

2008 Regional Road Show Newcastle

Feedback

Clinical/Laboratory Interface Workshops

1. How do clinicians order platelets in your hospital?

(a) Is it per patient?

- Most orders are requested on a named patient basis and accepted once approved by a Haematology Consultant (unless patient is on ITU), especially if request is for more than one pool.

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

- The cut off point for orders is around 10.30 -11am but it was appreciated that some orders can not be anticipated e.g. due to trauma, when patients 'come through the doors'.
- Some large or remote Trusts hold a small amount of platelets and the general feeling was that this was a useful practice. Holding platelets on site can cause problems if they are no longer required but it does allow for transfer of platelets within one Trust.
- Stocked platelets tended to be irradiated and group A.

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

- Clinical need, although the blood results may not indicate platelet transfusion there as so many other variables that the 'bigger picture' needs to be understood.
- Majority of hospitals, if not all, had a policy for guidance on the indications for platelet use.
- The use of drugs such as clopidogrel has altered practice as some surgeons (mainly in cardiology) feel the need to have platelets on 'standby'. If they are ordered and not required they are likely to be wasted.
- If the hospitals could have an additional delivery of platelets late evening, it is thought it may reduce the amount of ad-hoc deliveries.

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

- Many felt the reduction in blood use can not be lowered any further.
- Trusts may be affected by removal or movement of specialist services and transfusion departments are not always involved in communications. Most staff work to strict guidelines.
- One IT system has a built in connection to the MSBOS and staff refer to Haematology Consultants 24/7.
- Some felt it depended on the confidence and experience of staff as to whether they would challenge / query a request they felt may be inappropriate.
- Electronic issue has reduced blood usage.
- One Trust stated that its staff felt very empowered to do this, with electronic prompts and protocols.

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

- Some staff don't feel comfortable in questioning medical staff.
- Some staff feel like they are 'banging their head off a brick wall' as no-one seems to be listening to what they say.
- Building relationships takes time.

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

- Data collected and presented to appropriate directorates on over-ordering, inappropriate use, under usage (FFP x 2u given to adults) etc.
- Quality reports / errors presented to directorates to encourage a change in practice, if no improvement then 'Name and Shame' tactics have been implemented.
- Notice is taken if data / education is presented by peers and a reduction in inappropriate use has been noted since the introduction of a TP.
- Use of Haemacue and near patient devices, mandatory training for all consultant staff.
- Introduction of Hb triggers and electronic issue as blood is cross matched on demand.
- Communications work best when appropriate language and style is used for a particular group.

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

- A proactive HTC/HTT, audit and feedback, education and competency assessments.
- A clinical "champion" e.g. strong HTC chair, interested haematologist.

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?

- Most felt they used what they needed and queried the figure of 8.5%.
- Some felt vulnerable being so far from an NBS centre.
- A table top exercise re: Emergency Planning to assess the validity of the plan.
- One Trust thought that 10% of patients were O negative. However, another Trust had demonstrated 7.9% to be O neg.

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

- Use of O positive red cells to males, reduce the Hb trigger for O negative patients (and all in amber/red status).
- One Trust would like group O blood to be used for all in major emergencies- this has been raised before.

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

- Appointment of a Near Patient testing officer to ensure haemacue etc. have correct controls and validation.
- Ensure Risk Management / Clinical Governance are represented on HTC's.
- Sharing of data and as a last resort 'name and shame'.
- Reduce holding period from 48 hours to 24 hours where able, especially once electronic issue is operational.
- More requests to be 'vetted'.
- Once electronic issue introduced, ensure it is linked to MBOS.

Replenishment and Blood Ordering Workshops

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

Not discussed.

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

Not discussed.

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

- This generated a great deal of discussion most of which was very positive.
- Like Amazon which flags up stock availability and allows reservation to be made
- Can see progress of order
- Simple to use, if based on commercial on line ordering systems
- Provides real time stock levels
- Would need to have a cut off for processing orders for journeys as now
- Electronic order form as now with standard and non standard requests
- Needs to be assessed as this may not work for all hospitals – start small and simple then build on success
- Removes possible transcription errors during phone calls

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

- Only suitable for routine and ad hoc's

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

- Urgent orders would still require phone call to 'jump' queue

(c) Would you like a confirmation receipt?

- Would need feedback system to confirm order is
 - Received
 - Created
 - Filled
 - Despatched

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

- Would require some input from Trusts/CE to upgrade IT systems

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

- Liked the idea of data transparency but unsure if they were happy about it being a 2 way process, they could look at NBS and each other but not sure about NBS looking at them.

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

Not discussed.

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

- Not happy with this idea.

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

- Poor service
- Loss of local contacts
- Put on hold
- Bad experiences with call centres in general.

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

- There will always be the demand for ad hoc deliveries for specialised products
- Availability of platelets can be problematic

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

- Perhaps a system of stock rotation amongst a group of hospitals – this happens in the Newcastle Hospitals Trust where all products are rotated between the 3 hospitals. Dependant on same IT system.
- Different way of being charged for products, at point of transfusion to patient not up front as now. This would enable products to be moved between hospitals/trusts.
- At present there are 2 routine journeys daily to all Newcastle hospitals. These journey times are not always ideal for hospital workloads.
 - Different journey times
 - Evening journeys – problems with lone worker in evenings receiving large stock orders
 - Hospitals work 24/7
 - Routine weekend deliveries
 - Some of these would cut down number of ad hoc deliveries.

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

Not discussed.

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

- Larger stock holding by hospital would increase wastage.

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

Not discussed.

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

- Hospital stock holding centres
 - Would depend on geographical location
 - How would they be supplied and what happens if there is a run on a certain product.
 - How would hospitals be charged?
 - Could there be a 2 tier system where routine orders are processed by NBS but emergency orders are supplied by hospital?
 - What happens if the holding stock is not used, who is charged
 - Would need some sort of hospital network
 - Who would supply staff NBS or hospital
 - MHRA approval and compliance.
 - Not thought to be workable.

- Mobile stock van
 - Would work for local hospitals as they would have first call on specialist products but hospitals further away would find reprovisioning of anything but red cells difficult