



**South East Regional Transfusion Committee
Presents:**

Shared Learning from the Amber Alert

held on
Wednesday 3 May 2023

Kim East, Lead Transfusion Practitioner
and Transfusion Quality Lead
Berkshire and Surrey Pathology Services (BSPS)

Transfusion Practitioner Network Approach to Demand Management



Berkshire and Surrey Pathology Services

Blood stocks are low!

By Kim East

Lead Transfusion Practitioner
and Transfusion Quality Lead

Review/postpone non-urgent surgery anticipated to require transfusion support



Reduction of red cell stocks within the laboratory/wastage



Only request blood you know you will use



Strict Adherence to national indication codes



Increased use of tranexamic acid to reduce blood loss



Multi-dis meetings

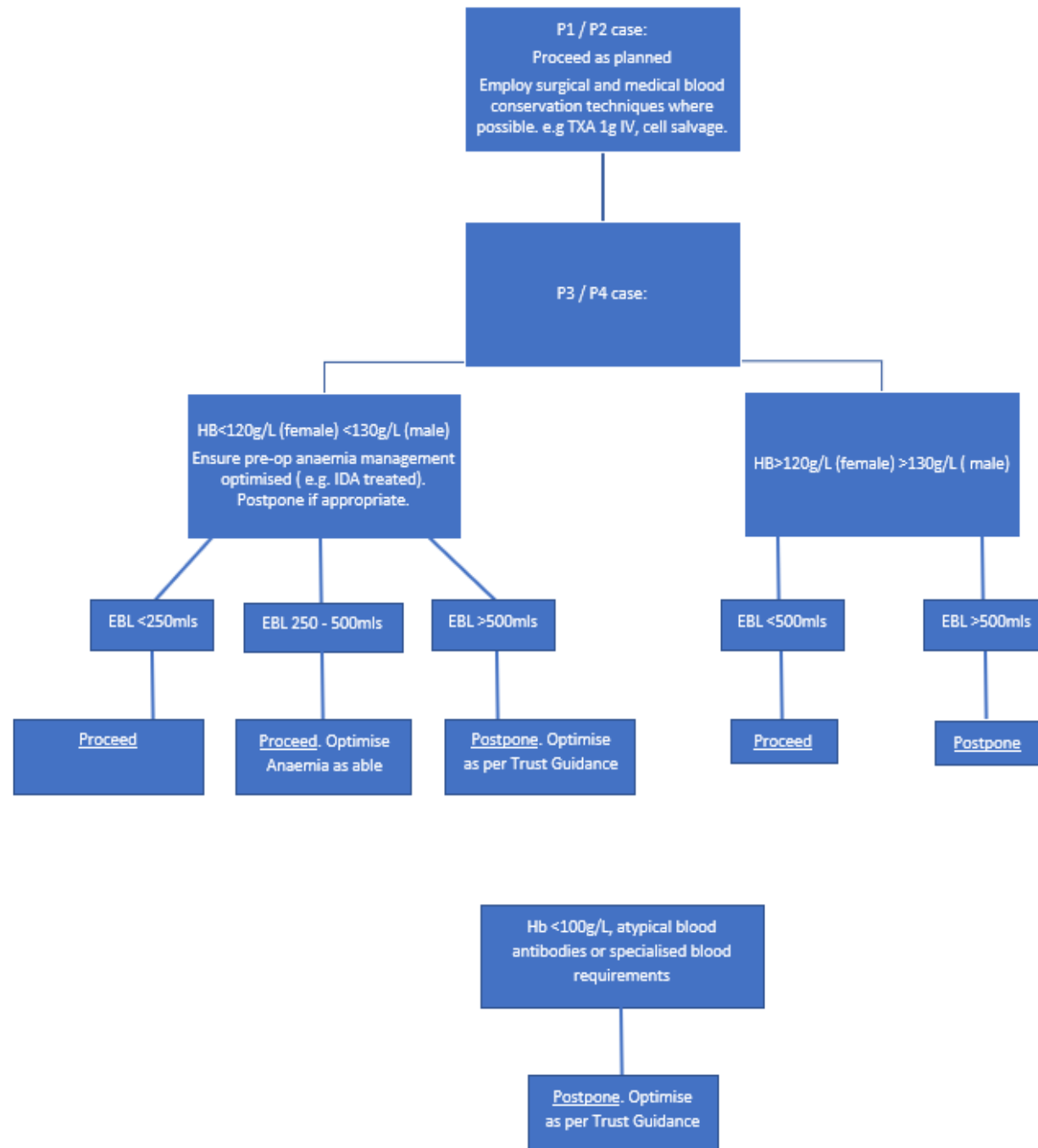


Comms with satellite sites



Actions taken in Amber Blood shortage

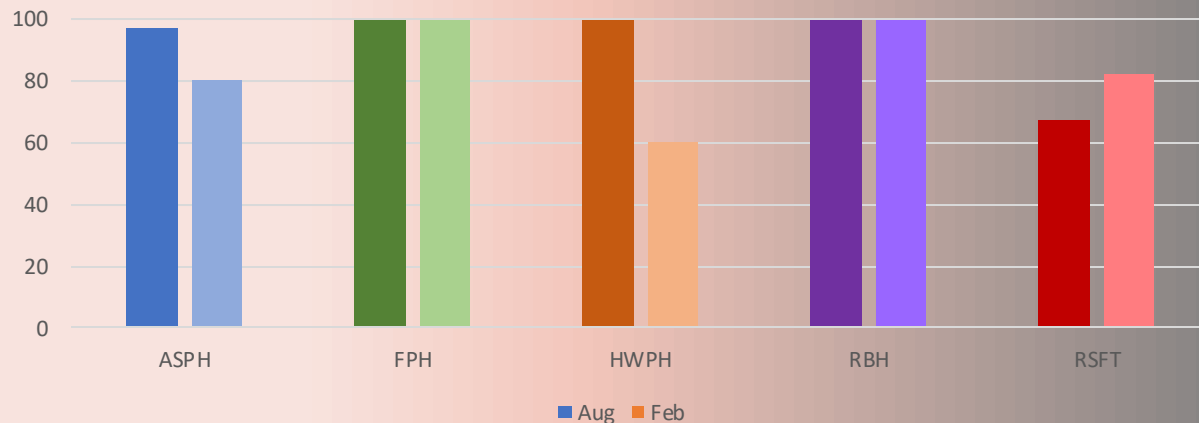
Review/postpone
non-urgent surgery
anticipated to require
transfusion support



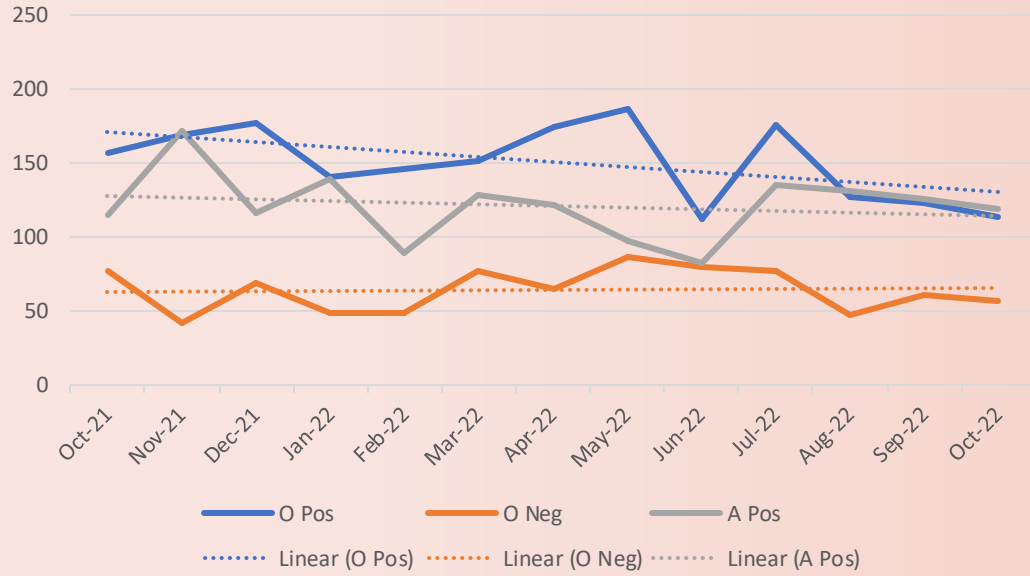
- Lab reduced stocks of group and O and A positive units at each site
- Where safe to do so O negative stocks reduced
- Decision made NOT to remove emergency O blood from satellite fridges (but to bring back to stock if levels became low)
- De-reservation period was already 24 hours
(Could reduce to 12 hours if stocks became low)
- O positive emergency blood already in use and monitored by KPI's

Reduction of red cell stocks within the laboratory

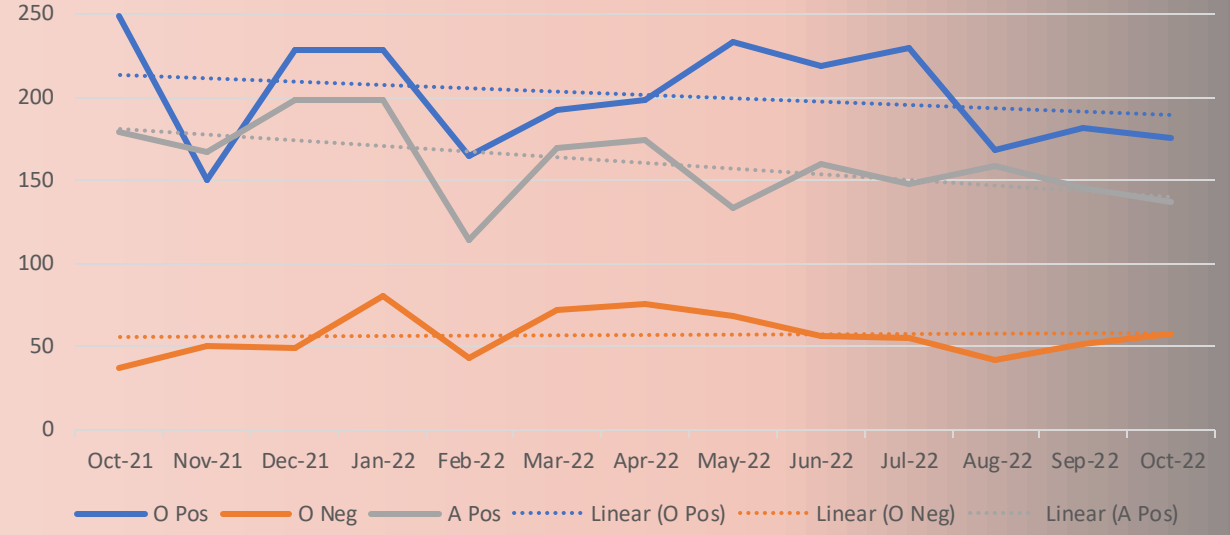
Percentage of adult patients with no childbearing potential to receive O Pos emergency Blood



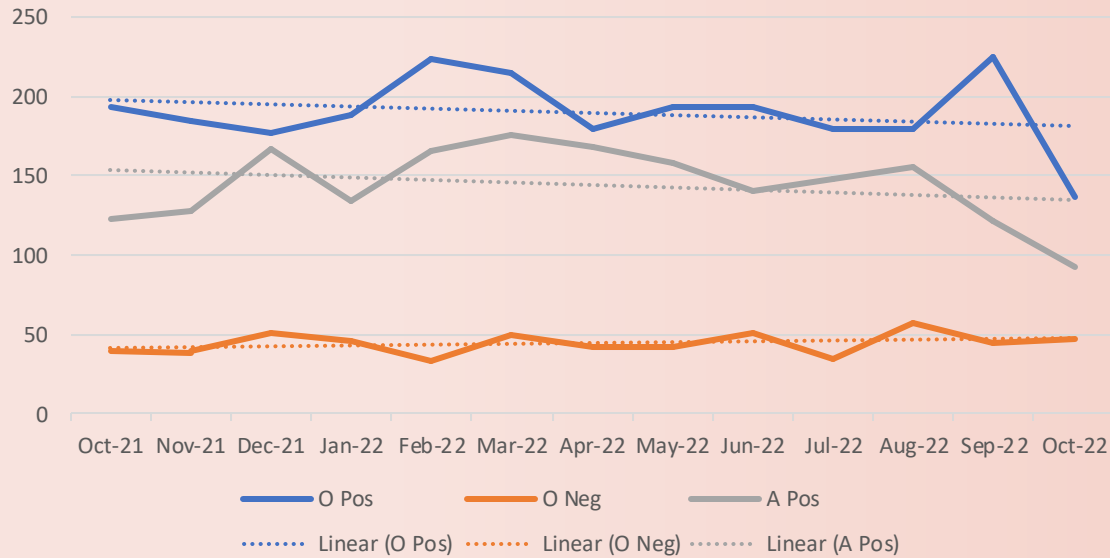
ASPH



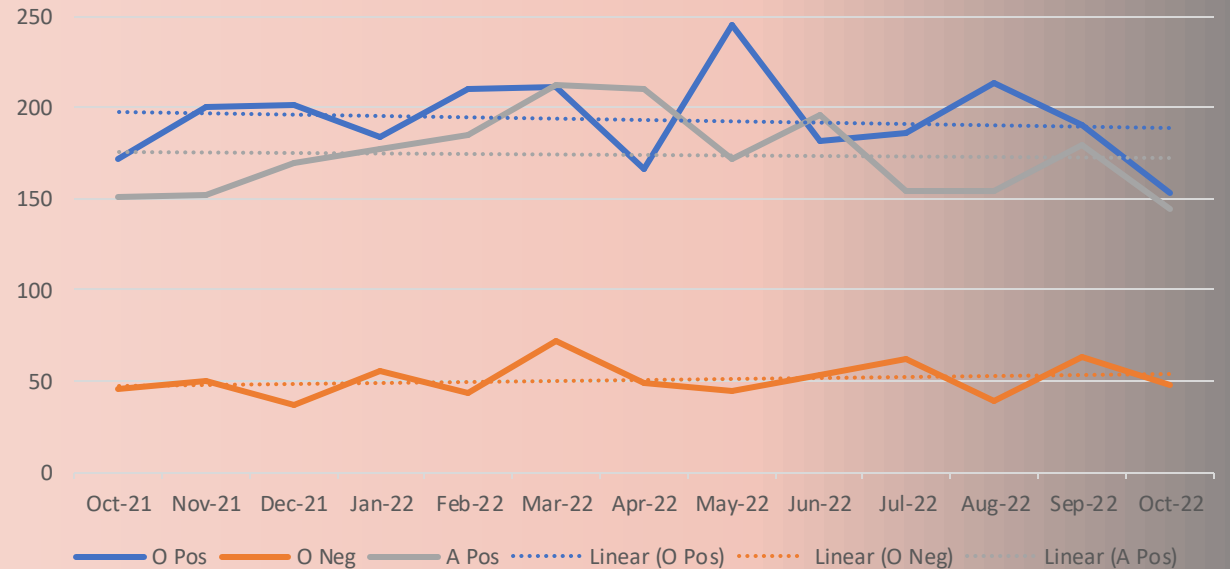
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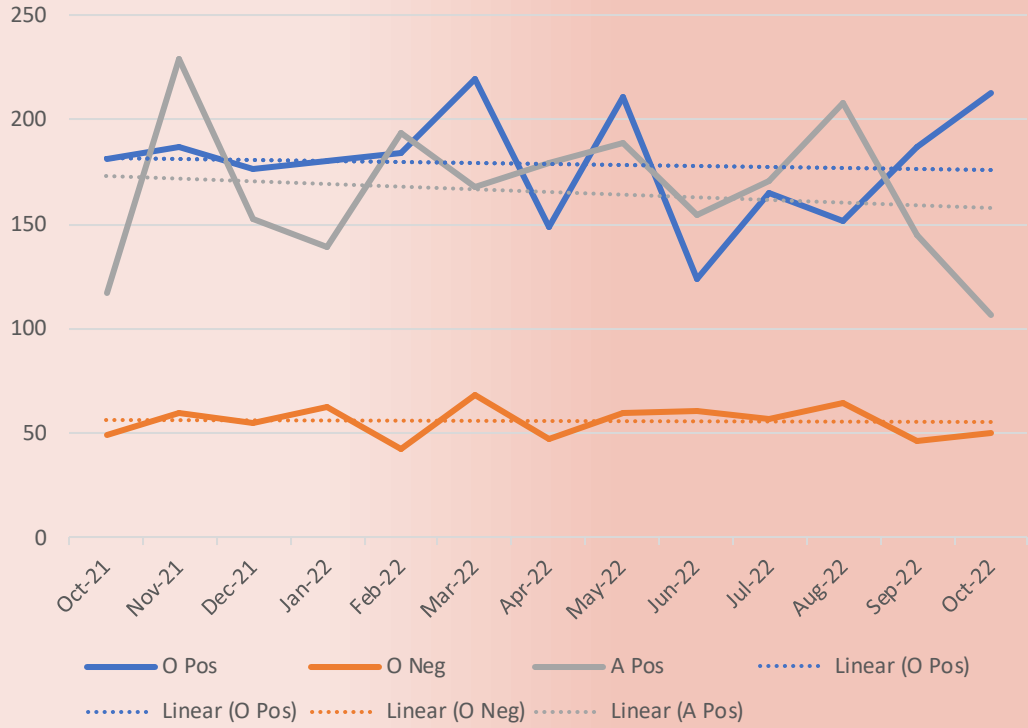
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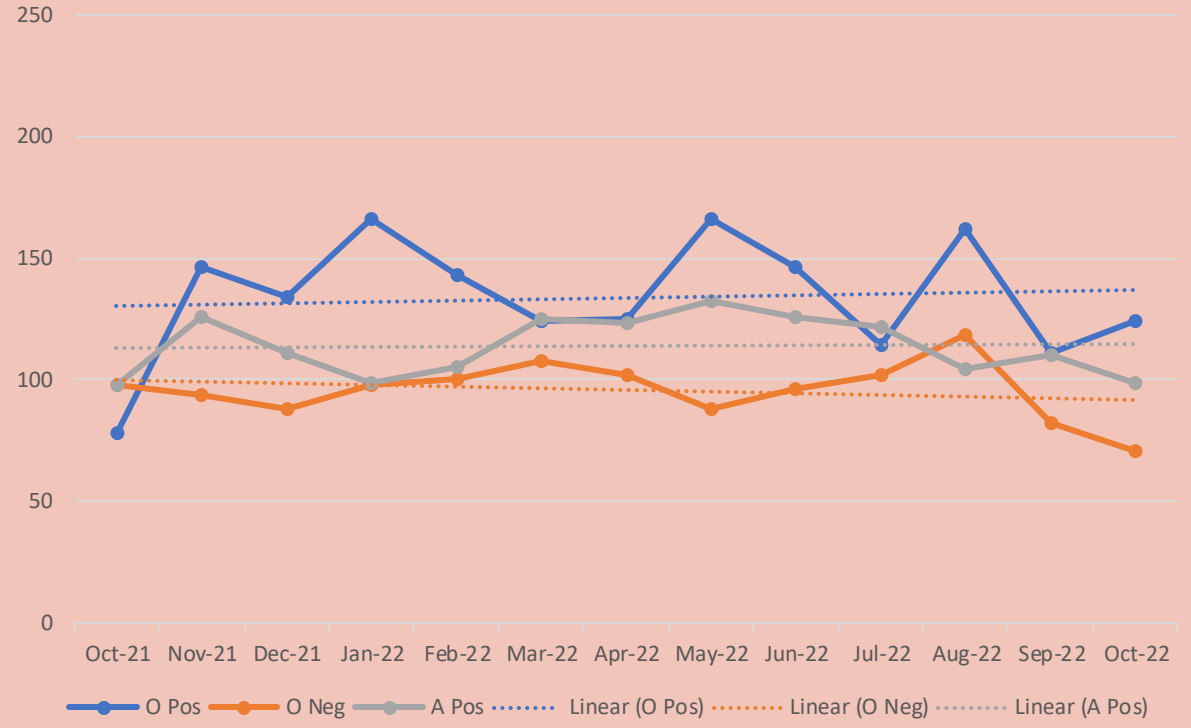
RBH



RSFT

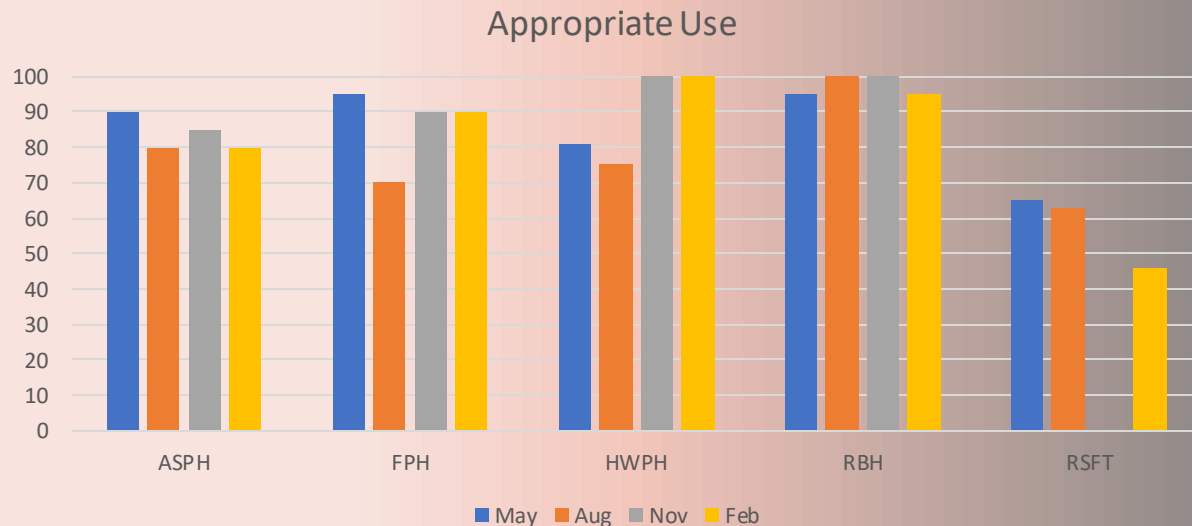


ESH



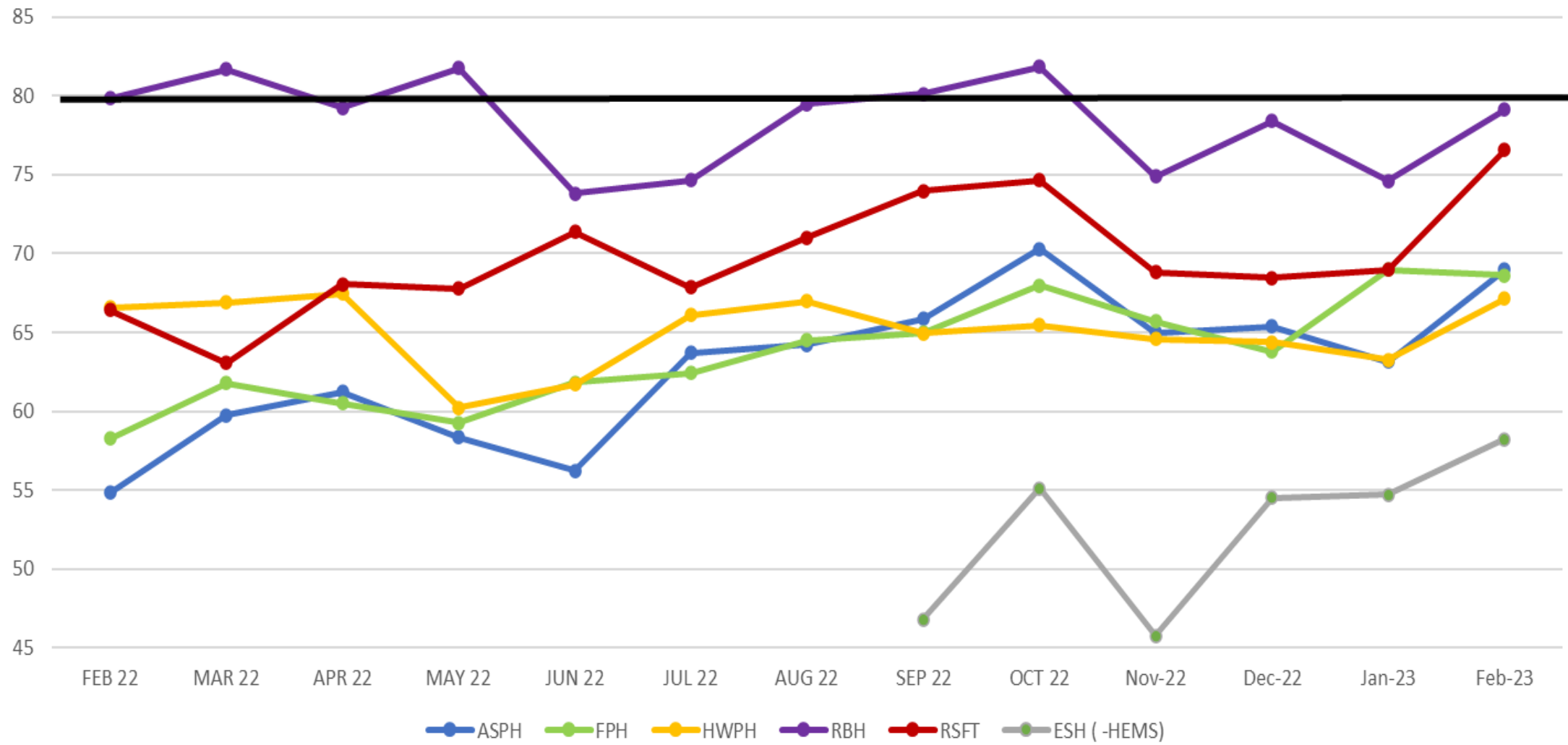
- Review of all requests by laboratory staff or transfusion practitioners
- Referral of all non-bleeding requests outside of guidance referred to consultant hematologist
- Single unit transfusion only
- Monitoring XM:TX ratio through KPI's

Strict Adherence to National indication codes



Only request blood you know you will use

Percentage of crossmatched blood transfused (%)



- Use of Txa already being monitored
- Where poor compliance was identified consultant hematologists held Qu and Ans session with key personnel to encourage use
- We ran out!
- Learning- We should have ensured adequate stocks

Increased use of
tranexamic acid to
reduce blood loss

Multi-disciplinary Meetings

Frequency and attendance varied across trusts

Best results from weekly multi-disciplinary teams which included following representation:

- Surgical
- Anesthetics
- Medical
- Haematology
- Medical director/deputy medical director
- Patient safety representation
- Transfusion Practitioners +/- Lab
- Trust Operation Centre (TOC)
- Associate Director of Operational Capacity
- Communications team

Learning- All trusts wanted assurance that other partner trusts were doing the same!

Positive feedback including money saved!

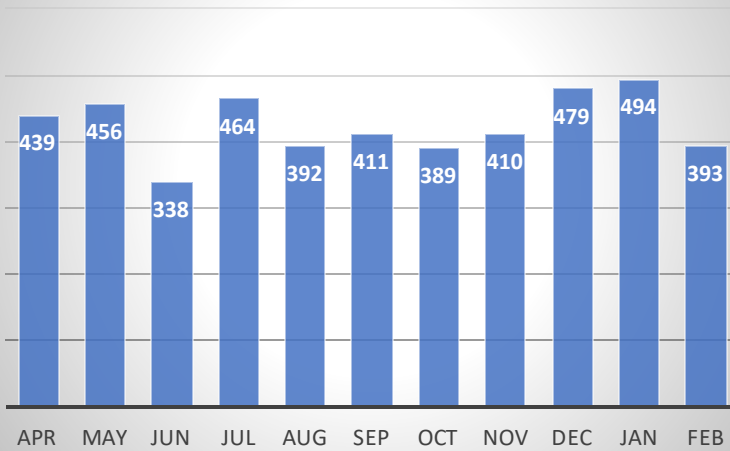
Emergency Blood
Management Team

- We have remained at reduced stock holding at all sites
- Review of SI index to ensure stock levels are still appropriate
- Review of incidents to ensure actions have not had detrimental affect
- Continue to monitor KPI's that include XM:Tx ratio (Percentage of blood transfused, appropriate use
- Feedback to trusts on reduction in stock and cost savings!
- Is it sustainable?

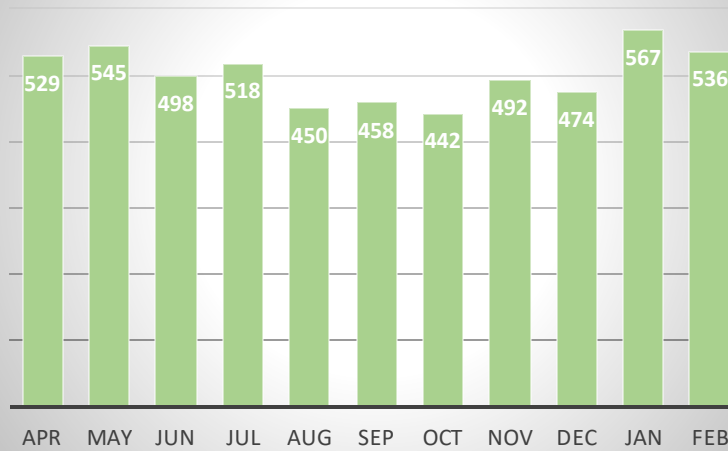
Learning/
Sustainability?

Sustainable?

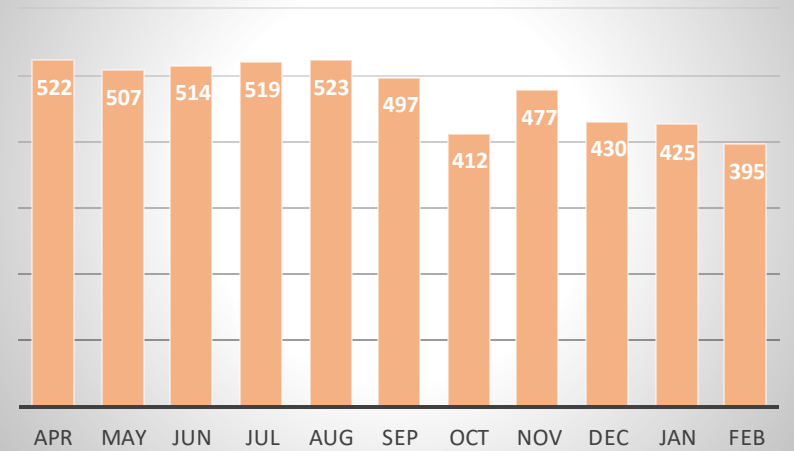
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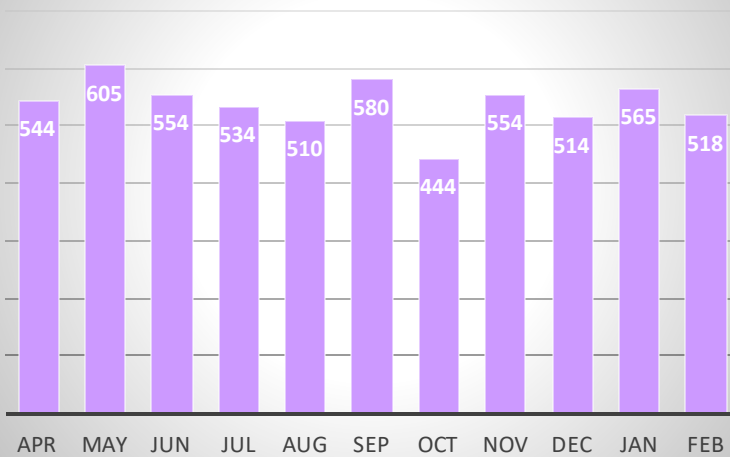
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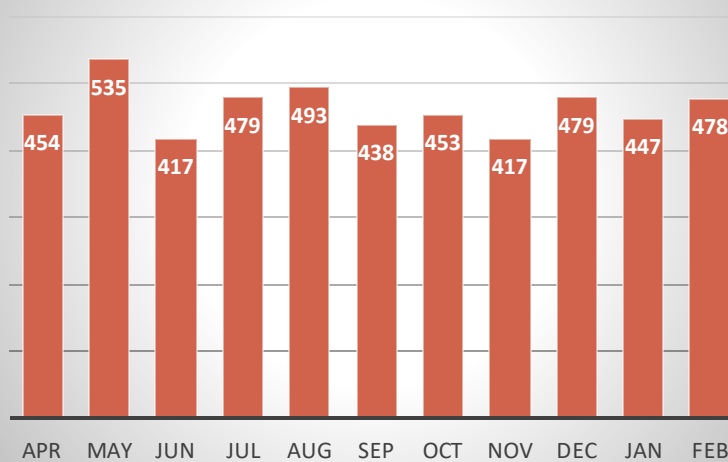
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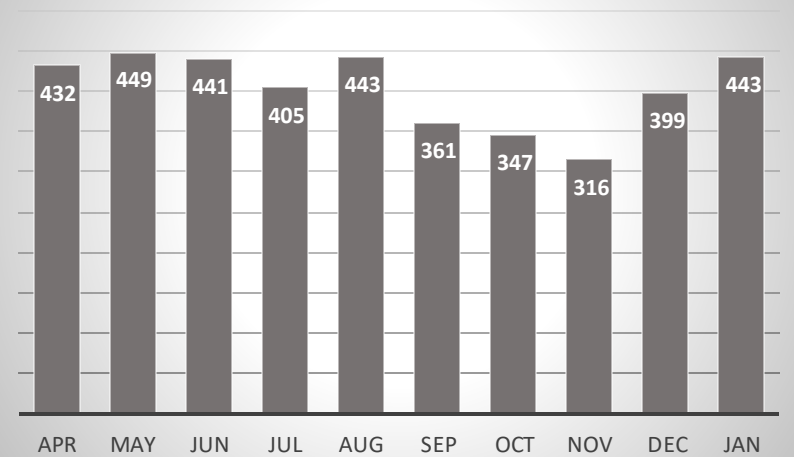
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Questions?

Thank You