

2008 Regional Road Show Manchester

Feedback

Clinical/Laboratory Interface Workshops

1. **How do clinicians order platelets in your hospital?**
 - (a) **Is it per patient?**
 - Ad hoc ordering, on receipt of platelet count result.
 - Ward rounds often later in the day, even though results available early morning.
 - Order one patient at a time, rather than multiple orders once ward round complete.
 - Noted that nurse-led Haematology clinics seem much more organised with respect to ordering.
 - (b) **Do you have an ordering cut off time – if not why is this?**
 - Tried to – OK for a while, but drifted.
 - Failed when new registrars rotated and consultants did not stress that orders had to be in by a certain time.

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

- Educate doctors/wards in ordering so that platelet orders are in by a certain time.
- Strong lead from Consultant Haematologists / vetting requests.
- Consultant Haematologist has set up a standing order for platelets.
- Educate junior lab staff to batch orders together rather than send each as they come in.
- Use own transport to collect from NBS.
- Devolve blood budget – financial accountability

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

- Do not want to keep more stock; more stock = more wastage as highlighted by BSMS graphs
- Told to reduce stocks / usage, make savings – driven by Trust finance
- Peaks and troughs in demand.
- Trend towards ordering pre-operative blood cover at short notice, when patients are admitted, usually during the night shift.
- Less impact than on platelet provision, as with red cells you are dealing with larger numbers of longer-dated units, making stock management easier.

- 4. Have you tried changing the clinician's practice? If so what are the difficulties that you experienced?**
- Some sites too small to justify holding platelet stocks, and it would increase wastage;
 - Often it's HLA matched platelets that come on an ad hoc delivery, therefore holding a stock would not help.
 - Would like to hold stock but can't get them - NBS can't always fulfil order, even though pre-arranged to hold stock.
 - Restrictions of availability – NBS will issue on 'named patient' but not as stock.
 - Ad hoc platelets have short expiry date, they still end up wasted.
 - Clinicians have a 'fallback' position of 'give them O Neg' – they don't understand the implications of this.
- 5. If you have had some success what strategies did you employ to change practice that you are willing to share?**
- Need to educate BMS staff - some hold stock / order more / order as requests come in, for comfort factor / out of ignorance / inexperience.
 - Clinician awareness / education with regard to laboratory practices / availability of products helps – engage with influential groups such as anaesthetists.
 - Get 'buy-in' for transfusion policies at Trust level – easier to do if you can already demonstrate savings / improvement in practice.
 - Basic transfusion education needed for junior medical staff especially.
 - One hospital that has recently started holding a platelet stock of one unit has noticed a reduction in ad hoc deliveries - got to off-set risk of expiry / wastage of stock platelets against cost of ad hoc delivery

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

- Education regarding basic transfusion practice, and what the laboratory can do for them.
- Financial cost of ad hoc orders sent to medical director / finance director to influence ordering.

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?

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.

- More active stock management by senior BMS staff – better laboratory guidelines on selection of blood for crossmatch for particular patients.
- Concept of centrally held stocks for a group of hospitals that could be delivered as necessary.
- Concept of flexibility in NBS delivery (ie could deliver to Crewe/Macclesfield from Birmingham rather than Manchester depending on traffic or other factors)

Replenishment and Blood Ordering Workshops

1. **What would your ideal way of ordering be for regular orders?**
2. **What would your ideal way of ordering be for urgent requests?**
 - Prefer telephone ordering
 - Web based ordering ok for standard products
 - Would need phone call for urgent requests
 - Often requires discussion/negotiation over the phone
 - Rapport with local centre
 - What is the advantage of using website over fax?
 - Would be difficult to use out of hours
 - Confirmation receipt – would need message back to acknowledge receipt
 - Prefer web based ordering, but would need to know how it would work.
 - Some liked web ordering idea – used to using the internet for ordering at home etc.
3. **What are your views on ‘on line’ ordering?**
 - (a) **What types of orders would it be suitable for?**
 - Routine, standard products

(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?

- Would need to know how system worked
- Some IT problems with hospital systems which would need to be overcome
- PCs not always available in the lab/limited number
- May not be able to access out of hours
- One Trust is hoping to get rid of all faxes, received instruction to avoid fax use as not secure

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
- Fear of 'Big Brother'
- Feel lack of understanding by NBS of situation hospitals face regarding need for blood
- All you will get is trends
- Being in a hospital lab doesn't compare in anyway to NBS, so will they understand?
- Issue staff don't always appreciate the urgency
- Look but don't touch

- 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 – confusion reigns
 - Too impersonal
 - Not streamlined for users
 - Another variable
 - Lack of expertise/local knowledge
 - Again not sure of the advantage to users
- 7. Why would you not like the idea of a call centre?**
- Could cause delays
 - Would be put on hold!
 - Would call centre staff understand scientific/clinical terms
 - Local contact still required
 - Phone calls would not be reduced
- 8. What are the reasons for the ad hoc orders that you make?**
- Mainly for platelets but also irradiated products, phenotyped units, frozen products.

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

- Educate doctors/wards in ordering so that platelet orders are in by a certain time
- One hospital explained that their Consultant Haematologist has set up a standing order for platelets
- Educate junior lab staff – batch orders together
- Use own transport to collect from NBS
- Devolve blood budget, this increases financial awareness.

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 that has recently started holding a platelet stock of one unit has noticed a reduction in ad hoc deliveries
- Some sites too small to justify holding platelet stocks
- Would cost more in wastage
- Often its HLA matched platelets that come out via ad hoc therefore holding a stock would not help
- Would like to hold stock but can't get them
- NBS can't always fulfil order
- Restrictions of availability
- Ad hoc platelets have short expiry date, still end up wasted
- 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
 - Told to reduce stocks, made savings
 - Peaks and troughs in demand
 - NBS don't know the hospital and stock would fluctuate
 - Red cell usage is variable
 - Dates of stock at issue – would help if NBS issued units of various expiry dates rather than all expiring at same time. One hospital explained that they order 10 each day rather than all at once.
 - Change in 'order by' time suggested, current times not practical
 - Would still need ad hocs, may even make them worse
- 12. Do you think the replenishment model would be suitable for all hospitals?**
- Proximity to centre – some hospitals close to a centre don't need to hold large stocks
 - Some hospitals not staffed 24/7
 - Some hold stock/order more for comfort factor – need to educate BMS

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

- Idea not well received by group
- Depends on proximity
- Could work for hospitals at more of a distance
- Who would own stock?
- Who would be in charge?
- Would NBS fund?
- Could be a full time job
- Drain on manpower - staffing issues when Trusts already stretched
- Would need to be independent of hospital
- Who would have responsibility for the fridge – use and supply?
- Issue raised about asking NBS to reserve blood/have units on standby – variation in practice at centres

Discussion also took place about paediatric platelets and substitutions:

- NBS underestimates need for neonatal platelets
- Often given Group O in lieu of Group A (against guidelines)
- Told them won't accept Os but informed will take hours to get As
- Should have more stock of Group A