major haemorrhage protocols in some hospitals.
  - This works quite well in the hospitals that already do this.
  - Overall this stock is kept in the blood bank and is managed by the senior person of the day.

6. What would be the most useful tool to help you try to change clinician's ordering practice?
Not discussed.

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

- Lack of control for O Neg in remote fridges.
- Lack of feedback on use.

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

Not discussed.

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

Not discussed.

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

- Some hospitals issue: 2 units 0 neg, then group specific, then fully cross matched. While others issue 0 neg until fully cross matched blood is available.
- Some hospitals issue only 0 neg to A&E to prevent wrong blood to wrong patient in the emergency situation.
- Some hospitals have withdrawn satellite fridges altogether and issue 0 neg from the lab, others find that due to the size and site layout this is not an alternative and have to manage satellite fridges.
- Some hospitals have audited and reduced stock holding of flying squad 0 neg.
- Some use electronic issue 24/7, some use manual cross match issue at night.
- Some hospitals do not have electronic issue and work manually at all times.
- General principles.
    - Personal approach most effective.
    - Communication.
    - Consultant haematologist support.
    - Access to information/results.
    - Feedback, Education, Evidence, Audit.
    - Planning (weekends and BH predictions).
    - Gate keeping.

- Specific solutions.
  - Algorithm/protocol, empower BMS to challenge and build in consistency of message to clinicians.
  - Name and shame.
  - Feedback to HTC (data from BSMS, wastage).
  - Scare tactics.
  - Moral/ethical pressure (wasted resources).
  - Memos.
  - Labels attached to components with messages/memos.
  - Transfusion practitioner or other person as communication channel, time to chase and follow up, feedback, educate, chastise.
  - Educate re pre-op planning, pre-assessment clinic timing (atypical Abs).
  - Training, perhaps mandatory.
- O Neg Flying Squad.
  - Removal from satellite locations back to central lab.
- Keen for sharing of algorithms/protocols to support gate keeping.

Replenishment and Blood Ordering Workshops

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

- On line ordering preferred in the first group / reservations regarding facilities in the second.
- Fax as second best.
- Ideally NBS access stocks & send what's required – would all hospitals mind NBS doing this?
- Agreed that fax &/or phone is easiest/best.
- Could have NBS stock ordering web page, vetted by NBS, as need to be alerted to any extra large orders.

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

Not discussed.

3. What are your views on 'on line' ordering?

See response to question 1.

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

- Routine and Ad Hocs.

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

- Blue Light.
- Need to take account of special requirements (CMV, K, Irradiated, HLA).

(c) Would you like a confirmation receipt?

- Yes.
- On line? Need receipt at NBS end, don't want double orders.

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

- One hospital said it would be difficult as all facilities for on line access is in the offices not in the laboratory.
- Not all staff in hospitals can easily log-on to email.

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

- No.
- Yes in shortage situation.
- Suitability of stock may not be appropriate for all patients eg K neg, CMV neg.
- Stock required – need to know what's "pending" for X/M & how much will be de-selected.
- Everyone counts units in their fridges – no-one does their stock from their computer system when ordering, except perhaps some on-call staff.
- Many hospitals now have 40% of their work coming in for late shift, so lot more routine X/Ms & may not have right stock mix.
- Use Vanessa to keep hospital up to ideal stock – but problems when NBS has shortage.
- Want to be able to top-up orders – can be time lag.

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

- The NBS can only see the stock level not the outstanding orders and patient mix.
- The replenishing model would work combined with manual adjustments.

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

- No.
- Advantages to NBS would be no more small centres with lone workers, could then triage timings & level of urgency for ad-hoc deliveries, but how to do it?

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

- Local knowledge can not be replaced and it would mean that if questions arise there is a middle man in-between.
- The strength of feeling against the idea of a 'non-local' call centre for ordering - many disadvantages given.
- Everyone said no to National Call Centre because they would lose the working relationship. Local Issue know their hospitals too & can have dialogue about “exotic” issues, distance & time it will take – all may be relevant.

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

- Platelets and phenotyped RBCs.

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

- Increase platelet stock will benefit as well quality of care.
- Strength and impact of HTC.
- Backup from Haematology Consultant.
- Education section at induction for medics.
- Ice cream van idea - driver has spare products to be dispatched en-route.
- The timing of routine orders has to be changed to suit the hospital.
- To allow adding to order prior to the driver leaving the NBS.
- Although all the points in 9 were discussed, the groups also acknowledged that no matter how much education is given and support from the RTC/Haematologists, patients simply don't conform - hospital life has changed - the bed won't wait for the next day whilst the platelets arrive as may have happened a few years ago. It only takes one patient to cause an ad hoc situation.

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

- Yes for Hospitals with Oncology units and large hospitals.
- Stockholding of platelets reduced Ad Hoc deliveries by 70 – 80% and did not increase wastage.
- No for small hospitals.
- Very positive response to stock platelets (although Wastage may go up).

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

- General no to this model.
- The NBS can only see the stock level not the outstanding orders and patient mix.
- Wastage would go up.

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

- No.
- Move stock between hospitals, especially those in same Trust – this already happens in some places, which results in less wastage. Stock “sharing”.

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

- Yes for remote areas.
- Yes for small private hospitals.
- Idea of “bonded” fridges – hold NBS stock that hospital can access if required – but who would staff them?