Electronic Blood Tracking: the UK Experience

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In 2009, following the review of a serious incident involving the administration of incompatible red cells, collected from a remote blood fridge, approval was given for the purchase of an electronic tracking system for blood fridges. This is one step in the complete electronic blood tracking process which checks and tracks the location and handling of blood products and transfusion samples, improving transfusion safety and reducing blood product wastage.

The systems are widely used in the UK but have not been installed in any Australian Hospitals and research into the implementation of the system, and communication with transfusion staff in UK hospitals, has shown the change from traditional manual methods to the use of modern technology has been challenging on many levels.

The aim of the UK visit was to determine the most effective strategies required for the successful implementation of an electronic blood management system at the RHH.

Following my successful application of the 2012 ANZSBT Travel grant for the purpose of visiting UK hospitals using EBT I looked at the things I should do, in order to gain the broadest information and experience of the successes and failures in the implementation and ongoing management of the systems.

The following steps were undertaken

: Hospital selection to cover variations in the following demographics: location: hospital size and EBT timeline. I chose 4 different hospitals to cover these variations and organised an interview with the UKs leading analyst of serious transfusion events.

: Discussion with a variety of stakeholders in each institution: laboratory staff, transfusion nurses, ward staff, medical staff, data managers and patients.

: Exploration of the differing methods of change management implementation including advertising, education and training, rollout and troubleshooting.

: Exploration of our “assumptions” surrounding the change process.

At the conclusion of a very busy and informative week a clear picture of the “do’s and don’ts” of a successful change from “time honoured” processes of patient identification and the “vein to vein” blood product process emerged.

I had a long list of all the “questions” one should ask the systems provider before “going live” in order to avoid the many pitfalls along the way, and discovered that to my surprise “change management” issues are not the major cause of a failure to meet the expected outcomes of improved patient safety.

The expected long term outcomes of the implementation of EBT will only be fulfilled by a combination of a well implemented change management plan, a robust IT system, an ongoing commitment from the controllers of health funding and a well-established relationship with both service providers and users and that the take home message is the we as individuals are still responsible for haemovigilance. EBT is a tool, not a magic bullet.

As we lead up to “going live” with the Blood Fridge Tracking system at the RHH, the lessons learned from my UK visit have been, and will continue to be invaluable in progressing a smooth implementation and transition to this new technology, and produce the expected outcomes of improved transfusion safety, improved tracking and decreased blood wastage.