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Implementing Nurse Authorisation of Blood Components

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Caring Expert Quality

Background

- Fragmentation of patient care for patients who require blood transfusion support
- A collaborative project between Scottish National Blood Transfusion Service (SNBTS) and NHS Blood and Transplant (NHSBT) explored the feasibility of nurses and midwives 'prescribing' blood components (started 2005)
- Supported by UK Better Blood Transfusion Network

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- The Administration of blood and blood components and the management of transfused patients (1999) stated:
  - *The prescription of blood and blood components is the responsibility of a doctor.*
- The Handbook of Transfusion Medicine (2001) stated:
  - *It is a medical responsibility to prescribe blood components or blood products (i.e., to give the authority to administer).*
  - *Completion of the request form may be delegated to a nurse or midwife.*

(Handbook of Transfusion Medicine 2001,BCSH, (1999)

Project Findings

- Literature review – no published papers
- Nurses assessed the patient's clinical status and transfusion requirements, influenced the decision to transfuse
- 60% respondees supportive
- Blood components excluded from 1968 Medicine act since 2005
- No specific legislation, which requires a doctor to carry out the activity of writing the authorisation for blood components

If you would like to contribute to the art and science section contact: **Gwen Clarke, art and science editor, Nursing Standard, The Heights, 59-65 Lowlands Road, Harrow-on-the-Hill, Middlesex HA1 3AW. email: gwen.clarke@rcnpublishing.co.uk**

Should nurses prescribe blood components?

Pirie E, Green J (2007) Should nurses prescribe blood components? *Nursing Standard*. 21, 39, 35-41. Date of acceptance: April 5 2007.

Abstract

Aim To explore the feasibility of nurses prescribing blood components.

Method Using a convenience snowball sample, a UK-wide questionnaire survey was undertaken to identify transfusion practices and canvass the opinions of nurses and doctors.

Results A total of 179 (59%) of 302 respondents were supportive of nurses prescribing blood components, saying it would have a positive effect on the quality of patient care, result in fewer treatment delays and help doctors and nurses to use their time more effectively. The remaining 123 (41%) respondents had reservations about time and resource constraints and worries about undermining medical care and responsibility.

Conclusion Development of non-medical prescribing to allow nurses to prescribe blood components has the potential to deliver a more patient-centred quality service.

Authors

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Keywords

Blood and blood disorders; Nursing role; Prescribing

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DEVELOPMENT OF THEIR roles in recent years has led nurses to consider new ways of working. To meet the needs of patients who require blood transfusion support, some nurses have considered extending their role to include prescribing blood components, that is, red cells, platelets, fresh frozen plasma and cryo precipitate.

Currently, prescribing blood components is viewed as a medical responsibility but anecdotal evidence suggests that some nurses are assessing patients, making treatment decisions and then having these decisions 'rubber-stamped' by a doctor. Similar prescribing practice was identified 20 years ago in the *Cumberlege Report* (Department of Health (DH) 1986).

This practice has potential risks for patients and nurses because there are no accredited training programmes to ensure safe and appropriate prescribing of blood components. Therefore, the National Blood Service (NBS) and the Scottish National Blood Transfusion Service (SNBTS) agreed to lead a collaborative project to explore the feasibility of nurses with relevant experience and who work in the appropriate clinical area gaining the right to prescribe blood components. This article presents the findings of a survey designed to identify current practices of prescribing blood components and canvass the opinion of nurses and doctors on role development in this area. Directions for future practice are suggested.

Background

In 1996, the Serious Hazards of Transfusion (SHOT), a voluntary, confidential reporting scheme for the serious sequelae of blood transfusion, was launched in the UK. The annual reports have consistently demonstrated that the largest number of reported incidents (2,317 cases, 71.5% of all reports) related to the 'incorrect blood component transfused' category (SHOT 1996-2006). Also highlighted were cases of patients receiving inappropriate or unnecessary transfusions as a result of sample errors, communication failures and prescription errors. There have been 106 (6%) such reports and two patients have died from unnecessary transfusions (SHOT 1996-2006).

Ref: Pirie, E., Green, J. (2007) Should nurses prescribe blood components *Nursing Standard*

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- No legal barrier to an appropriately trained nurse or midwife authorising blood transfusion

- Each hospital should identify the limits of which practitioner can carry out each activity relating to blood transfusion

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National guidance changed, now states:

- *Section 130 of the 1968 Medicines Act has been amended by regulation 25 of the Blood Safety Quality Regulations (BSQR) (SI 2005 no.50 as amended). The effect of this amendment is to exclude whole human blood and blood components from the legal definition of medicinal products and thus incapable of 'prescription' by any practitioner.*

The Framework

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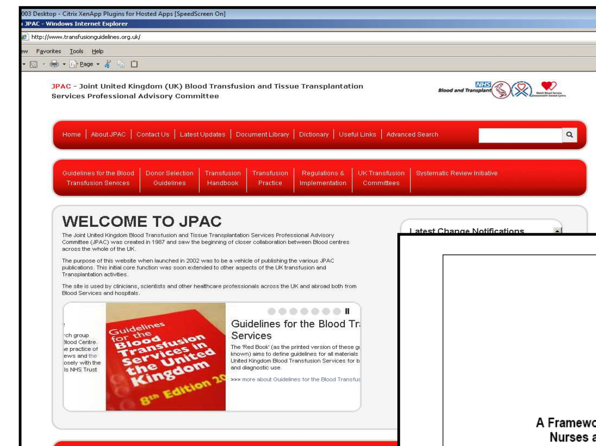
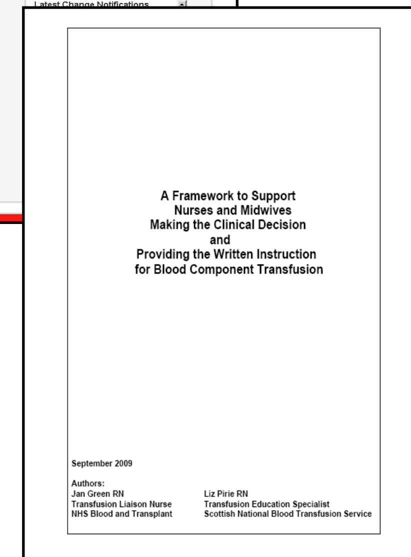
- Briefing Paper - Undertook a wide consultation with regulatory and professional bodies
- Set up a multi-disciplinary group to consult on the content of a governance Framework - launched 2009
- Support received from key stakeholders, UK Blood Transfusion Services and the National Hospital Transfusion Committees




A Framework to Support
Nurses and Midwives
Making the Clinical Decision
and
Providing the Written Instruction
for Blood Component Transfusion

September 2009

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Ref: Pirie, E., Green, J. 2009
www.transfusionguidelines.org.uk

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To encourage a structured approach

- Patient selection
- Selection criteria for nurses and midwives
- Indemnity issues
- Education and training
- Clinical governance procedures
- Responsibilities of the nurse/midwife, medical consultant and management
- Informed consent
- Reviewing and monitoring practice

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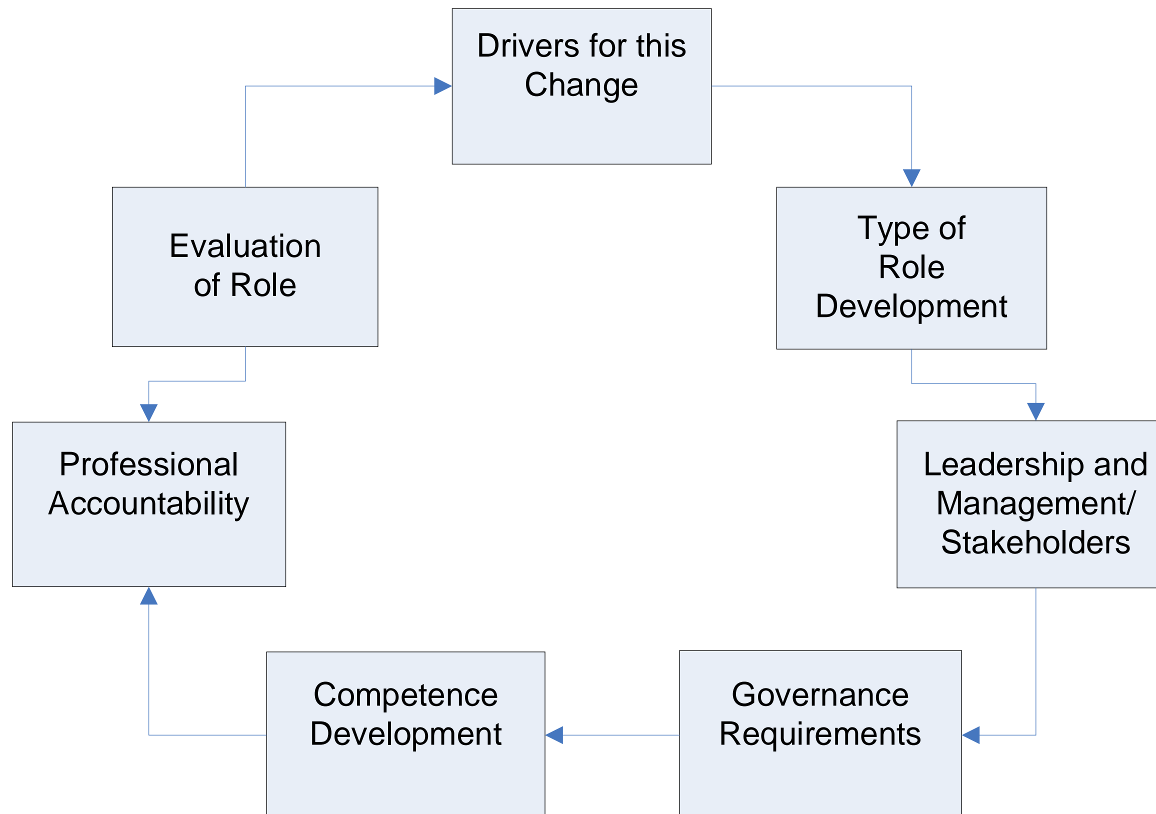
Role Development



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- Policy aims:
  - *enhance patient care*
- Managerial aims:
  - *potential to address service needs*
- Professional aims:
  - *enhance practitioner autonomy*

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Type of Role Development

- Which nurses?
  - e.g. Advanced Neonatal Nurse Practitioners, Haematology Nurses, Intensive Care Practitioners , Advanced Renal Practitioners
- Boundaries of the role

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- Senior management and clinician support
- Lead person identified
- Ensures access to education
- Identify barriers
- Governance arrangements in place

Governance

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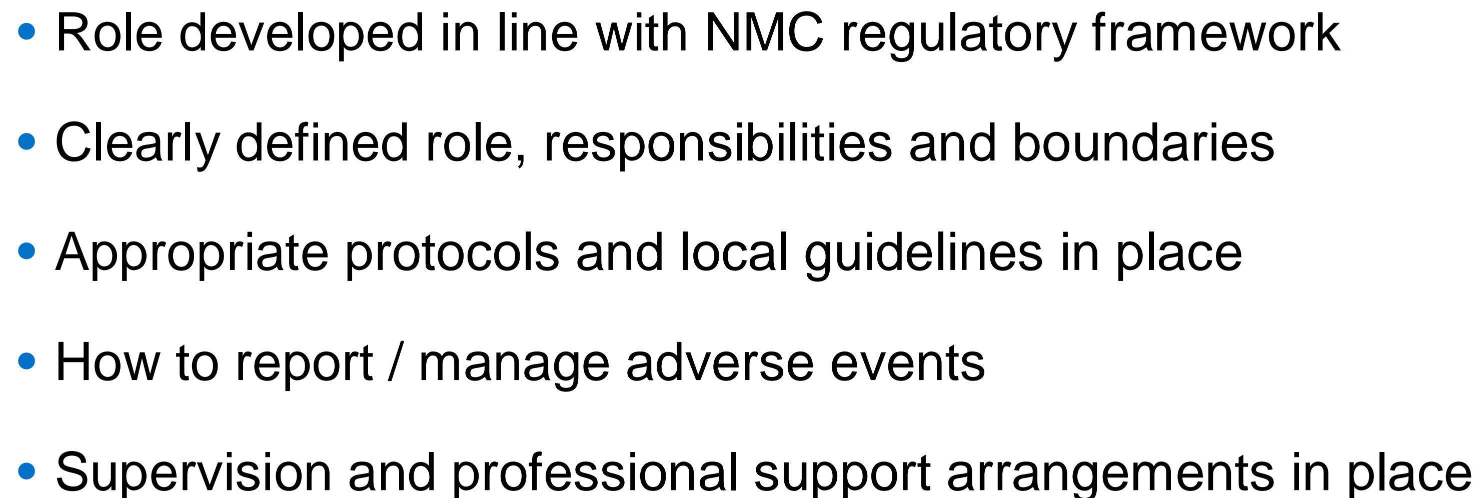

- Role developed in line with NMC regulatory framework
- Clearly defined role, responsibilities and boundaries
- Appropriate protocols and local guidelines in place
- How to report / manage adverse events
- Supervision and professional support arrangements in place

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Framework provides info on knowledge/ skills required

- Identify appropriate learning activities e.g.
  - *Learnblooodtransfusion.org.uk*
  - *Authorising Blood Components for Nurses workshop*
- Identify any remaining knowledge gaps and develop action plan
- Undertake appropriate learning activities and provide evidence in a Learning Portfolio
- Supervision and assessment of competence by workplace case based assessments

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- NMC does not place any conditions or restrictions on the practice of registered nurses or midwives
- Adjust their practice in response to changing patient needs
- Develop practice in accordance with their knowledge and competence
- Ensure they are appropriately prepared to take on new aspects to their roles
- **Personally accountable** for their own practice
- Able to **justify decisions** regardless of advice or directions from other professionals

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- Legally, nurse or doctor expected to provide the **same standard** of care
- Nurses and midwives are covered for vicarious liability by their employer
- Additional professional indemnity insurance e.g. by means of membership of a professional organisation or trade union is recommended

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Evaluation

- Assist in process of continuous quality development
- Assess impact of role development
- Performance review
- Sustainability / succession planning

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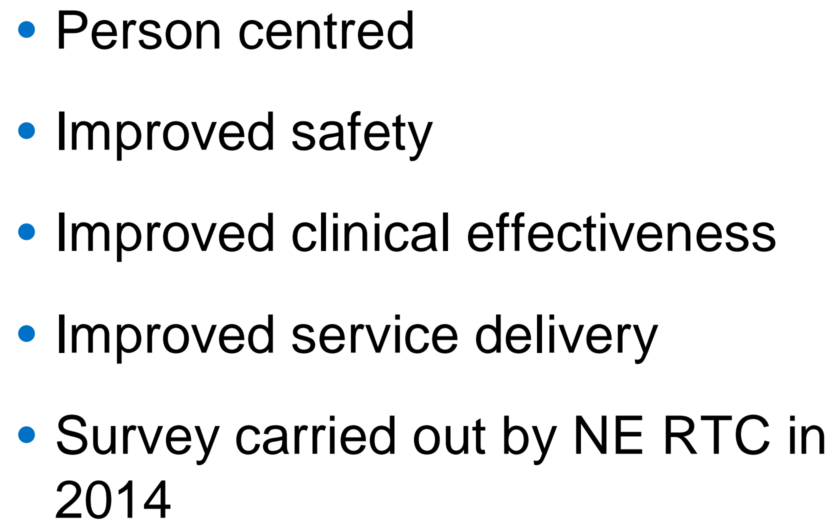
Benefits



- Person centred
- Improved safety
- Improved clinical effectiveness
- Improved service delivery
- Survey carried out by NE RTC in 2014

Has the theory been put into practice?

- Short survey to gain feedback
- Survey emailed to the 55 delegates who have attended an event
- 26 completed the survey

Are they authorising blood components?

- 18 are fully competent
- 1 is authorising with supervision
- 7 are not authorising
  - Role change
  - Non clinical role
  - No longer in post
  - Job change
  - Competencies not complete
  - No Trust policy

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Which components and how often?

- 15 of the 17 who answered, do so for both red cells and platelets
  - 4 authorise once a week
  - 4 authorise 2-3 days per week
  - 5 authorise 4-5 days per week
  - 3 authorise daily
  - 1 authorise once every 2 weeks

Difference to clinical practice

- More autonomy
- Necessary for role - now able to fully undertake my role as an advanced practitioner on the medical rota
- Smoother pathway for patient / completes the pathway
- Allows effective management / ability to respond quickly to meet the patients transfusion needs
- Made me competent to order blood components
- Better access to blood, especially in emergency situation
- Greater understanding of the whole process

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- Immediate care / fewer delays
- Increased safety, as well as increased efficiency
- Patients not waiting for prescription
- Reduce length of stay and effective patient care management
- Increased patient education
- Bloods done by community staff and I organise transfusion, it saves the patient a clinic visit
- Not sure if patients notice a difference

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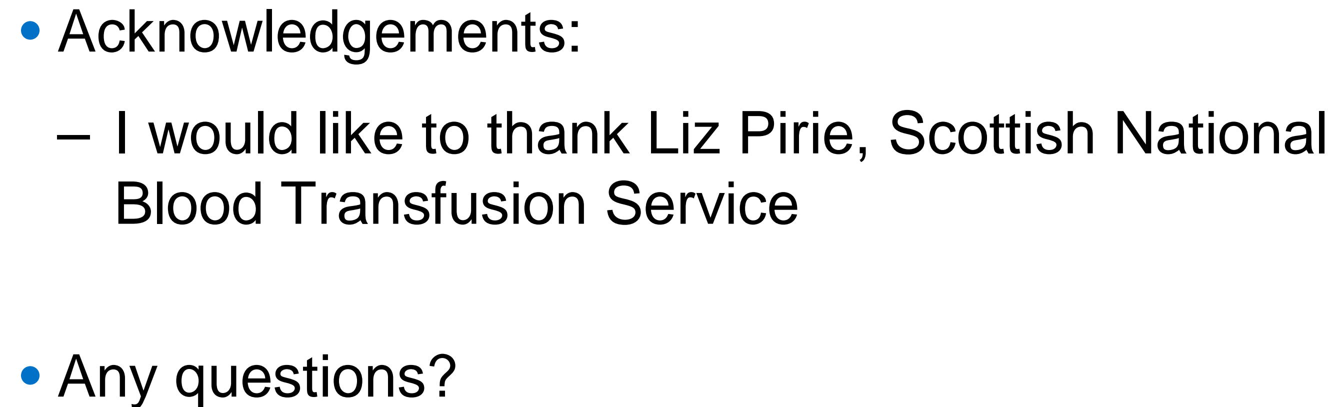

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- Any questions?