ADL - Linley

I'd like to thank the MBA for the invitation to come over here to present and it's been really great catching up with some colleagues that I've worked with over the years, so lovely to see everybody. Today I'm actually going to be presenting some work that was undertaken by the Blood Matters program last year and as Claire has said it was an audit that was helped to be put together by the Consent Working Party. For those of you who don't know about Blood Matters, I'm sure many of you do, it's a very similar program to BloodSafe. We are trying to promote the safety and quality of blood and blood products. We have a number of transfusion nurses and trainers employed across Victoria to help try and promote that. As you see here I'm presenting data that includes Tasmania, ACT and Northern Territory, we actually have memorandums of understanding with those jurisdictions for them to be able to participate in our audit programs and activities within the Blood Matters program, so that's why their data is included in it and we're really appreciative to have them on board.

So we looked at measuring the current policy and practice against guidelines and we also included what patients understood or really it was about recall not so much we didn't give the patients a test. We were looking to see do policies actually exist and what elements are included in those policies? Were the transfusions that were administered given with consent? And what did the patients understand or recall about the consent process? The measurement was actually done against the Australia and New Zealand Society of Blood Transfusion Royal College of Nursing Guidelines for Administration, the National Standards and the ARMAC Stewardship Statement. So they were the three documents that we used to measure compliance against. It was a three part audit. The first part was a desktop audit and that was really looking at your hospital policy. Did you have a policy and what did it include? The second part was around was the transfusion given with consent and the third part was patient's understanding. Both B and C we looked at 30 randomly selected transfused patients at each health service. We invited 140 health services to participate and the data was entered electronically by our Blood Matters website.

Of the 140 hospitals that were invited to participate 110 health services responded to at least one part. So in Part A when we talked about policy 105 health services actually responded that they had a consent statement within their policy about obtaining consent for transfusion. Now it could've been within a hospital wide policy, it could've been a standalone consent for transfusion policy. There were five health services that did not have a policy related to consent for transfusion. The majority of respondents when they talked about their policy had defined within that policy what was actually covered, so what product was covered whether it was fresh products, fractionated products and that's in line with the national standards.

And 90% actually included where the consent was to be documented. Now this shows the different types of documentation that were actually reported through in the audit. We were quite surprised that there were 48% of standalone specific consent for transfusion forms. Twenty-one percent had a generic consent form but did actually have reference to transfusion and then the next largest group was "other". Now we didn't have the capacity in our audit for people to select multiple sites, so they responded to "other" and said that they had two different sites, both

the medical record and the consent form were points of documentation.

Claire mentioned about timeframe and she talked about the chronically transfused patients and that they had a validity for 12 months I think for their chronic transfused patients that where their medical conditions weren't going to be changing and the requirements for blood products weren't going to be changing. So this is something that can be done and health services can nominate this at their own discretion and what works within their organisation. So we looked at measuring that in the audit and we found out that 50% of the actually people who had a policy on transfusion had stipulated the timeframe that that transfusion was valid for or that consent was valid for. There were 46% who had it for six to 12 months, 25% had it for greater than three months and up to six months and there were 16% that included it for an admission only. It was interesting to note that the 4% of the hospitals actually had it for an indefinite period of time.

So what elements were actually included in those policies? Now this has been taken directly from those documents that were referred to earlier. So 77% of those policies that were audited actually included the reason for the transfusion, 84% for the risks and benefits of receiving that blood product. That dropped to 68% of the risks and consequences of not receiving that product. One of the things that we thought was a bit surprising was that there was only 59% that had included any other blood management strategies. And less than 50% included the use of a competent interpreter, so if a patient was linguistically diverse. Sixty-five percent of the policies did say that they should use written information where it was appropriate.

So we ask the question on who could obtain consent and as you would imagine seeing consent is the responsibility of the prescriber the majority of people that responded was around the medical officers. The three nurse practitioners that were nominated in there are three nurse practitioners who have transfusion in their scope of practice. It was interesting when we got to the practice part there were no nurse practitioners documented as taking consent. And the other description that was included here, included a variety of descriptions to cover medical officers, so it's just how you define that roll. And there were two hospitals in there that had included the scope of practice for obtaining consent to include registered nurses. Those policies have now changed since this audit.

So what actually happened in practice? One hundred and three hospitals reported on the practice part, there were 75 public and 28 private and the reported 1,788 transfusion episodes. Forty-five percent of the patients that were audited were male and 55% were female, 68 years was our average but it did have quite a broad range from less than one year up to 98 years. Fifty-five percent of those people who received a transfusion were over 70 years of age and the predominate blood product that they received was red cells with 92% and where the patients did receive more than one product on one day it was red cells that they received so they might've received two units or multiple units of red cells. It was interesting to note that informed consent was documented and valid according to the hospital's policy in 75% of those cases. We looked at age group in accordance to clinical speciality and as you can see here there's quite a proportion sitting in those 70 or over and medical specialities was the highest group and particularly in the 70 or over, followed by haemoglobin oncology and then surgical and obstetrics.

Now we had no oversight on who was audited, that was the discretion of the people who were doing the audits at the hospitals or the health services. So they could've (8.23) that by just selecting an easy to access group but we don't know that. So who did obtain consent? There were differences between public and private health service and as you would imagine there's a different workforce spectrum in the public and private arenas and so there are very few registrars and interns working in the private scene, so most of the consents in that private setting were taken by consultant medical officers. Of note there were a number of registered nurses who were actually documented as taking consent. Of those RNs that were documented as taking consent 39% of those were from those two hospitals that had included the scope of practice but the rest of those were outside the scope of practice of the policy from those health services or maybe they were at a health service that didn't have a policy around consent.

So the next part of the audit was around what patients understand or what they actually recall of the consent process. We had 93 health services report into this part of the audit, there were still quite a number of transfusion episodes reported, so there were 1,386 episodes across those health services. Eighty-eight percent reported some form of information was given to them with 32% of that being written information and 86% being verbal information. Approximately half received this information at more than two time points of care, 20% received it just prior to admission, 18% received it at the time of consent and another 18% on admission, so at lots of different time points. When we actually asked what the patients recalled they said that they received data about the possible risks of transfusion but many of them didn't have the possible risks of not receiving a transfusion explained to them. And as you can see, the alternatives to transfusion were very low, so 7%. So it shows that there's significant improvement required in these areas for the health services to meet the standards that are expected of them and also to comply with national standards.

Of the 89 patients that could recall being offered an alternative to transfusion, 54% of those were around iron therapy, it's unable for us to determine in the data whether alternatives to transfusions were not offered because clinicians lack the knowledge of it or whether perhaps there wasn't an appropriate alternative available. That wasn't able to be drilled down. So from the information that we've received we have made several recommendations for health services in relation to consent for transfusion. First of all for health services who don't have a consent policy that they should actually develop one and that policy should include all of those elements of consent that are outlined in the Australian New Zealand Society Royal of College of Nursing Guideline and in the national standards.

We actually have complied or put together in our consent report a checklist for health services to actually see how they measure up against all of those elements. Two of the five health services without a policy once we made an enquiry had actually developed a policy following the audit and the other three health services were waiting to get their data back so that they could go to their executive and say "we need to have this, we're not compliant".

For the health services that do actually have a policy we need to get them to revise that policy to make sure that they do actually include all those elements that are stipulated. One of the areas that we didn't look at in or audit was refusal of consent, so that wasn't actually audited at all but that is something that should

be an element of the transfusion policy or consent policy. So in regards to practice, we said that consent responsibility does rest with the prescriber and that should be documented well within the policy so that everybody knows who is responsible and who can actually document consent. Many of the health services need to actually look at improving their documentation and the documentation of patient information, so making sure that the patients are involved in the decision-making process and we've had a few people ask questions around that today and I think that's a big area that health services will grapple with is that involvement of patient and how do you do that and how do you engage them more. We need to improve the information that we give patients around risks and alternatives and particularly in the area of alternatives and trying to increase the awareness of appropriate alternatives if it's available.

This is the checklist, it was a two-page checklist but I have put it up there and I know that you won't be able to read it, it's pretty small but it's available in our report on the website and this is how we reported back the individual health services report. So they were actually shown which part of the standard they met and what percentage that they met it and they were also given comparative data for summary data there. These reports were sent to the CEOs and one of the health services rang us up after their CEO had received it, it was a couple of weeks after he received the report, to say that they thought that was a really great thing to do because their results weren't quite so good and this person had been trying to champion consent for quite some period of time. The CEO took it to the board and now the board are very engaged and they'll have a consent policy enacted and working very soon. So it was really great to hear that having some evidence for the executive has helped drive change.

Along with that we've actually developed this transfusion data collection tool to assist health services to look at documenting appropriateness documentation and wastage. Now this tool can actually be modified, each health service can modify it and make it appropriate for their health service and put in their parameters and make it customised. It actually does provide some lovely graphs that can be used at your transfusion committee, governance group, patient blood management committee. This is an example of what the graphs could look like from the audit tool. This is the documentation ones which does include consent. So that's available for anybody to utilise from the website.

I can't go by without acknowledging first of all my team within Blood Matters who have helped put the audits together, our working party that helped develop the tool and all of the health services that contributed. We had a number of reviewers help us review our report and we need to also acknowledge materials that we've utilised in developing our audit tool from New Zealand Blood Service from Western Health in Victoria and from the Australian New Zealand Society's Survey and Documentation in Transfusion. So that's our website and just open up if there's any questions to either Claire or myself. Thank you.

Questions?

(16.16) for anti D or do you use the usual blood product consent form?

Yes, the question was do we have a separate consent form for anti D. Many of our health services do have a separate consent form currently although they are looking at trying to incorporate them in and I'm not sure, does yours include …

Ours does include for plasma (16.37) like anti D however at this initial stage we are just asking for consent for the fresh blood products, so that may change.

That was a great presentation, great data, it showed some deficiencies in actually informed consent. Probably I don't know and I'd appreciate your comment about the quality of the informed part. As in, as you identified, our experience of the MBA is some clinicians aren't actually engaged on blood so having a clinician informing someone on something they don't really know themselves, do you want to just one, comment on whether that's an accurate perception and two, how can a health service address that?

I guess it is probably an accurate perception. We don't necessarily know what informed is. An informed to one person might be quite different to another. I have told them they need a blood transfusion and so they've signed for it. And I guess it's also the patient not always questioning. I guess that's becoming a bit more this day and age with so much knowledge being available for people but often the doctor says "I need it" so I'll believe them. And so they don't necessarily ask but obviously Claire has shown with them that the doctors want to have the risks available, not everybody can know everything.

I'll just comment just from when I actually conducted the audit for the Department of Health and spoke to patients, I did find that the older population, over 65 for example, they said "oh the doctor spoke to me and discussed this and that" and when I asked "did you have any questions for me" they said "oh no, look, whatever the doctor says that's fine with me". It was generally the younger patients that had more questions. And they felt that they were answered. But once again, you can't tell exactly how much information they got.

I guess there were a number that received written information but then that's another thing, can everybody read and we do have things written in a level which we hope people can understand but that's another thing that having some of the tools that we have available or not necessarily about to be used by those people who may not be able to read or have an understanding, so that's another area of dilemma.

The picture card?

The picture card, I think the blood service is going to be trying to work on it as one of their tools, would be great.

Now questions.

I noticed in your audit you had a lot of private hospitals that submitted information. Did they make any enquiries or ask for some recommendations about how to go about documenting consent when the decision to transfuse was a phone order?

We haven't had any specific conversations about phone order with that. We have had probably a number of conversations with the private hospitals that were going to be involved because there are a number of them who are just embarking on the consent process and so that's why some of their results may not have been as good. Some of them were quite poor and those private hospitals wanted

to have that to help drive change. There's been quite a bit of conversation between the people who are trying to engage the consent processes at those private hospitals with the transfusion nurse network within Victoria, to try and get guidance and assistance with it but it certainly is a different area to try and get consent, your medical staff aren't there all the time. They might not see the patient that often. So it certainly is a dilemma but none of them have come across with any great hurdles that I can share with you, Trish, sorry.

Well Linley, Claire, in a difficult area I think for all health services, patient consent one, two informed and thank you very much for giving a perception from the Blood Matters program and as Linley highlighted there's a lot of materials there on top of the materials that I know exist already in South Australia as well. On behalf of everyone here thank you very much for coming all the way from Melbourne. And please show your appreciation.