0021

MEDICAL AUDIT WITHIN THE BLOOD TRANSFUSION SERVICE

Introduction

It is important to recognise that various avenues already exist whereby performance of the transfusion service may be measured. Some of these are universal, while others are more sporadically employed within the UK.

1. Universal Applications

a) participation in National External Quality Assessment Scheme (NEQAS),

b) regular inspections of the "productive" capacity of transfusion centres by the DoH Medicines Control Agency,

c) inspections by the Joint Committee for Higher Medical Training for recognition of centres in the field of senior registrar training,

d) inspection by the Royal College of Pathologists for recognition in the field of registrar training,

e) managerial accountability to regional health authorities or their equivalent, with professional accountability usually to the most senior medical member of health authorities,

f) guidelines on various aspects of transfusion practice now emanating from the Blood Transfusion Task Force of the British Committee on Standards in Haematology involving input from both the British Society of Haematology and the British Blood Transfusion Society,

g) Guidelines on Quality Control in Blood Transfusion Services, published by the Council of Europe,

h) internal quality assurance now widely organised in separately established departments within transfusion centres,

i) accepted specifications for supply of plasma for fractionation to BPL, Elstree and PFC, Edinburgh.

2. Sporadic Measures Available

a) regionally organised external quality assurance schemes,

b) the formation of regional and hospital transfusion committees,

c) institution of blood ordering schedules,

d) agreed criteria for the use of blood components and products.

3. Anticipated Measures

a) UKBTS/NIBSC Guidelines for the Blood Transfusion Services in the UK (publication imminent),

b) the formation of audit teams to inspect QA measures instituted in transfusion centres and BPL,

c) laboratory accreditation (pilot scheme recently carried out under the auspices of the Royal College of Pathologists),

d) management information system based at the National Directorate.

In many of these examples, input from medical staff at transfusion centres is inevitable but nevertheless it will be necessary to consider medical audit as a separate item, and this was considered by a small working party on 5 February 1990.

Medical Audit

The assessment of performance of medical staff within the transfusion service falls broadly into three major facets:-

1. The interface between BTS medical staff and medical staff in hospitals.

2. The performance of BTS medical staff within the transfusion centre environment.

3. The interface between transfusion centres and donors, which has a large medical input.

1. Interface with Hospitals

It is felt that this aspect is best covered by the formation of hospital transfusion committees and regional transfusion committees.

a) hospital transfusion committees should meet approximately two-monthly and amongst other things would produce data of usage of blood and blood products, develop guidelines for their use within the hospital, and in essence be one feeder group producing data for statutory audit within the hospital concerned. The transfusion committee within the hospital should interface with internal medical audit systems to ensure that transfusion topics are covered fully from the clinical point of view. There should be right of access to transfusion committees by BTS consultants, but it is recognised that on most occasions the hospital haematologist concerned would speak on behalf of the BTS and pass on advice regarding optimum use of blood and components, storage and record keeping. The involvement of BTS medical staff in the monitoring of issues raised by hospital transfusion committees would be itself assessed by other medical members of the transfusion committees, and by any visiting audit team. It should

be noted that the right of access and inspection of hospital blood banks by senior transfusion service staff should be secured as part of product liability and that this right should encompass blood banks in private hospitals and clinics. Hospital transfusion committees would be expected to monitor the service received from transfusion centres with regard to reference laboratory work as well as to supplies of blood and components.

b) regional transfusion committees should be established to meet six-monthly as a minimum, with heavy representation from users. They should be chaired by Regional Medical Officers or by delegation to a similarly independent medical officer. It is not thought appropriate that the chairman of this committee should be a transfusion service consultant. The regional committee would take a broader view of the service being offered and given by the BTS to all users within the region, including general practitioners who may take advantage of laboratory functions. This committee will inevitably perform an audit function on the medical input from the transfusion service and should report to the Regional Medical Officer.

At the level of both hospital transfusion and regional transfusion committees, it might be appropriate for monitoring of the usage of blood, blood components and products to be carried out and this should be decided at local level. It is recommended that prospective audit of such usage be carried out in advance of the institution of crosscharging between RTC's and hospitals/districts, so that redistribution of budgets may be attempted on a fair basis. Minutes of the meetings of these committees should be made available to visiting teams carrying out medical audit at transfusion centres.

2. Audit of Transfusion Centre Medical Staff by other BTS Consultants

It is recommended that this aspect of medical audit should not be carried out by, or linked with, the quality assurance audit teams shortly to be formed. It should be carried out on an annual basis by a separate team of transfusion service consultants, perhaps formed by a representative from the other two divisions of NBTS. If SNBTS is to be involved in the same organisation, similar independent audit should be arranged.

At this level, interface between medical staff and donors can best be assessed, and topics to be covered might include:-

a) application of guidelines,

b) meetings with and education of sessional medical officers,

c) the existence of satisfactory SOP's,

d) the organisation and running of a typical donor session,

e) the organisation of pheresis programmes of all types,

f) assessment of donor satisfaction and dealing with complaints. This should be done via some form of donor questionnaire rather than by waiting for letters of complaint (the appointment of a nominated complaints officer is already obligatory),

g) follow up of donors and donor counselling procedures.

Other aspects to be assessed would include:-

a) medical input to laboratory functions within the transfusion service,

b) the production, including signing, of laboratory and other reports,

c) teaching and research carried out by medical staff,

d) training offered to doctors employed within the transfusion service and to nurses, if the latter have delegated functions,

e) involvement in autologous transfusion programmes, if these are associated with the transfusion centre.

f) the on-call service offered by the BTS,

The visiting team should decide whether all medical functions should be assessed at each visit or whether different topics should be selected for each year. It is anticipated that a typical visit would occupy two days.

The report from this audit team would first be sent back to the transfusion centre staff concerned for checking of factual content and then sent as a final document to:-

a) the transfusion centre medical staff concerned,

b) the Regional Medical Officer,

c) the National Directorate.

As far as possible the normal rules of confidentiality should be observed in this report but it is recognised that identification of individuals with their specific areas of responsibility would be almost inevitable.

Time Scale

It is recommended that the system of audit by other consultants within the transfusion service be instituted as soon as possible, for example by September/October 1990. If such a system is accepted as being desirable, then it is further recommended that a check-list be supplied for the use of auditing teams in an attempt to achieve uniformity.

It is acknowledged that the universal introduction of hospital and regional transfusion committees cannot be accomplished in a short

period of time but steps should be taken to ensure that they are in place by April 1991. It should be pointed out to those involved in any negotiations for the formation of these committees that the data they would generate would in any case be needed for coping with the financial consequences of the new style interraction between suppliers and users consequent on the adoption of the White Paper.