

Regional Shared Care Process: Introducing Patient Empowerment

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Guy's and St Thomas'

NHS Foundation Trust



Are you aware of what a shared care system should entail?

Yes

No

Not Sure

Patient Blood Management: Shared Care

Only transfuse when it is in the patient's best interest to do so

Always transfuse the **RIGHT BLOOD** to the **RIGHT PATIENT**

How do we cope with the Patient's choice of where to be treated?

Introduction

Why do we need a shared care system?

- 2009 SHOT report: 282 IBCT reported
 - 87 were due to special requirement not met in the clinical area.
 - 17% of these were patients having shared care.

No communication **back** to referring hospital transfusion lab

Shared Care: SHOT report 2012

Specific requirement not met	Total 107
•Irradiated	= 82
•CMV screened	= 18*
•Irradiated and CMV	= 2
•Phenotyped units for sickle cell patients	= 2
•Emergency O Rh D negative blood given to patient with known anti-c	=1
•K negative unit required	=1

Who has a system for flagging patients that need special requirements?

YES

NO

NOT SURE

Shared Care: case study

Patient admitted to St Thomas' for breast reduction :

Tx 2 red cells.

Day one post transfusion: Symptoms of an acute reaction

- Hb fell from 117g/L to 66 g/L (Normal 120-150)
- Bilirubin rose to 90 umol/L (Normal 0-21)
- Lactate Dehydrogenase rose to 2832 IU/L (Normal 240-480)

Investigations showed that the patient was a sickle cell patient:
Indicated in the notes but not on the blood request.

Shared Care: Case Study cont'd

Patient had received 10 unit exchange at another teaching hospital in preparation for the operation.

She also attends 2 other local hospitals which are near to where she lives.

The results of the reaction confirmed the production of a red cell antibody (Anti-Jkb) and the need for phenotyped blood.

All information was then relayed to all the other 3 hospitals to ensure appropriate future selection of components via the share care documentation.

Who should be responsible for the system?

Clinical area

BT laboratory

Both

Not sure

**NURSE
DOCTOR**

The patient?

**NURSE
DOCTOR**

There are many links in the chain that delivers the right blood to the right patient

**CARE OF THE PATIENT
DURING TRANSFUSION**

DOCTOR

**ORDERING AND
PRESCRIBING THE
BLOOD, DOCUMENTING
THE TRANSFUSION**

**CHECKING THE BLOOD AND
STARTING THE TRANSFUSION**

**PORTER
NURSE**

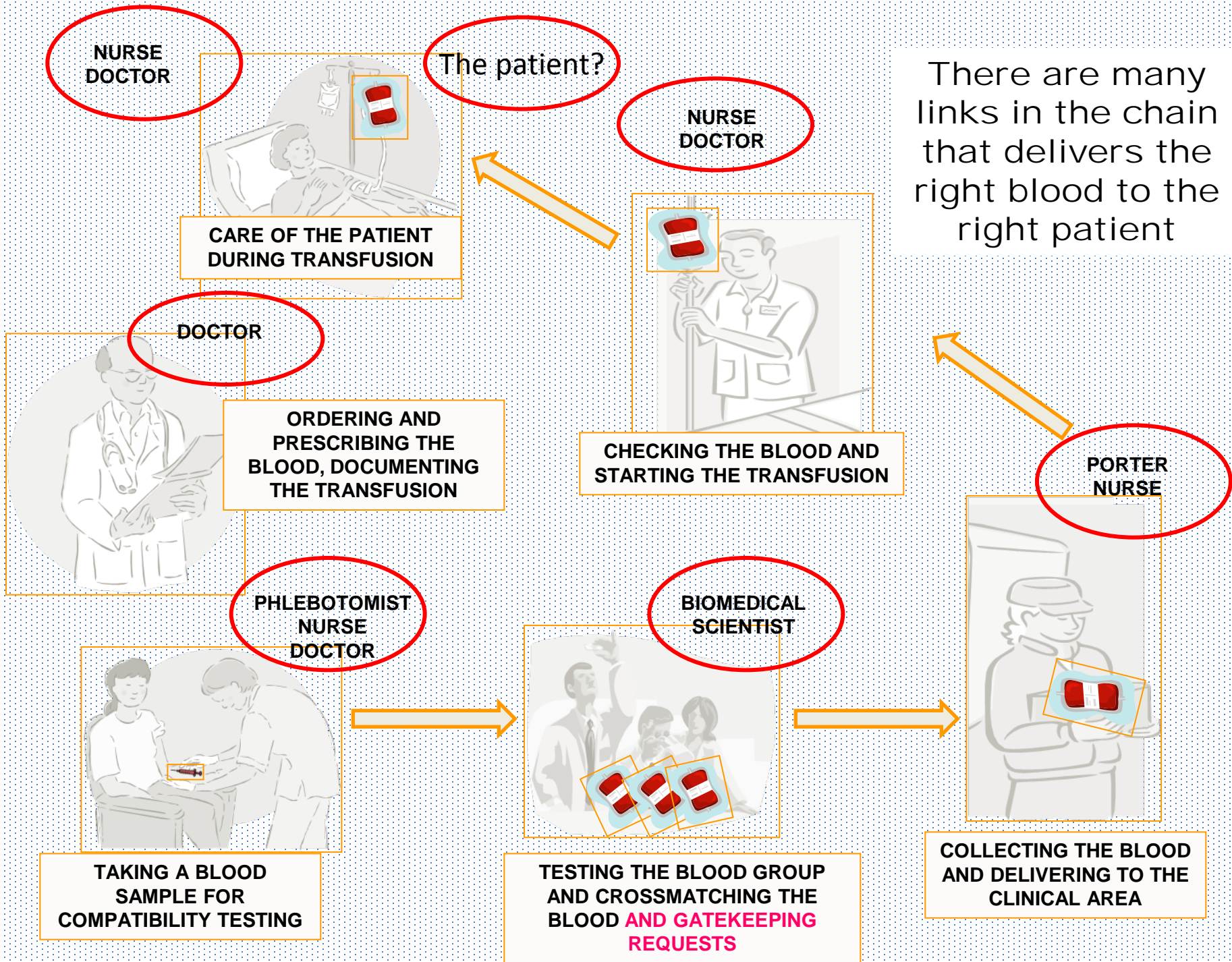
**PHLEBOTOMIST
NURSE
DOCTOR**

**BIOMEDICAL
SCIENTIST**

**TAKING A BLOOD
SAMPLE FOR
COMPATIBILITY TESTING**

**TESTING THE BLOOD GROUP
AND CROSSMATCHING THE
BLOOD AND GATEKEEPING
REQUESTS**

**COLLECTING THE BLOOD
AND DELIVERING TO THE
CLINICAL AREA**



Should the system include other special requirements

e.g. Antibodies, HLA matched etc ?

Yes

No

Not sure

Cases Study 1



Friday evening: Oncology patient transferred to St Thomas' from A.N.Other Hospital with a red cell component running.

- Component Tags were removed and no prescription available.
- Patient received 2 further units at St Thomas' over the weekend.
- Monday: TP initiated investigation on why there was no tag ID or rate of transfusion on the transfer:
- Only to find that the patient had a history of Anti-Jka
- 1 of the red cells transfused over the weekend was Jka Positive.

Does the system include special requirements for patients outside Haematology Oncology area?

Yes

No

Not sure

Shared Care: Case Study

A patient admitted with an Hb of 70 g/l and a possible myocardial infarct.

Admitting doctor noted the history of Hodgkin's disease but was not aware of the requirements for irradiated blood.

Patient was transfused 2 units of red cells (Non Irradiated).

Patient then transferred to another local hospital and received another 2 units of red cells (Non-Irradiated).

The error was picked up by consultant who checked with Haematologist on special requirement needs.

Shared Care: SHOT REPORT 2013

Recommendations from last year are still active as are others from previous years: 2011 – Care needs for patients with specific transfusion requirements

- 1. Patients should be provided with an appropriate card**
- 2. Patients education about special requirements**
- 3. Haematologists should implement & audit this process**
- 4. Patients with sickle cell disease identified on admission**
- 5. General practitioners can also note important transfusion requirements and include these in the referral to hospital whether emergency or elective**

Shared Care: What we did in London

LONDON RTC workshop

- Joint venture across the region
- Development for improvement



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Shared Care: RTC Brainstorming



Shared Care

Review of what was currently in place.....

1.How many Trust aware of any shared care processes within their own Trust?

2.Do you have specialities that are not provided by your Trust?

3.Are you aware of the documentation provided to support shared care?

4.How many Trusts are using shared care documentation?

5.How many patients have been involved in shared care in your Trust?

This section ONLY is to be completed by a member of the clinical team at the Specialist Treatment Hospital and then sent to their Transfusion Laboratory for the remainder of the form to be completed.

Referring Hospital	ABO and RhD Group Details	Specialist Requirements Needed
Patients First and Family Name	Specialist Treatment Hospital	Donor Group
Date Of Birth	Diagnosis	Transfused
NHS Hospital Number	Specialist Treatment received	CMV Neg
Address	Signed	Print Name
	Date	Print Name

The following sections are ONLY to be completed by the Transfusion Laboratory.

Please document below the ABO and D (where applicable) group of the blood component that the patient currently requires

Ref code	Diagnosis	Specialist Requirements	Additional Requirements
Historical Antibodies	HLA / HPA Abs	Yes / No	RBC Phenotype
Current Antibodies	Specificity		Washed RBCs
DAT			Washed Platelets
Signed	Print Name	Date	

Copy of completed form to be sent by Secure Fax to Specialist Treatment Hospital Laboratory or Referring Hospital Laboratory.

Confirmation of receipt by Referring Hospital Laboratory.
To confirm receipt of this form please sign, print name, and date below and fax back.

Date Fax sent	Signed	Print Name
Signed	Specialist requirements input ENVO Referring Hospital LIMS computer	Yes / No
Date	Date	

A blood component pack of stock contains: Adult Red Cell Component (1000ml), Adult Plasma Component (1000ml), Adult Platelet Component (1000ml), Adult Cryoprecipitate Component (1000ml).

London Regional Transfusion Committee **NHS**

Box for Document Control and Hospital Logos

Blood Transfusion Special Requirement Request

Patient Details

Hospital Number: _____ NHS Number: _____
First name: _____ Surname: _____
Date of Birth: ____/____/____

Patient treated at other hospital? Y / N _____ Referring Hospital: _____ *Mandatory

Diagnosis / Reason for Special Requirements:
(See below for indications for special blood requirements)

Complete this box if ABO Mismatched Transplant (HSCT/Solid Organ)

Component Requirements ABO/RhD group

Recipient ABO/RhD Group: _____ Red Cells: _____
Donor ABO/RhD Group: _____ Platelets: _____
FFP/Cry: _____

Component Requirements (circle option below)

Transfused Component: Yes/No _____
CMV Negative blood required: Yes/No (Neonate/Planned transfusion during pregnancy) _____
HLA/HPA Matched Platelets: Yes / No _____
Washed cells: Yes / No _____
Date Started: ____/____/____
Review Date: ____/____/____

Atypical antibodies present: Yes / No Details: _____

Signed: _____ Blazep: _____ Date: _____
Print name: _____ Job Title: _____

Form/copy sent to Laboratory: Yes / No

Lab Use Only - Transfusing Hospital
Received in Lab (Date/Time/By): _____
Fax Entered on Patient LIMS record (Date/Time/By): _____
Date and time faxed to referring hospital: _____

Lab Use Only - Referring Hospital
Date received at receiving lab on Date/Time/By: _____
Issuing patient V/N: _____
Received on LIMS (Date/Time/By): _____

PLEASE SEND Recipient fax back on number above: _____ Faxed to Transfusing Hospital (Date/Time/By): _____

Completion of this form confirms that this fax is located in a secure and safe environment

(For Document Control/Hospital Logos)



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Shared Care: Agreed Suggestions

1) Special Requirements Form

- One Regional generic Template.
- Needs to include the referring Shared Care Hospital name
- RTC to provide all regional lab fax numbers through its website which is password protected .

2) Patient Empowerment

- Get them involved, give them information
- Use of cards, and education programs.

RTT Recommendations 1

All Trusts should have controlled special requirements request form

Use of Shared Care Form to continue but need more enrolment to be successful

- a) Form requires Trust HTC endorsement
 - Move it through clinical area with Trust buy in
- b) Receiving Shared care hospital
 - When form received put patient Flag on LIMS.
 - Get confirmation from own Trust before blood release?

Recommendation 2

PATIENT EMPOWERMENT

a) Get them involved: **How?**

- Patient alert systems- Cards and education on its use.
- Patient representatives?

b) Patient information for all special requirements

including all **CMV-, IRRAD, Pheno, Antibodies**

- Simple and generic message given by Healthcare provider
- Get the patient to follow up and take ownership

Box for Document Control and Hospital Logo

Blood Transfusion Special Requirement Request**Patient Details:**

Hospital Number: _____ NHS Number: _____

First name: _____ Surname: _____

Date of Birth: ____/____/____

Patient treated at other hospitals* Y / N Referring Hospital: _____ * Mandatory

Diagnosis / Reason for Special Requirements: _____
(See Reverse for Indications for special blood requirements)

Complete this box if ABO Mismatched Transplant (HSCT/Solid Organ)

Component Requirement ABO/RhD group

Recipient ABO/RhD Group: _____ Red Cells: _____

Donor ABO/RhD Group: _____ Platelets: _____

FFP/Cryo: _____

Component Requirements (circle option below)

Irradiated Components Yes/No

CMV Negative Blood required Yes/No (Neonate/Planned transfusion *during* pregnancy)

HLA/HPA Matched Platelets Yes / No

Washed cells Yes / No

Date Started: ____/____/____

Review Date: ____/____/____

Atypical antibodies present Yes / No Details: _____

Signed: _____ Bleep: _____ Date: _____

Print name: _____ Job Title: _____

Form/copy sent to Laboratory: Yes / No

Lab Use Only - Treating Hospital

Received in lab (Date/Time/By): _____

Flag Entered on Patient LIMS record (Date/Time/By): _____

Date and time faxed to referring hospital: _____

FAX Number: [Insert Hospital Fax Number]

Completion of this form confirms that this fax is located in a secure and safe environment**Lab Use Only - Referring Hospital**

Confirmation of receipting lab on Date/Time/By: _____

Existing patient Y/N

Entered on LIMS (Date/Time/By): _____

PLEASE SEND Response fax back at number above. Faxed to Treating Hospital (Date/Time/By): _____

[For Document Control/Hospital Logo]

Generic Special requirement Requests covers.....**1. Patient details****2. Identifies care at another hospital****3. Transplant information****4. Special requirements****1. Includes other needs****5. Communication to other BT labs****6. With user information on the back**

Guy's and St Thomas'



Who should be responsible for ensuring the patient's special requirements are met?

1. Blood transfusion lab (flags)
2. Person prescribing component
3. Nurse administering the component
4. Patient
5. All

Shared Care

So what we did at Guy's & St Thomas'



Shared Care: **Special Requirements**

BLOOD TRANSFUSION STATUS:
All haematology patients & skin lymphoma patients

Hospital Number:
NHS Number:
First name: Surname:
Date of Birth:/...../..... Gender: M / F

Referred patient** Y / N
Referring Hospital**
Faxed to transfusion lab** Y / N

** Mandatory

IRRADIATED COMPONENTS: YES / NO **

☒ Tick as appropriate

☐ BM/PBSC transplant: donors (**autologous/family**) – for 7 days before harvest

☐ BM/PBSC transplant: recipients (**autologous/allogeneic**) – indefinitely

☐ Hodgkins – all stages regardless of their disease status – for life

☐ Treatment with purine analogues (e.g. Fludarabine, Cladribine, Pentostatin, Clofarabine, Bendamustine) – indefinitely

☐ All patients receiving Campath (Alemtuzumab) - indefinitely

☐ Congenital immune deficiency & IgA deficiency

☐ Aplastic anaemia patients receiving immunosuppression with ATG

If YES, give patient the NBS irradiated blood info leaflet and alert card

Other e.g. HLA platelets, CMV neg (pregnancy)

Signed: Bleep: Date:
Print name: (Registered Doctor only)

HAVE YOU PLACED ALERT STICKER ON PATIENT'S BLOOD PRESCRIPTION CHART? ☐

PLEASE FAX TO BLOOD TRANSFUSION (Guy's x84783 / STH x84775) WHEN COMPLETED
(Telephone Transfusion Lab on Guy's x84785 or STH x80751 to confirm receipt)
FILE FORM IN PATIENT'S NOTES

NO STATUS WILL BE CHANGED UNTIL A SIGNED FORM IS RECEIVED
NO BLOOD WILL BE ISSUED UNLESS STATUS IS KNOWN BY LAB

Status form
Reviewed on every...

1. Admission
2. New Prescription



FAX to BT lab.
where flag is placed on LiMS

3. Back up
Pharmacy report to lab on any
new prescriptions of Purine
Analogues

Electronic Patient requests (EPR)

Blood Bank Crossmatch Form V2 - ZZZ ZPIMSTEST, ARUAN TEST

Order: .Units to be Crossmatched Order ID: 001HFNMTJ

Requested By: Dabideen, Kamela

Messages: Phone the lab directly for blood if they already have a 'Group and Antibody' sample. ...

Ordering Information

☐ Conditional Order Template Name:

Collection Date: . Collection Time: Routine Result Priority: Urgent

★ No. of Units Required:

NB: Failure to order appropriate 'Special Requirements' can result in fatal transfusion complications. If you are unsure about this for your patient please check Trust Blood Transfusion Policies (see GT) or contact Blood Bank on 84774 or 82766

Special requirements: It is important that the patient receives the correct special requirements and selection of the appropriate prescription/clinical status will increase assurance that we meet these requirements.

★ Irradiated Special Requirements: .

★ CMV Special Requirements: .

★ Date Required: .

★ Time of Procedure: .

★ Site Blood Required: .

★ Previously Transfused? .

★ Has Pt received Anti-D in last 12 weeks? .

★ Patient Pregnant? .

★ Clinical Details: .

★ Bleep/ Ext. .

OK Cancel Repeat

Blood requests have a mandatory drop down menu for special requirements

★ Irradiated Special Requirements: .

★ CMV Special Requirements: .

★ Date Required: .

★ Time of Procedure: .

★ Site Blood Required: .

★ Previously Transfused? .

★ Has Pt received Anti-D in last 12 weeks? .

★ Patient Pregnant? .

★ Clinical Details: .

★ Bleep/ Ext. .

Shared Care: Prescription Chart

Surname First name NHS Number Hospital Number Date of Birth Gender ATTACH ADDRESSOGRAPH OR COMPLETE		BLOOD COMPONENT TRANSFUSION PRESCRIPTION CHART (Use this to prescribe Red Cells, Platelets, FFP & Cryoprecipitate)				Guy's and St Thomas' NHS NHS Foundation Trust				
See guidance overleaf - please inform the lab if the patient has any special transfusion requirements						Does this patient need CMV negative blood? YES / NO and / or irradiated blood? YES / NO				
Unit	Date	Component / product type	Dose	Duration (Not to exceed 4 hours)	Prescribed by (signature, print name, status & GMC number)	Blood unit number (place sticker from blood/product tag here)	Time started	Time ended	Given / checked by	2nd sig (if double-independent check used)
1						**Please remember** complete the Red Book complete the tag & return in the Red Box				
2						**Please remember** complete the Red Book complete the tag & return in the Red Box				
3						**Please remember** complete the Red Book complete the tag & return in the Red Box				
4						**Please remember** complete the Red Book complete the tag & return in the Red Box				
5						**Please remember** complete the Red Book complete the tag & return in the Red Box				

Transfusion Triggers:

Red cells:
Consider transfusion if Hb < 7g/dl (< 8g/dl if co-morbidities present)

FFP:
Bleeding patient with APTT/INR > 1.5

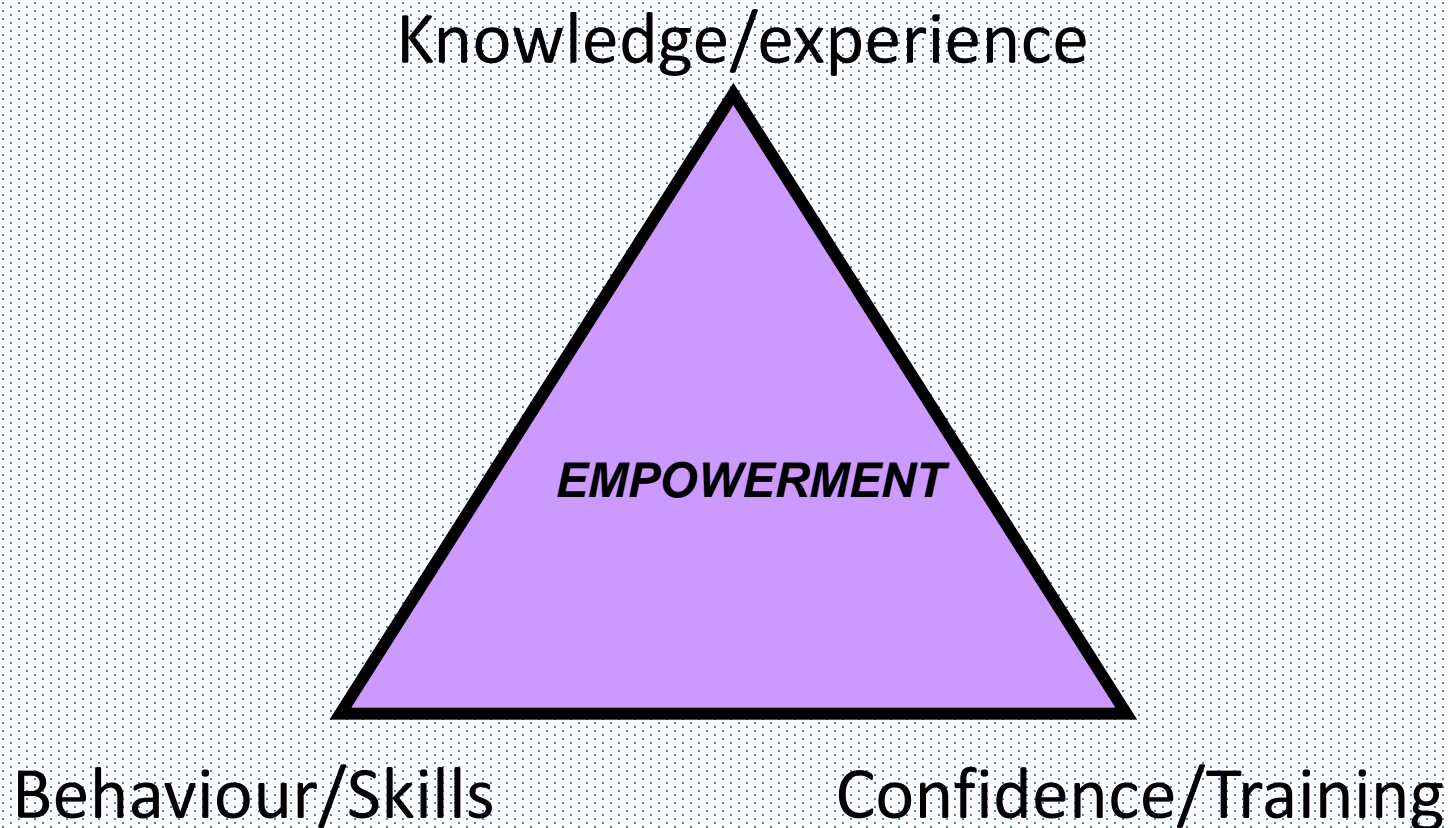
See trust guidelines for further advice

Consent: is this part of an ongoing episode for which consent has already been gained? Yes / No (if no, complete below)

Consent is required for each separate transfusion treatment episode: use a new chart for each new transfusion indication (prescriber to complete)
Please see over for guidance

Reason for transfusion:	
Verbal informed consent gained, and documented in notes?	Yes / NA
Transfusion information leaflet given to patient? *see over	Yes / No / NA
Clinician signature, print name, status, GMC number and date	

Patient empowerment



Shared Care and Patient empowerment



Program to improve

- Special Requirements
- Patient with antibodies
- Shared Care with patient referrals

All patients with special requirements

- Irradiated
- Washed
- HLA matched
- Phenotyped due to antibodies etc
- others

Patient survey

- Patients liked the card
- Enabled empowerment
- Helped to educate on needs

**I need
“Special Blood”**

Please Contact:

Blood Transfusion Laboratory

Guy's & St Thomas' Hospital

Tel: 020 7188 4474

2011-To date:

- 581 patients have been issued a card



Do you think there is some value in having a shared care program within your own Hospital ?

Yes

No

Not Sure

Share care: System in your Area?

Think about the system in your Trust which ensures.....

The right patient gets the
right component

- Paper system
- Electronic system
- Patients' existing prescription
- Patient empowerment



Shared Care

AND REMEMBER.....

COMMUNICATION =
QUANTITY
CARE



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