

Welcome to the Spring 2017 newsletter.

National Patient Blood Management Collaborative

To support the implementation of PBM in Australia, the Commission was funded by the Australian Government Department of Health to lead the National Patient Blood Management Collaborative (the Collaborative). The Collaborative is designed to implement change in small, manageable cycles, and identify where a change leads to improvement. Through learning workshops and learning cycles, health services share ideas for improvement, measure and benchmark outcomes and contribute to the future direction of best practice in the identified topic area. The aims of the Collaborative were achieved, and focused on:

- Improving patient care
- Promoting and supporting health services in the uptake of PBM Guidelines developed by the National Blood Authority
- Increasing the number of patients who have their anaemia identified and managed prior to elective surgery.

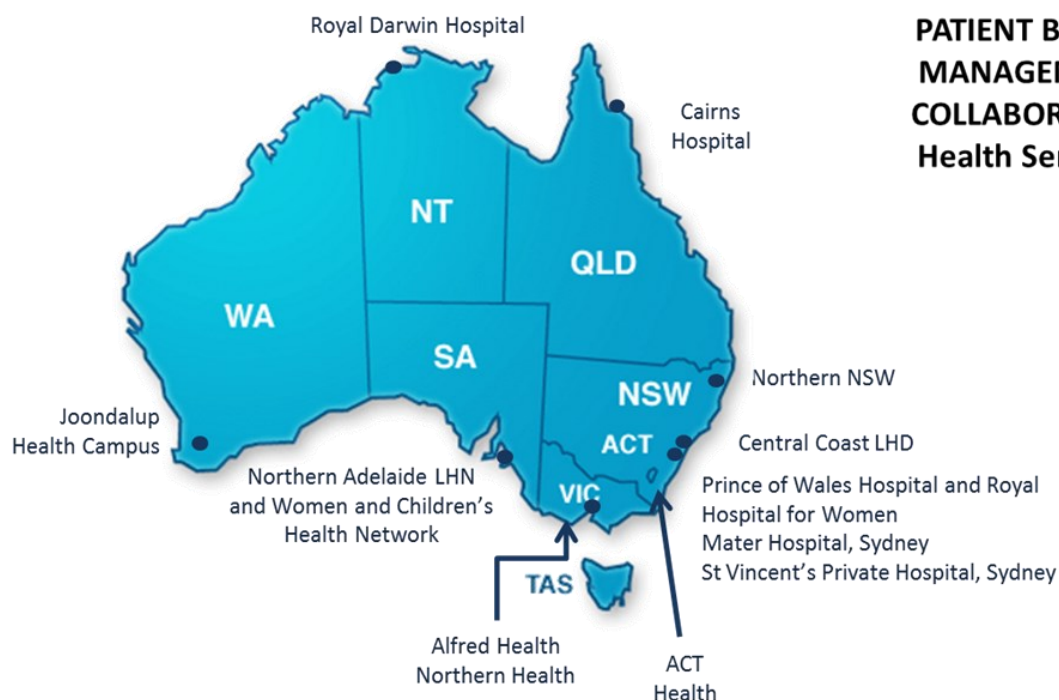
The Collaborative supported best practice in PBM in public and private hospitals across Australia, and promoted the assessment and management of anaemia and iron deficiency before elective surgery to reduce unnecessary blood transfusions.

Twelve health services from across Australia, participated in the Collaborative and provided data to stimulate improvements in clinical practice.

The Commission led a series of learning workshops with the twelve teams meeting to analyse and compare their data with other services across the Collaborative; to share this data and their experiences and learnings from local quality improvement processes; consult with experts in the field; gather new information; and, develop ideas for further clinical practice improvements. The Collaborative philosophy of 'steal shamelessly and share generously' enabled teams to learn from each other and adapt these learnings to their local service.

Knowledge-sharing through the Collaborative also demonstrated that a coordinated approach between health service executives, lead clinicians and general practitioners who care for patients before and after surgery is essential to improve evidence-based care

The Collaborative resulted in a marked improvement in the management of iron deficiency and anaemia across the health services involved. Of the 12,648 patient records documented during the Collaborative, assessment rates for iron deficiency more than doubled for each surgical specialty.



NATIONAL PATIENT BLOOD MANAGEMENT COLLABORATIVE Health Services



Key outcomes from the Collaborative included:

- Improved assessment and management of anaemia and iron deficiency prior to surgery was able to be achieved across participating health services
- Changing clinical practice and workflow at the participating sites was successful in achieving improvements in the overall management of elective patients
- Improved integration of care between primary and acute service systems provided better opportunities for continuity of care
- Clinical leadership by the health services, and in general practice, was vital to progress being made
- Reduced red cell transfusions were achieved for patients
- Collaborative sites have worked to embed PBM related activities within the usual work of the health services, with a view to ensuring long term sustainability
- Critical success factors for the Collaborative were identified as health service Executive 'buy-in' and support; strong and effective clinical leadership; well defined project support; and support for data collection, analysis and reporting to clinicians.

The Collaborative was successful in changing clinical practice at the 12 participating health services, which has resulted in improvements in the rate of preoperative investigations for anaemia and iron status.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

• **12,648 patient episodes recorded**

• **33% male and 67% female**

• **6% aged under 49 years;
58% aged 50-69 years and
36% aged over 70 years.**

• **4.6% identified as Aboriginal
and/or Torres Strait Islander.**



**National Patient
Blood Management
Collaborative**

**Assessment rates for iron
deficiency more than doubled
for each surgical specialty:**

Gastrointestinal - 25% to 57%

Orthopaedic - 35% to 71%

Gynaecology - 18% to 42%

Your Transfusion Professional Representatives

Area	Name
ACT	Maria Burgess
New South Wales	Sally Francis
New Zealand	Liz Thrift
New Zealand Blood Service	Fiona King
Northern Territory	TBA
Queensland	Susan Kay, Fiona Clarke
South Australia	Barbara Parker
Tasmania	Dawn Richardson
Victoria	Chris Akers & Adrienne Wynne
Western Australia	Angie Monk & Sue Darby
Australian Blood Service	Bev Quested
ANZSBT Council	Debbie Pinchon

What's happening around Australia and New Zealand?

Queensland:

Participation in the national Patient Blood management collaborative drew to a close in mid 2017—This was a worthwhile project with some great outcomes for Queensland Health Services.

South Australia:

Central Adelaide Local health Network has noted an increase in the number of wrong blood in tube incidents. This is thought to be due to changed workflows and technologies introduced in preparation for relocation. Relocation has also prompted a review of transfusion related procedures to ensure new workflows and technologies are accounted for. A second review will be undertaken after the move which should coincide/complement the release of revised ANZSBT guidelines.

Western Australia:

“Take 5” education packages to be implemented at RPBG— reducing the duration of education sessions to 5 minutes has been shown to increase the knowledge retained by the learner.

The ARCBS are facilitating a WA transfusion study day to be held on 21st November at SCGH

King Edward Memorial Hospital has commenced an RMO led service improvement project looking at development of Maximum Surgical Blood Order Schedule for planned surgery. The new MSBOS will be introduced at medical orientation and aims to reduce late group and hold requests and ensure the laboratory has adequate time to crossmatch blood for patients with atypical antibodies (Higher than average numbers of patient with antibodies treated at KEMH)

Tasmania:

Tasmania awaits the approval of State-wide Tasmanian Health System Policies and Protocols for blood transfusion. Standardisation of these documents has required an enormous amount of work over the past 18 months, during which transfusion related documentation has also been standardised.

Victoria:

Blood Matters is currently advertising a new position to assist health services with the implementation of SCIg. There are a number of guidelines already developed and available to use on the Blood Matters website.

Northern Territory:

The Transfusion Nurse role is currently being advertised as the former NT Transfusion Nurse has been seconded to a new role.

Australian Capital Territory:

Efforts are ongoing to standardise clinical practice in correlation with PBM guidelines. In-services for Nursing and junior medical staff continue

A tool for following up wrong blood in tube incidents has been developed—contact Maria Burgess in the ACT for further information

We congratulate our ACT colleagues on the publication of their article on obstetric Patient Blood Management in the latest edition of the BMJ.

New Zealand:

All NZ blood transfusion laboratories will be affected by a Laboratory Information Management System (LIMS) update. For one weekend in September all laboratories will revert to manual systems while the update occurs. This has required a lot of training and communication.

Australian Red Cross Blood Service:

Flippin' Blood is currently under review. This will be finalised after the revised ANZSBT guidelines are released.

Preparations for the implementation of ISBT128 labelling continue.

A project regarding the orientation of junior medical officers was undertaken and a handbook for their orientation is being developed, which should be ready for 2018.

BloodSafe eLearning Australia

Three new courses have been released to support the PBM Guidelines for obstetrics and maternity:

1. Obstetric Haematology;
2. Antenatal Blood Management; and
3. Postpartum Haemorrhage.

Neonatal and paediatric PBM courses will be released in the first of 2018.

Key events

ISBT: 28th Regional Congress, Guangzhou China, 25-28 November 2017

ISBT: 35th International Congress, Toronto Canada, 2-5 June 2018

HAA: 29 Oct –1 Nov, Sydney. Australia.

This year at HAA we will have a session for Transfusion Professionals. This will be on Tuesday 31 October, 08.30-1000. Come along to find out what your colleagues are doing in transfusion and share ideas and problems.

The TPN AGM will also be held at lunchtime on the Tuesday. Please come along, meet your committee members and tell us what you would like from TPN going forward.

The 2nd Royal Brisbane & Women's Hospital Perioperative Patient Blood Management Symposium, Saturday 24 February 2018:

Local, national and international experts in the field of Patient Blood Management will present state of the art knowledge and latest research. Our workshops will provide hands on experience with plenty of take home material.

- Clinicians have the opportunity to exhibit their scientific poster
- Being held on Saturday 24 February, 2018 8am - 5pm at the RBWH Education Centre, Royal Brisbane and Women's Hospital
- Participants in the ANZCA CPD program, may claim this major haemorrhage course as an emergency response activity in their CPD portfolio otherwise participants in the ANZCA CPD program may claim this event under the Knowledge and Skills Activity Learning sessions at 1 credit per hour
- Registration fee is \$250 for medical specialists, \$150 for medical trainees or \$100 Nurses/Anaesthetic Healthcare Practitioners and Scientists

Four different workshops will be held from 7:30 – 08:30am. The workshops can be booked separately at a cost of \$30. (Select 1, 2, 3 or 4 at booking process)

Register at www.trybooking.com/RKIF

Do you have an interesting case study?

If so please write up a synopsis of what happened to share with other Transfusion Practitioners in the newsletter.

Send case studies to Chris Akers email: cakers@redcrossblood.org.au