

Blood Matters report for blood management (or equivalent) committee

August 2021

Strategic Plan 2019–22

Goal:

Through a collaborative approach support and enhance best practices in quality care, clinical safety, and blood management (sustainable, responsible, safe and appropriate use), for improved patient outcomes in Victorian health services.

Objectives:

Use innovative and diverse approaches to:

- Promote and support the development of strategies that optimise appropriate use of blood products, alternatives, and person-centred care through national and local governance frameworks and standards
- Foster and strengthen partnerships and stakeholder relationships
- Analyse data and disseminate findings across the sector to raise awareness, influence practice, promote efficiencies, and provide value
- Provide and promote expert knowledge sharing and collaboration across the sector, including specific initiatives, tools and specialised advice.

Inventory issues

Group O emergency issue red blood cells (RBC)

Nationally, the high demand for O RhD negative RBC's has been highlighted. In response, Queensland and New South Wales have implemented policy changes regarding the emergency issue of O RhD negative RBC's. In Victoria, the current issue of O RhD negative RBC's comprises 17.1 per cent of all RBC issues, whereas only 8.3 per cent of donors in Australia are O RhD negative. Recent communications asked that Blood Management/Transfusion Committees look at your local use of O RhD negative RBC.

Does your health service have a policy relating to Group O emergency issue RBC?

If yes, does it include:

- When to transition from O RhD negative to O RhD positive RBC
- When to transition from O RhD negative to group specific RBC; i.e.
 - once the group and screen has been finalised; or
 - when the blood group of the patient has been completed
- If O RhD positive RBC be given to any patient groups as an initial response to critical bleeding/massive transfusion
- How to obtain a specimen for pretransfusion testing as quickly as possible?

Has an audit been done to assess the adherence to your policy?

If yes:

- How does practice compare to the policy?
- Are there gaps in practice?
- Were barriers identified why staff may not be adhering to policy?

If no:

- Is this an area that can be examined at your health service?

Is education provided about the use of emergency issue RBC?

If yes, does it include:

- O RhD negative emergency issue RBC are not without risk – they are not “universally safe” for everyone
 - Benefits must outweigh the risks of giving emergency issue uncrossmatched RBC
 - Importance of receiving blood samples as a priority to provide the most suitable product

Available for download from the Blood Matters webpage:

[Blood Matters STIR Bulletin: Issue of O RhD negative emergency red cell units - not without risk](#)

Is there a policy/strategy in place to minimise the use of O RhD negative RBC to prevent time expiry?

Reducing our reliance on O RhD negative RBC is essential, particularly as recent inventory demands have resulted in many products including O RhD negative RBC being on Transfusion Medicine Specialist approval.

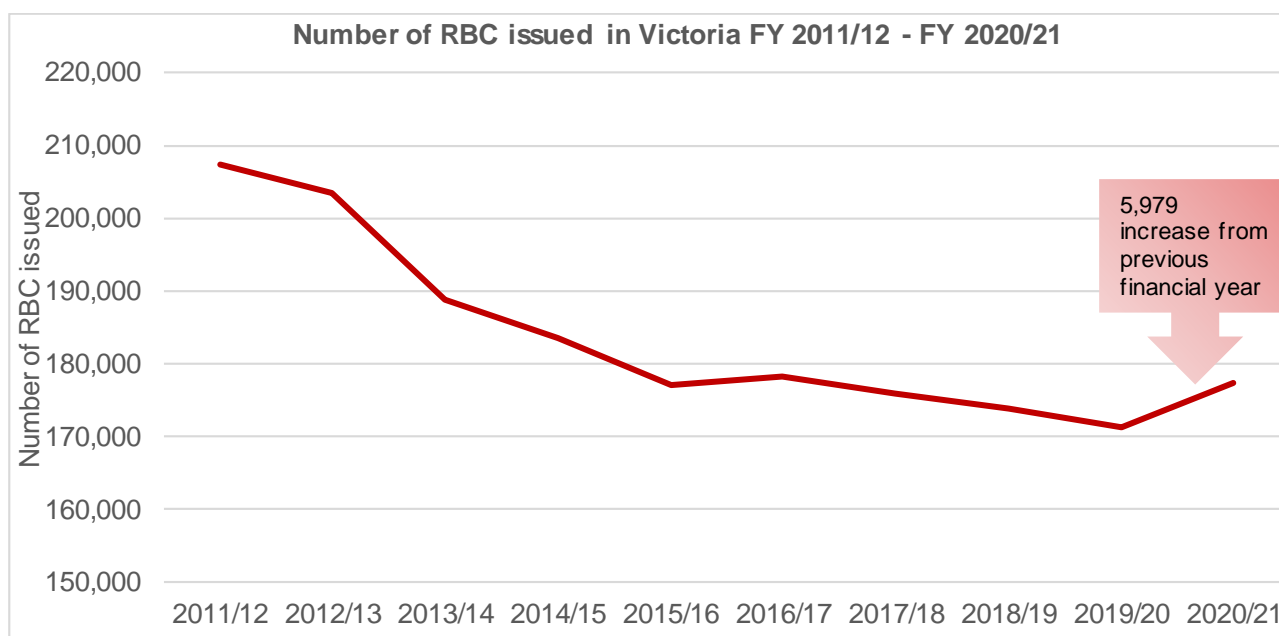
Number of RBC issued financial year 2020-2021

After recent year on year decreases of RBC issued across Australia, there has been an increase in the number of RBC issued in the last financial year. The National Blood Authority (NBA) and Lifeblood are trying to understand the reasons behind the increase, and have asked health services/laboratories to provide advice to assist them in understanding demand pressures. The email address provided for this advice is

Supply.Management.Fresh@blood.gov.au

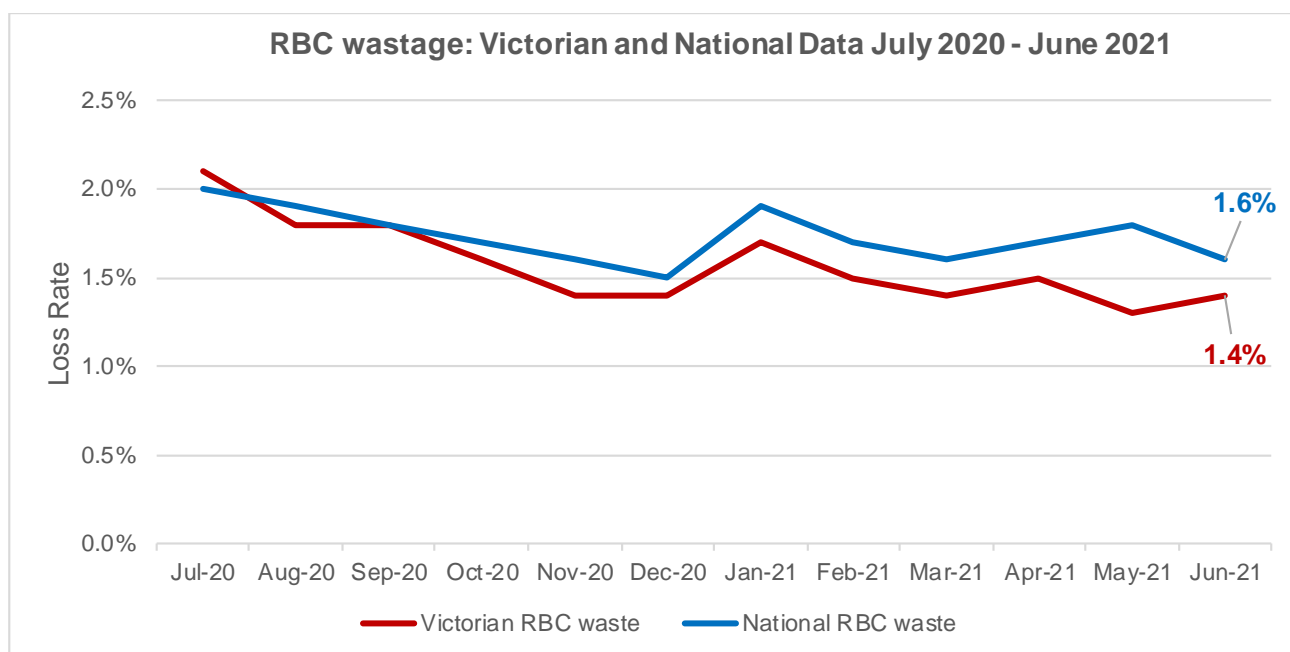
The NBA has developed a poster promoting the importance of appropriate use of blood and blood products.

This poster is available for download from <https://www.blood.gov.au/national-standard>



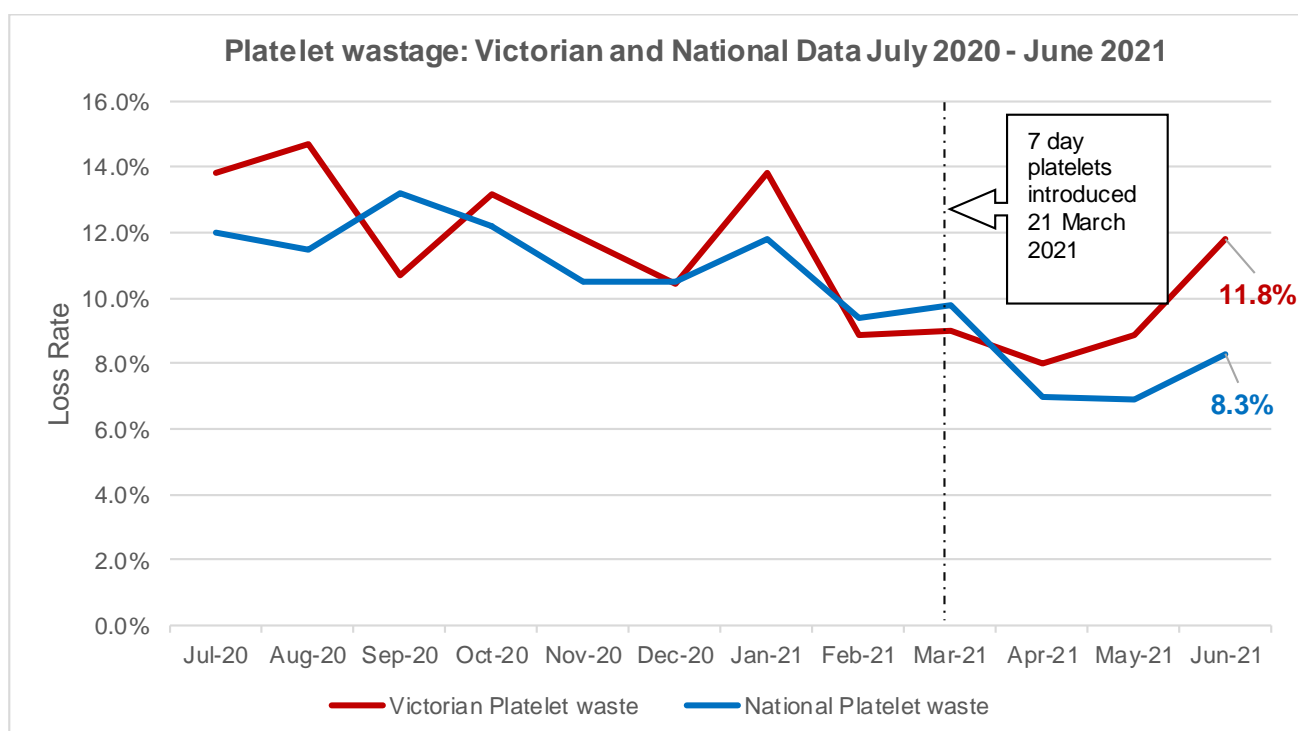
RBC wastage

RBC wastage remains at a consistently low level. Thank you for your hard work and dedication to keeping this at such a low level over the previous year.



Platelet wastage

Seven day platelets were introduced on 21 March 2021. While there was initially some reduction in platelet wastage, Victorian platelet wastage rates remain above the national average. Close monitoring of inventory and waste is encouraged.



Auditing:

Perioperative anaemia assessment and management in elective surgical procedures – preoperative, intraoperative and postoperative 2020

A retrospective audit of patients who had major elective surgical procedures in 2020. This audit was designed to assess the compliance of practice to the PBM guidelines: Module 2 related to the assessment and management of reversible anaemia prior to elective surgery, and blood conservation strategies used intraoperatively to reduce postoperative anaemia.

The audit report will be supported by individual information for health services on their own results comparing to previous audits and with peers. Other resources that will be produced to support the results will include infographics that can be shared with different surgical groups and presentations.

The final report will be published shortly. <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/reports-audits-journal-articles>

Current audit - Survey of electronic medical record implementation

A survey of health services experience of blood management using an electronic medical record (EMR) commences in August 2021. The survey is requesting input from a number of different perspectives. For those with an EMR the questions cover planning, implementation strategies, blood ordering and administration. For those working toward EMR implementation questions are aimed at understanding the planning process.

The survey can be accessed by the following link: <https://dhhs.vic.limequery.com/216314>

The survey is open from 2 August – 24 September 2021.

Serious transfusion incident reporting (STIR) system

STIR is directed and supported by a group of professionals, medical, nursing and scientists, who have an interest and expertise in transfusion. The expert group review and validate reports of reactions and incidents sent from health services, and help to promote good transfusion practice by development of an annual report, bulletins and presentations at conferences.

The STIR Bulletins provide expert insight into potentially serious or confusing aspects of blood transfusion and are based on real incidents reported through STIR. Bulletins for 2021 are available on the Blood Matters webpage, including the latest bulletin relating to the risk of bacterial contamination of blood components. <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/serious-transfusion-incidents>

The STIR annual report 2019–20 will be available on the Blood Matters webpage. [Serious Transfusion Incident Reporting system - health.vic](#)

Currently over 100 health services are registered with STIR for reporting of incidents, 40 contributed to the 2019-20 report. Reporting to STIR plays an important part in meeting the National Safety and Quality in Healthcare Standards for accreditation. Thank you to the health services who participate in this STIR program.

For any health service in Victoria, Tasmania, Northern Territory or Australian Capital Territory not currently reporting to STIR, please contact Blood Matters at: Bloodmatters@redcrossblood.org.au if you wish to participate.

Blood Matters Project Nurse – Subcutaneous immunoglobulin (SCIg) implementation project

Farewell to Trechelle Herington who recently joined the team in the Project Nurse role. After much deliberation, Trechelle has decided to return to her specialty area, paediatric care. We thank Trechelle for her contributions to the role, and the team wish her all the very best in her future endeavours. Recruitment is currently underway to fill the vacancy.

The SCIg Forum for SCIg Coordinators will be held on 11 August 2021.

The current state of SCIg in Victoria:

- 17 sites with active programs
- 342 Victorian patients receiving SCIg (Q4 2020-2021)
- 2218 Victorian patients eligible for SCIg by medical diagnosis (Q4 2020-2021)

SCIg implementation tools, resources, and health service SCIg contacts available at:

<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/speciality-diagnostics-therapeutics/blood-matters/scig-implementation-program>

Blood Matters forums

Blood Matters forums continue to be virtual. While we are unable to meet face to face, it is still important to have the opportunity for education, networking and the sharing of ideas. The July forum covered several different aspects of patient blood management, including obstetric care and PBM in the emergency department. A link to the recording of the event has been sent to the Blood Management/Transfusion Nurses/Trainers and Quality Officers.

Blood management summit for scientists

The annual blood management summit for scientists, offers scientific and local industry updates for our laboratory colleagues across the blood sector.

The next virtual forum takes place on 4 August 2021 and will focus on discussion of the pros and cons of using O RhD positive red cells for emergency issue.

Blood Matters journal club

This year, Blood Matters has held two journal club meetings, with a third meeting due in December. Anne Kinmonth from the Royal Children's Hospital presented the first meeting of the year and Leanna Pickles from Alfred Health presented our second meeting. Both provided a great analysis of their chosen journal article and facilitated interesting discussion for the participants. We encourage participation from all, as both a professional development exercise and an educational event to improve our critical appraisal skills and understanding of transfusion and PBM related topics.

Education

Virtual education sessions have enabled us to reach a larger and broader audience. Feedback from these sessions has been very positive.

Upcoming virtual events for 2021:

- Five in 5 sessions, 5 topics over 5 days - attend one or all (August 9-13)
- Five in 5 sessions for midwives, 5 topics over 5 days – October 11-15

Further information will be sent out closer to the dates.

Please contact Blood Matters if you would like further information or if we can help you to run a virtual education event.

Conference presentations – 2021

Australian and New Zealand Association of Neurologists (ANZAN), May: Virtual poster Improving the quality of life for patients with chronic inflammatory demyelinating polyneuropathy (CIDP) by offering home treatment with subcutaneous immunoglobulin (SCIg).

International Society of Blood Transfusion (ISBT) June: Linley Bielby along with her international colleagues Rachel Moss (London), Clare O'Reilly (Vancouver) and Jana Vander Broeck (Belgium) presented two live interactive workshops at the ISBT (International Society of Blood Transfusion) In focus virtual congress.

The workshops were:

- Transfusion Practitioners investigate... Transfusion reactions and wrong blood in tube
- Transfusion Practitioners investigate... Audit and data for change

Changes to the Specialist and Graduate Certificates in Transfusion Practice

The course is being completely reviewed for delivery via a new training organisation. It is anticipated the new course will commence in mid-2022.

The course content covers all aspects of blood management and transfusion, and governance within health services. It provides a framework from which to build knowledge and skills to help manage, monitor and improve blood management and transfusion and associated processes within your health service.

If you are interested in hearing about the new course when it becomes available, please contact Blood Matters to register your interest. Bloodmatters@redcrossblood.org.au

Blood Matters staff

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