MELB – Kerry Dmytrenko

Some of you know me and I am a bit of a story teller so I have notes here to try and keep me on track. I didn't really expect so many here today, I thought, I went to a forum in Canberra and probably expected 50 or 60 here today.

So I quickly, when I found out how many there was, just put in this quote, and I'm going to quote Katherine Wales nee Middleton, as she stepped onto the balcony at Buckingham Palace, looking out to the crowd after her wedding "wow, there is just so many of you".

Susie has gone through a bit of the background regarding the establishment of the Eastern Region Transfusion nurse role. I'll give an overview to the current role.

Firstly I would like to share with you a quote I have stolen from Jennifer Roberts' presentation at the NBA private sector health forum in Canberra in May this year "blood transfusion is a liquid tissue transplant. I quote this often and go onto remind people that we are not so blasé with a bone marrow or a kidney transplant, and whilst blood transfusion in ingrained in medical practice, we really need to give it the respect granted to other transplants".

I've been told how to do this. Oh yeah, beautiful, sorry. My background is Oncology, Haematology and Palliative care, so I've had vast experience at the user end of the product. I've also been a donor and a recipient, and I had my transfusion in 1997. I had a haemoglobin of 49, I was working until the day before I had my transfusion, I had five units. So today, they probably wouldn't have given me five units; they might have given me one and worked on what the reason was, rather than topping me up so much.

I'm also a nurse practitioner, so I can prescribe. I've held the transfusion role for about 17 months. It is currently a two day a week role, and encompasses responsibility for St. John of God in Geelong, so I do that one day a week, and the other acute Victorian Divisions; so Ballarat, Bendigo, Berwick, Frankston and Warrnambool, and there's also one day a week of that.

Supporting their clinical champions at their site, these clinical champions take on the blood role in addition to their normal role such as a NUM of the ICU, the afterhours coordinators, quality manager and an Oncology educator. This support will increase once the other Victorian divisions head towards organisational wide survey for accreditation. The plan is to commence the extra support with education, auditing, which we all love, and policy review and development at each of these sites towards the end of the year.

The position has a seat on the group blood reference committee, and as such has input into policies and decisions at a group level.

The role has some local governance perspective in the writing and review of policies and protocols, and these are rolled out to other sites where appropriate. As Susie explained, we have lots of different sites, lots of different people trying to have their own policy or consent form.

Incident investigation and review including reactions, wastage, no consent, product recall and documentation, and ensuring changes to policy, protocols and procedures as a result, if required.

Reporting incidents to STIR if they're within the guidelines, and obviously to ensure that the hospital works towards and within a framework that encompasses the national standards, and especially Standard 7. And Geelong undergoes organisational wide survey in three weeks.

So some of my nerves is that, as well as being here.

As you all know this has involved a large amount of auditing, your baseline so you know where you're at, re-auditing after a change to a policy, procedure or paperwork to check the effectiveness of these changes, and of course re-auditing again to establish if you're maintaining these changes.

It has also meant changes to paperwork and forms and the introduction of new forms to align with the requirements to achieve a MET at accreditation. And all of the evidence gathering that goes along with that, and I'm sure many of you have been met with a "yeah we do that", or something similar we're trying to audit. And I also pay tribute to Anne Kinmonth for giving me great foundation to work on, and I also had to apologise to her today, because I thought as a nurse manager of the Oncology Day Centre I must have been a huge P in the A when I was just trying to get on with what I was doing, and really told her one day we were closed for auditing.

Consumer involvement is something that we're taking baby steps in and Susie touched on that a little bit, not yet having consumer representation on our local transfusion committee. We did a survey within our consumers to ask them which patient information leaflet they preferred, and we ended up with the, have all your questions been answered, and that was a surprise result for some of us because we thought that they might go for the one with the pretty picture of the happy person on it.

Along with all the audits that we do and Queensland audits, all Geelong blood product episodes are audited on a monthly timeframe, in regards to documentation, consent, observation, reactions, and the results reported to the nursing leadership team, the NUMs and the transfusion committee and actions are planned to address deficits, and using education in-services and workshops, and in the case of no consent a letter is sent to those doctors informing them that this event has occurred. We have had an older consultant who's probably not ready to die yet, who has been sent a letter a couple of times, he happens to be an Oncologist, becomes more embarrassing for me because that's my other job, and more recently we rang him and said "these patients present to Day Oncology and then cannulated, we have two units, always two units", and his answer was when he was told no consent is to "send the patient home and rebook them, I do not have time to come over there and I do not have time to consent them over the phone". So we, quite concerned about that patient given that we'd already cannulated and the haemoglobin was less than 80 the week before and they were a transfusion dependent patient. God, five minutes already. So we bypassed him and got ICU to consent that patient.

In July 2012 we saw the introduction to mandatory consent for transfusion of fresh blood products, and after discussion with senior medical staff the decision was to consent with fresh products only. They felt this was the best way to manage the change.

The introduction of mandatory consent was supported by the medical advisory committee and all the consultants sent a letter signed by the Chair, advising them of the change and the timeframe and providing them with information regards their responsibilities. Nursing staff were also informed and received a memo outlining their responsibilities regarding consent i.e. not transfusing blood without consent except in the case of an emergency. And there is provision for an unable to consent declaration to be signed in a limited set of circumstances.

I've probably got lost now. No, right.

Our compliance rate sits around 100, with some of them sneaking through the system, and usually that's a sedated patient in ICU post-theatre and I guess they presume that the patient was consented at the time of surgical consent.

St. John of God Geelong is aiming to introduce mandatory consent for all blood products in 2014 after an extensive education for both medical and nursing staff.

The blood reference group has achieved the introduction of standardised blood administration policy that was consistent across 10 St. John of God acute divisions in both WA and Victoria, with many drafts, but finally, it's complete until our next review.

Give that I've got short time I won't actually click on the policy, it's quite a long document and it goes into refusal of blood in there as well.

A working party has embarked on the journey of standardising the blood prescription form across all our acute divisions and is still very much a work in progress and I'm sure will present its own set of challenges.

The clinical indicator Susie's touched on. We are very mindful that some of the information that we will collect in 6.3 may not give the full picture because there is no qualifying subset such as comorbidities, and some divisions have elected not to collect this information.

The roll out of BloodSafe eLearning was commenced in Geelong about two years ago and has now gone through all divisions, and some Victorian divisions are only making that change from a paper based to the eLearning this year.

All nursing staff undertake the transfusion clinical practice, and all midwives also do the PPH course right across all our divisions, including WA. Nursing staff education includes in-services and workshops and we use simulation workshops and PPH in critical bleeds for the midwives and ICU staff. And, the anaesthetists who've run our codes with their critical bleed have commented they've also increased their knowledge by being involved in it, their understanding of what goes through when you call a massive transfusion protocol.

As you're aware the commissions developed a set of clinical indicators that are different, aside from the normal clinical indicators and clinical indicator 12 is on

wastage rates. At the private health sector forum I found out that Sydney Adventist Hospital has their wastage rate is 0.5%, and we were given St. John's wastage rate and that was quite horrific. So one of our plans is to adopt some of their strategies, and one of those is for the blood bank staff to undertake the transfusion clinical practice course, which they had done at Sydney Adventist.

Next I've got some challenges, and I call them opportunities as well, because sometimes we're told to change them into that. Our challenges are the change of policy and protocol. Change is hard, there's a book out that says "change is good, you go first".

Consent, the change of practice, and now looking at fractionated products.

Education, change from the paper based to eLearning and not all staff are at the same tech savvy level, so we have a lot of senior staff, we don't have a lot of transient younger staff, and so some of those don't even have a computer at home. So that's sort of the difficulty we're dealing with.

Multi-sites, varied expectations and individual barrows to push.

Recall of plasma expanders of Voluven, will increase our use of albumin because albumin's free, according to our ICU doctors.

Our opportunities in collaboration with the senior haematologist and senior blood bank staff were looking at the introduction of the single unit guidelines, and when I wrote this I had "once they've been approved", they now are, so we're going to educate and roll that out to all the medical consultants, nursing staff and blood bank staff.

In the private sector our management issues regarding pre-op anaemia are different to the public sector. Public sector waiting times, to actually get into the system, so once you're in outpatients and get on the waiting list for theatre, in the private sector the waiting time is to get to see the consultant, not getting onto the theatre list. So we're looking at trying to educate the GPs in maximising the haemoglobin before the patient gets to theatre, so if you go on the waiting list for an orthopaedic surgeon review to get to the rooms, that GP who does that referral is best placed to look after that patients anaemia and treat it. So we will look at forums and educating those, and so we're lucky that our hospital will support that and the senior haematologist will be involved.

We're looking at introducing zero tolerance, and I know a lot of you have that around labelling mistakes and admissions, but that is an extreme challenge for St. John of God pathology in Geelong and our hospitals. They will correct thousands and thousands of our mislabelling, so we're now going to need to change everyone's mindset to get that done, and a midwife said to me recently that you only have to explain to a set of parents once why you're re-bleeding their newborn to remember how to sign a declaration and fill in all the forms.

And on a personal level, a challenge for me will be looking at some research, in the amount of blood that we give to patients in the couple of months leading up to their death, and I'm not talking about alleviating palliative care patients quality of life, but when I audit all these I look at a lot of my patients from an oncology perspective and palliative care and think "did we do them any favours giving them

this blood?" So that's something that I'll, might put the call out for some help there.

And lastly I'll leave you with this fact. The blood group of Star Trek's Mr Spock, was T negative.

Any quick questions?

Are you as a nurse practitioner able to prescribe the blood?

I can prescribe blood, it's in our policy, I was very proactive when we were doing it, and actually as nurse practitioners, we do have a couple in New South Wales and Western Australia already, so it wasn't hard to get that into my scope of practice. So in my scope of practice when we were writing the scope of practice for approval, I had to make referrals to the ICU.

Oh you made referral's out to put her into the ICU?

Oh that's, at the moment with the medical responsibility to get consent, so we got the medical consent person to come down and get that for that patient. Maybe down the track.

Just behind, do you want to speak there Kerry? Just there, Nathan.

As a nurse practitioner, do you then also consent patients for blood?

At the moment I don't, but then down the track that may be something that we'll look at. If it was my patient I could do that if I was prescribing, because if I can prescribe I can consent, but I don't randomly wander around the hospital and consent them, no.

Okay.

Yeah, quick one.

Do you have a collection of articles that you provide to the doctors when they challenge your recommendations?

No we don't, we try to dazzle them with a bit of science, and support from senior haematologist's to do that. I must say that I have worked in the hospital for a long time and people know me and know that if I say something that it's based on scientific and I'm not just trying to BS them. So, I do get a lot of respect in my role, so it's a bit easier.

With these types of challenge, evidence based recommendation because they'll be challenging the consultant about this, and it depends on who wins …

Yeah, who wins. That is why we're going to do an education roll out and use the senior haematologist with us. Who wins, I can refer up.

Alright, sorry.

Also from a group perspective the changes to practice will also be facilitated through the blood and blood products reference group back up to the group

director of medical of services who will then work with the medical advisory committees in all of our divisions. So we're using a bottom up and top down approach as well.

And I'm just going to have to bring it to close there. I mean a couple of the key lessons and the intent of this particular session was and was brought out that if you thought you were the lone nut out there, there are other nuts as well, and some of the challenges confronting the private sector of which we have a wide number of representatives from private sector. From the NBAs point of view we're very conscious that you have unique challenges and we've got a range of strategies to try and help you in that space. On behalf of everyone here Kerry, and please at lunch time if you have other questions, approach Susie and Kerry and ask them your questions.

But on behalf of everyone here thank you very much for your perspective and particularly as one nut to another.