**MELB – Linley Bielby**

Now today I'm presenting on an audit that was undertaken through the Blood Matters program on consent for transfusion, it was only done last year and before I get into it I'd like to thank the NBA for being able to present this data today. And I'm also presenting on behalf of our Blood Matters team.

So Clare's outlined the work that the program has undertaken about establishing support for consent but I'll be presenting the data and you'll notice that Victoria has also included Tasmania, ACT and the Northern Territory; we have memorandums of understanding with those jurisdictions to participate within our program, so we value their support and interactions with our program.

So our audit actually looked at measuring the current policy and practice guidelines, so we were measuring against the ANZSBT and Royal College of Nursing guidelines, National Standards and the ARMAC Stewardship Statement. We wanted to see if people's current policies and practice actually reflected those guidelines and standards. We looked at do the policies exist, what elements are included in those policies, were transfusions given with consent and did patients understand or recall what happened within that consent process?

It was a three part audit; the first part was a desktop audit where we looked at hospital-wide transfusion policy. The second part was actually auditing blood transfusion consent practice, so we looked at 30 randomly selected transfusion episodes within a health service and the other part was auditing a patients understanding or recall of consent and that was also 30 randomly selected patients.

140 health services were invited to participate and the data was electronically entered via our website.

So what did we find? Overall 110 health services responded to at least one part of the audit. In relation to policy, 105 had a statement regarding consent for transfusion and there were five that didn't actually have a consent policy. The majority of respondents actually had a policy that covered what products should be covered under that consent process, which is actually in line with the National Standard. And 95 included what sort of method of documentation should be used.

Now as you can see here from this graph, it shows the types of consent documentation that was reported. We found it quite interesting that 48% of the participating health services actually had a specific blood transfusion consent form. 21% actually had a generic form, which had a reference to transfusion and where we've got the other greater percentage was 16% in other, that incorporated multiple places of documentation, so the policy actually included documenting in the medical records as well as the consent form and we didn't include this on our audit form.

Now Clare has mentioned that their policy included those patients who had ongoing care, so we looked at the timeframe for consent, so those patients who do require ongoing care may not need to have a consent at each time point unless their condition has changed or their management has changed.

So the policies that were reported showed that 46% had six to 12 months as the time of validity for their consent and 25% were between three and six months. There were I guess a smattering of other different areas as well; 18% for each individual admission. I guess of concern for us, there were two hospitals or two health services that responded that their policy had an indefinite timeframe.

So the ANZSBT guidelines outline what should be included in the conversation with the patient and so these are the elements that we ask people to look at in their policy. So we found out that 77% of those policies included the reason for transfusion. That 84% included the risks and benefits of the blood product. Now this dropped to 68% when you actually talked about the risk and consequent of not receiving the transfusion. And only 59% of those included other blood management strategies.

The use of written information was documented in about 65% of the policies. But the lowest part there was only 48% included the use of a competent interpreter and given our multi-cultural groups these days I think that's probably an area that we need to look at.

So in those policies that we reported, who could obtain consent? Now consent is actually the responsibility of the prescriber and as you can see here the majority of the situations documented that consultant medical officers or other registrars or interns were the people who could take consent. There were three nurse practitioners and these actually have it in their scope of practice to prescribe blood and blood products.

The other area had a smattering of descriptions for medical staff but it also had registered nurses, there were some hospitals that had increased the responsibility within their policy to cover registered nurses. Those health services have now changed their policy since this audit came out.

So in practice, what actually happened in practice? So we had 1788 transfusion episodes reported through the audit, from 103 hospitals. There were 75 public and 28 private. Of those episodes that were audited, there were 45% male and 55% female and the average age was 68% and so there was really quite a broad range of ages, less than one year and up to 98 so we've kind of got the whole spectrum. But it was interesting to note that 55% of those audited were over 70 years of age. The most common blood product that was administered was red cells and where patients received more than one blood product on the same day, theirs were also the largest proportion of red cells.

Overall informed consent was documented and valid for 75% of those transfusion episodes that were reported through the audit.

Now I thought this was a bit interesting, we actually looked at the age group of the transfusion episode in relation to their clinical specialty. Now, the majority of the medical specialties, is a medical specialty so that's this one here. You can see that the greatest proportion of those were in patients that were over 70 years of age. The next group is the haematology/oncology and that made up 30%, followed by surgical at 28% and then obstetrics.

Now we had no control over what patient groups were selected, that was up to the auditors at the individual health services, so that may have influenced the clinical specialty that was audited.

So in practice who did obtain consent? As you can see there's some differences we've put public and private up here. There were differences between the two areas and this would have reflected actually the workforce practices within those in the private setting there are very few registrars and interns whereas that's a great proportion within the public setting.

As we mentioned before the responsibility of consent does rest with the prescriber but it was reported that registered nurses had obtained consent. 39% of these episodes that were reported here were from those hospitals that had broadened the scope of consent. But the rest of them were either outside the scope of their hospital policy or they had no policy that stated who could take consent.

So now we're looking at the third part of the audit, what did patients understand or recall because really we weren't measuring, I guess we didn't give them a test, we are actually asking them what they recalled about the conversation around consent. So patients were asked to provide feedback and that was usually done within 72 hours or prior to their discharge. We had a total of 1386 episodes reported from 93 health services and 88% reported receiving some sort of form of information about transfusion, with 32% of these being written information and 86% of it being verbal information.

Approximately half of these people received information at two time points and another 20% received it prior to admission and 18% received it on admission.

So when patients were asked about the information they received, the data actually confirmed that the possible risks of receiving a transfusion were explained more often than the risks of not receiving a transfusion or the alternatives, which is only 7%. The data demonstrates that significant improvement is required for those health services to both meet the standards expected of them and to comply with the national guidelines.

So of the 89 patients that could recall being offered an alternative to transfusion, iron replacement or iron treatment was the most predominant there with being 54%. From our data we're unable to determine if the low rate of alternatives to transfusion being offered is due to lack of knowledge from those people who are taking consent or if alternatives were available or if they were appropriate for that patient, so we couldn't tell that.

So we've made some recommendations to the health services coming from this audit, that health services without an informed consent policy should develop one. They should make sure that it complies with the ANZSBT Royal College of Nursing guidelines, comply with the national standards and also with the Stewardship Statement. And we've actually devised a checklist within our audit report, so that health services can actually assess their policy to see if they've been compliant with all of those points that they need.

Now two of the five health services without a policy have actually developed one following the audit and the others are actually awaiting their individual reports that

they received from the Blood Matters program to give it traction and evidence so that they could take it to their executive to help them implement and drive change.

For those health services who do have a policy, they should actually review it to make sure that it includes all the required elements.

One area that we didn't look at in the audit was the refusal (11.23) consent but this does need to be included in a transfusion consent policy.

When we look at practice we need to make sure that the consent is actually taken by the person that's prescribing it and those roles who can take consent should be clearly documented within the policy.

Many health services actually require significant improvement in documenting the consent, so we only had 75% documentation and we need to make sure that we involve the patient more in the decision-making process and as we've talked about many times today, that that's an area that lots of people are grappling with.

We need to make sure that we involve patients and talk to them about the risks and alternatives and obviously we need to make sure that prescribers either increase their awareness of alternatives so that they are offered to patients where they are appropriate and not every situation that will be appropriate.

So this is an example and I know it's really hard to read. There are two pages of this, you can find this on our webpage, it's in our consent for transfusion report. This is how we're sent back the individual reports to each of the health services that participated in the audit. They actually had the percentage of yes's, so whether they complied with it or no. And we also included in the individual health service reports the cumulative data as well so they knew where they were sitting in relation to the whole audit.

These were sent to the CEO and one of our health services has come back to us and said that was really great because their results weren't so good and the CEO kind of took this straight to the board and the board are now taking action, so if something that she'd been trying to get in place for a while has now been actioned from the top down, so that's been very useful to hear that the information has been helpful to the health service.

Now, to assist health services in meeting the standards, Blood Matters have actually put together a transfusion data collection tool. Now this talks about documentation which includes consent, talks about appropriateness and also wastage. So this tool can be customised to your health services and it does produce some lovely graphs that you can use for reporting to your hospital transfusion or quality committee.

Now this is an example of the graphs that come from the audit tool and as you can see it's got prescription and consent and also the indication so that's seeing if somebody has actually documented the indication, so that's available for anybody to download and to modify for your health service from our website.

I can't go on today without acknowledging first of all my team in Blood Matters for all the hard work that they do to help getting all of these audits out, collated and

then reported. To all the health services that actually contributed to the audit, I know it does take a lot of time and we do hope that the data that we provide back is useful and able to help you in your practice. Our Blood Matters patient blood management steering group and our consent working party, did have a number of reviewers who reviewed our report and we'd like to thank the New Zealand Blood Service, Western Health here in Victoria and the ANZSBT for some of the materials that we actually utilised about consent.

Now this is a picture of our website and if you want to download the consent for blood transfusion it's over there and all the other tools are actually on there as well.

So now I guess I'd open up to questions if we've got time for Clare and I …

**Yes we have, you've done very well thank you, we're back on time. Questions for Clare or Linley? Yes. Come on Nathan, moving please.**

*Hi, Chris Marks, Northern Health. Just two questions, one, when was the data sent out to our CEO because I haven't seen our data yet?*

It was sent some weeks ago but we can, if you give me your email address I can send you your copy.

*Thank you that would be lovely, especially as we've got accreditation looming. The other one was, we've incorporated observation chart on our consent, so we've got all the risks and consent as well and we've actually put observation. Now, we're in a bit of two minds because obviously with a deteriorating patient there's a whole other, has anybody, you know, have you got any thoughts on that, just, you know, I'm probably going to leave it there for a while yet because rolling it out, we're having it rolled out to non-ICU areas in phase two, so anyway, just a comment, I thought?*

I guess that is something, we've got our transfusion nurse and trainer forum in November and the observation chart was something that we were going to be discussing with that to find out what everybody is doing within our transfusion nurse and trainer network. But it certainly has been raised as an area of concern with the chart because it doesn't clearly, I guess, reflect some of those changes that we might like to see in transfusion.

So it is a burning question; we haven't made any clear decision about it and we want to find out what the rest of our network are undertaking with that, I don't know if Clare wanted to make a comment on that.

Just to say that a lot of the examples of consent forms that we looked at in the working group had incorporated the risks plus the observations and the consent and the prescription even, all on the one form. We chose to take a more simplistic viewpoint for the template purpose but it's up to the individual health service what works best for them.

*Can I also just ask about brochures? Did you put anything on your consent about having brochures provided to your client and interpreters?*

Yes we did, we included an interpreter section down the bottom and the patient information brochures there's a link for them to access it from our intranet site.

**Questions?**

*I'll just make a comment about the observations because we've had three of our services go through accreditation under the new standards and it was very clear that the surveys preferred one observation chart to be used for the entire patient episode and not to be switching across to a different observation chart whilst the blood was in play because you don't have a baseline on that chart and so you're losing your baseline data, it's in a separate place, so just a suggestion; it might be better to get rid of it.*

Thanks Susie.

*I'd like to comment on that too. Thanks, I think with Standard 9, the deteriorating patient, most hospitals have got an observation and response chart and it seems not to flow to move away from that chart that triggers a response to a separate obs chart when you've got a risky product like blood running.*

I'll just comment, that's one of the reasons Eastern Health chose not to introduce a separate one.

**Other questions, comments? Here we go.**

*What are your plans in regards to bridging the consent or communication gap between non-English speaking patients considering that was something that you guys highlighted?*

Well I guess from the program's perspective we'd like to make sure that people have it included in their policies, that's there. We've got a number of our patient information brochures interpreted into different languages. We've purposely not replicated other ones that have been done because Blood Watch have quite a number of the CEC website that have been done in different languages. We've chosen a few languages that are common I guess in some areas within Victoria but bearing that in mind, not all patients can read either, so that's not always there.

I know that the Blood Service is looking at a picture tool and so we hope that we'll be able to work with the Blood Service on looking at some sort of education picture tool and they're also looking at trying to produce some products and I know that the Northern Territory are working on something for the indigenous population as well.

So we haven't got anything yet but we are hoping that's in some of our stuff in our future plans and I don't know Clare if you've got …

Just to say we've got our own Eastern Health brochure interpreted into nine different languages but we've also got links to the Blood Matters site, so if the language isn't there hopefully it will be included, otherwise yes, the interpreter.

*(20.45), is that on?*

**Is that on Nathan?**

*That one? Just wondering, that's working thank you, given that we have one set of national standards, is there a valid reason why can't have one consent form for blood?*

Lee, would you like to answer that?

**I can, I can answer that. As part of the toolset one of the early, I mentioned those projects that are coming first, the one I didn't mention which comes after cell salvage is patient consent. If you think you had a problem with the health service getting a consent or at a state basis, let me assure you getting it at the national limit, you're not going to get an absolute template. What you will get is "here are some suggested elements that you could incorporate" because it's just, well having been a health service before this job, getting agreement on a single form in a health service is difficult, so nationally we will produce something that provides you with guidance and that should happen before Christmas.**

*We're still tribals.*

**Tribal is an understatement but we'll be drawing and exactly, we're already drawing on the Blood Matters where as I said, looking right around the nation looking at some good examples and drawing up and trying to produce a best practice template.**

*Thanks.*

**Other, yeah? Last one I think.**

*Linley, one of your slides you said a practice point was consent is responsibility rests with the prescriber. So reading between the lines a bit, are you advocating for every episode of transfusion, the prescriber needs to get that consent because I mean, you've got consent for 12 months, we've got consent for duration of treatment so the person that obtained consent is not the person that's prescribing the blood product.*

No I guess we'd go with what's within the guidelines for transfusion and that obviously whoever is prescribing it, in the first instance if somebody has got an ongoing condition that requires and they're medically not going to be changing and their condition or their blood product that they're receiving is not going to change, we would still abdicate that they could have it for that episode of care but the person who's taking that consent in that first place would be the prescriber, even though that might be alternative, it might be different registrars and staff throughout the line, I think that's what the hospital policy would cover that that initial consent covers for that period of time.

But I think where it is outside of those ongoing patients, then it should be the prescriber and it should be for those single episodes. But it is up to your hospital policy to state that and state that clearly.

**Okay, on behalf of everyone here Linley and Clare, thank you very much. As I said and certainly from personal experience, this is a really complex area and very much appreciated your presentation today.**