

Blood and Blood Products Advisory Committees

- ***Doug Joshua , Chairman SSWAHS
transfusion committee,***
- ***Sydney, May 2009***



“Affaire du Sang Contamine”

***denial and deception of French medical
establishment***



Takehiko Kawano
President of the Green Cross
bows and apologises for negligence

From a combination of . . .

- ***Pride***
- ***Financial reasons (\$2 - 3,000,000 of FVIII)***
- ***Ministry insistence on self sufficiency for France***

Garetta made the crucial decision . . .

***In late 1985 Garetta allowed
contaminated products to go to HIV
positive individuals***

***“It is up to the supervisory authorities to accept
their responsibilities and forbid us from disposing
products with the financial consequences this
entails”***

Another major faulty decision . . .

1985 Abbott applied to licence its AIDS ELISA screening test in France

- ***French (Institute Pasteur) test not then available***
- ***Decided to delay the Abbott application until the French test was available***

***Reasons for the delay of the Abbott HIV
screening test clearly documented***

Financial

***“The moment tests are authorized the
French market will be largely captured by
the American test, therefore the Cabinet of
the Prime Minister requests that the Abbott
registration dossier be retained for some
time by the National Public Health
Laboratory”***

1985

***Institute Pasteur Test finally approved
one month before the Abbott test***

the price of 2 – 3 months delay :

thousands of untested donations

Trial - 1992

- ***Garetta claimed it was “up to the Ministry to restrain us”***
- ***Classical example of blame shifting and finger pointing***
- ***All blamed the Haemophilia Association which went along with the distribution of non treated factor***
- ***In turn, the Haemophilia Association claimed deception by the doctors***

Viral contamination

- *HIV*
- *Risk 1 in 7,299,000 (2000/01--1/3,415,000)*
- *HEP C*
- *Risk 1 in 3,636,000 (2000/01--1/911,000)*
- *HEP B*
- *Risk 1 in 1,339,000 (2000/01—1/483,000)*

» *Seed et al IMJ 2005;35:592*

Goal

Help the blood bank to obtain blood for patients in a safe, timely, efficient, and cost effective manner

Blood products committee

- ***Area committee serving all SSWAHS***
- ***Meetings alternate at eastern and western zones.***
- ***Constant chairman and executive***
- ***Representatives from blood bank, divisions of medicine surgery and anesthetics and all hospitals in the area (often irregular attendees)***
- ***Red Cross representative***

Important categories in the process of delivering safe blood

- ***Ordering practices***
- ***Patient identification***
- ***Sample collection and labelling***
- ***Infectious events***
- ***Near miss events***
- ***Usage and wastage***
- ***Appropriateness of use***
- ***Supply and demand***
- ***Compliance with peer review and committee recommendations***

Quality and organization of services for blood transfusion

- ***Monitoring and assessment.***
 - ***Collection data items including indications for transfusion***
 - ***Monitoring and management group***
 - ***Collection of clinical indicators***
 - ***Consumer issues of informed consent , risks and benefits of transfusion***
 - ***Implementation procedures***

Aims of quality procedures

- *Improve the consistency and appropriateness of transfusion practice*
- *Integrate transfusion practice into standard quality management systems*
- *Continuous monitoring of blood component use*
- *Increase community awareness of the costs, risks, and benefits of blood component therapy*
- *Reduce pressure on blood supply*

Transfusion Committees

Have senior management support

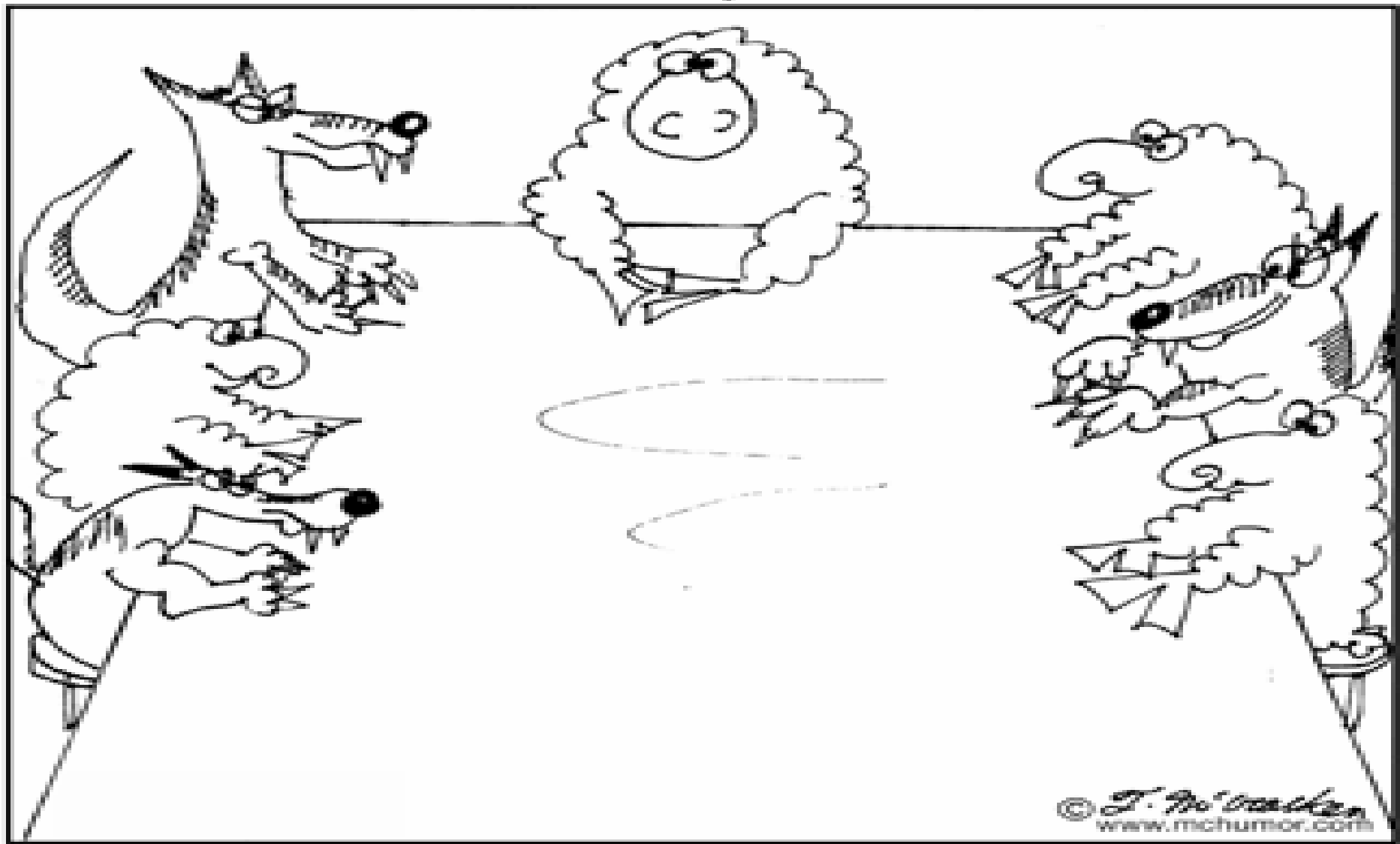
Are inclusive and bipartisan

Have consumer representatives

Have a clinical/scientific chairman

Are interesting

Are independent



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A bipartisan committee.



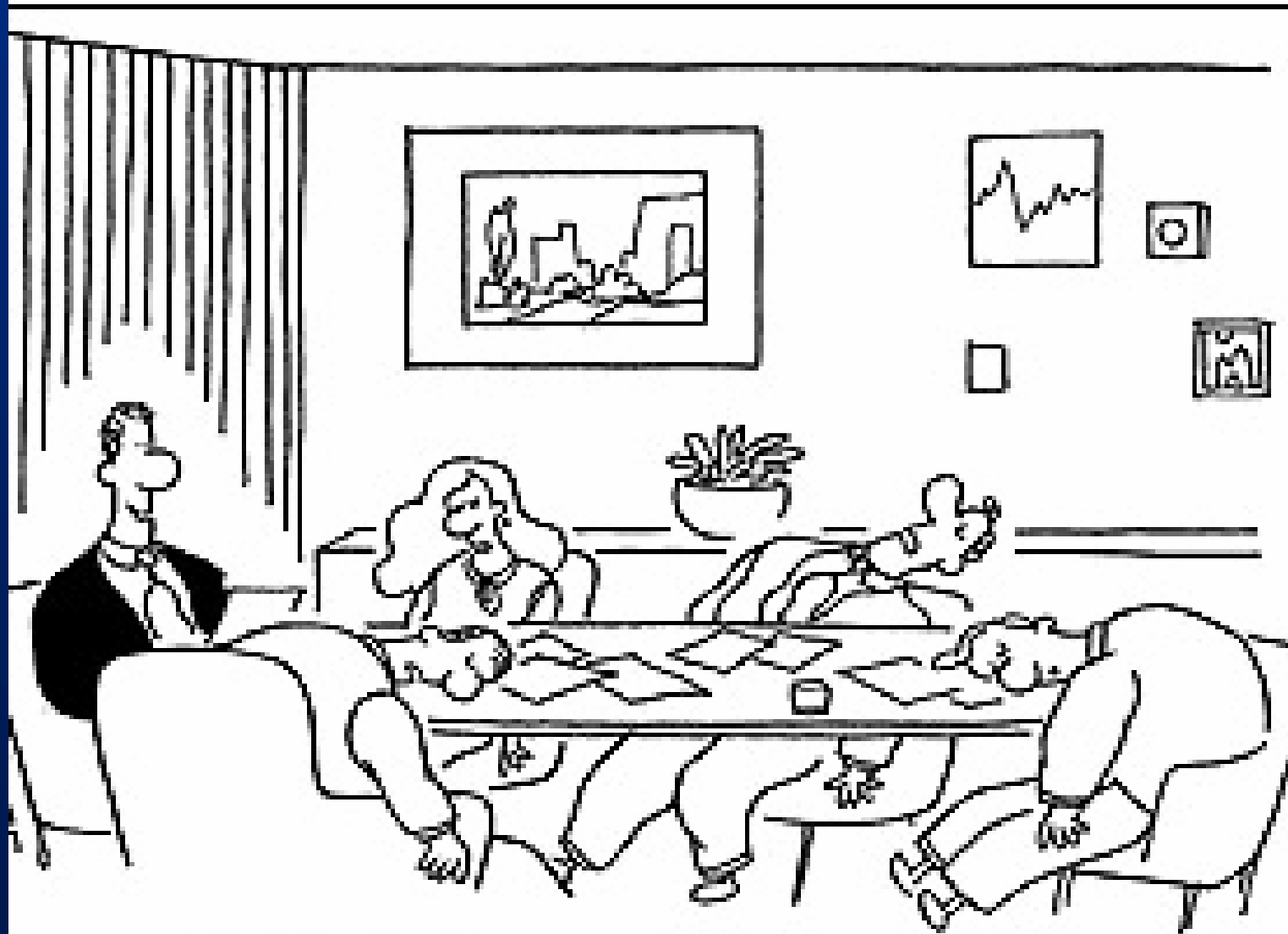
THE BODY PARTS IMPLANTS ETHICS COMMITTEE

INKCINCT

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We need to create an "independent" committee to evaluate the claims against some of our members. Raise your hand if you can say, "I'm independent" without laughing.





**"At last we've reached a consensus!
This meeting is boring!"**

Current issues

- ***Massive transfusion protocol***
- ***Perpetual electronic consent***

- ***Area transfusion protocol –completed and ratified by the quality clinical council***
- ***Audits based on NHMRC guidelines***
- ***Common protocols between diverse hospitals***
- ***Tabling of all IMMS incidents and changes in practice based on RCA's***
- ***Physician and nursing training***
 - » ***Sharyn Kelleher transfusion project officer***

Planning for the future Implemented

- *• expiry date reports,*
- *• cross match to transfused ratio reports,*
- *• compliance with the Maximum Blood Order Schedule,*
- *• computer cross matching to minimise the volumes of blood tied up unnecessarily,*
- *• patient specific platelets available on stock,*
- *• auditing of FFP expiry and the ability to consult with doctors,*
- *• paediatric packs utilisation to ensure minimal wastage,*
- *• Intragram audit and a standardised policy,*
- *• short expiry blood unit packs relocation from low utilisation hospitals to RPA and Liverpool to reduce wastage,*

Planning for the future

- *ordering of blood and blood products electronically triggers a series of prompt tests will be introduced to capture relevant data such as patient Hb etc*
- *. Redesigned Blood Bank requests to allow the capture of data,*
- *. specific product utilisation report by ward, clinical stream or Medical Officer*
- *Bar code reading from collection to administration*

Working party to improve BB sample collection

***169 participants including doctors,
pnebotomists and nursing staff***

Working party to improve BB sample collection

- ***57% ... Do not look at armbands***
- ***40% ... EVEN IF PATIENT UNCONSCIOUS***
- ***22% ...Identify patient by name on bed or bed number***
- ***47% ... Label incorrectly***
- ***51% ...Failed to correctly state the role of the witness***
- ***68% ...Will sign as witness without seeing patient or blood taken***
- ***38% ...Cannot describe the correct procedure for collecting samples***
- ***41% ...Cannot recall being given any training at all***
- ***AND 75% who have been trained got their training outside SSWAHS***