

Victoria's Better Safer Transfusion program

July 2006

BEST

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1. Introduction

Large numbers of Australian's rely on blood products to support them. All who are transfused expect that the blood products are safe and that the transfusion process meets the highest standards. Whilst in the past blood safety initiatives have focussed mainly on the infectious nature of blood products, evidence suggests that major risks to patient safety from transfusion are now unsafe clinical transfusion practices and inappropriate blood product transfusion, rather than inherent problems with the actual blood products.

The statewide Better Safer Transfusion (BeST) program was established in 2004–05 as a joint initiative of the Quality and Safety Branch and Programs Branch, Department of Human Services Victoria ('the department') and the Australian Red Cross Blood Service. BeST focuses on activities to enhance safety and quality of clinical transfusion practice in Victorian hospitals and builds on the successful Blood Matters Collaborative project 2003–04.

The aims of BeST are to improve appropriate and safe use of blood products using several strategies in combination.

These include:

- raising awareness and knowledge of transfusion practice
- monitoring and evaluating current practice against guidelines for prescribing and administering blood products
- collecting and analysing errors and adverse events, including near misses, to inform policy and procedure development.

BeST is a statewide program that encompasses private and public health services and is guided by a departmental multidisciplinary advisory committee and supported by a secretariat. Transfusion nurse positions are located within most metropolitan and major regional public health services to foster better practices. To be effective, these nurses must actively work in conjunction with an appropriate transfusion team and be supported by the hospital quality and safety governance framework.

This report summarises the activities and achievements of the first 18 months of the BeST program and introduces the next phase.

2. Background

The Blood Matters project commenced in April 2002 with the formation of a consortium (Australian Red Cross Blood Service, Peter MacCallum Cancer Centre and Melbourne Health) to develop and test tools and processes to improve transfusion practice in hospitals.

The Blood Matters project was expanded in 2003 to involve an additional 11 Victorian and Tasmanian hospitals in a Blood Matters Breakthrough Collaborative, using a project methodology developed by the Institute for Healthcare Improvement (IHI) in the United States. The participating hospitals further tested and developed transfusion practice improvement interventions over an 18-month period. These interventions included:

- seeking to improve clinician and patient awareness and knowledge of blood product use
- improving clinical decision making regarding transfusion
- enhancing blood administration processes.

A key component of the Blood Matters project was the introduction of a 'transfusion nurse' role into targeted hospitals. A Certificate in Transfusion Practice course was developed to provide foundation knowledge and skills to support the staff in this role.

The BeST program was established by the Department of Human Services in 2003–04 to follow the success of the Blood Matters Breakthrough Collaborative and ensure that efforts continue across the state to improve outcomes in patients requiring blood product transfusion. BeST promotes and supports activities that enhance the safety and appropriateness of blood and blood product use.

BeST represented a significant investment by the department and other contributors, initially in a one-year trial, with subsequent confirmation of the program as of 2005–06. The program remit does not extend to issues of blood supply or blood product safety, but aims to improve the transfusion processes within hospitals, especially those at the bedside of patients who require transfusion as part of their overall treatment.

There is evidence that fresh blood products tend to be over-prescribed in contemporary Australian practice. There is a real opportunity for clinical transfusion practice improvements to reduce demand for blood products and help avoid future supply shortages. Indeed, if the appropriate amount of blood is less than that currently prescribed, practice improvements will also reduce the risks to patients from transfusion by reducing their exposure to these risks.

3. Program governance

A multidisciplinary departmental advisory committee has been established to help develop and guide the work of the program. Membership of the committee is provided in Appendix 1.

BeST Advisory Committee terms of reference

Aim

To improve outcomes in patients requiring blood product transfusion in Victorian hospitals by enhancing the safety and appropriateness of blood and blood product use.

Objectives

- Promotion of safe and effective blood transfusion practice.
- Promotion of education and training programs.
- Promotion and dissemination of clinical practice guidelines.
- Promotion of effective blood inventory management in hospitals.
- Monitor and report on Victorian transfusion practice and the program's activities, including demand and utilisation of blood and blood products.
- Identification of key priority areas and problems in any aspect of blood transfusion including potential solutions to the identified issues and coordination of improvement initiatives.
- Respond to sentinel events and key transfusion adverse events referred to the program.
- Respond to any other specific matters referred to the program for investigation, review and reporting as required.
- Support of performance monitoring and audit including development of standardised audit tools and processes and monitoring of relevant indicators across different sites.
- Support of hospital transfusion committees.
- Identify and respond to patients' perceptions about the quality and safety of transfusion services.
- Report as required to the Minister for Health, the Department of Human Services Victoria and Victorian Quality Council.
- Liaison with appropriate state, national and specialist associations and organisations.

Performance measures

- Providing data on the blood transfusion practices within hospitals in Victoria.
- Monitoring trends and providing data on utilisation of blood and blood products in compliance with clinical/best practice guidelines.
- Monitoring, facilitating and reporting on transfusion performance audit at a hospital and state-wide level.
- Demonstrating delivery of education programs and quality improvement programs to enhance transfusion practice in Victoria.
- Providing data on patients' experiences of the provision of transfusion services.
- Maintaining a register of practical strategies to enhance the quality and safety of transfusion practice and the dissemination of relevant strategies to users of blood.

The committee shall review the terms of reference annually.

Membership

The chairperson and members will be invited and appointed by the department. The committee will reflect the following membership:

- Australian Red Cross Blood Service representative(s)
- patient/consumer representative(s)
- Department of Human Services (Quality and Safety Branch and Blood Programs Branch) representatives
- Australian & New Zealand Society of Blood Transfusion representative
- clinical epidemiology representative
- representatives from hospital transfusion committees (including private hospitals) and other relevant transfusion practitioners. The representatives should span the range of speciality medical, surgical practice with high blood utilisation, hospital blood bank scientists, haematologists and nursing practitioners.
- private sector representative.

Additional members shall be co-opted as necessary.

The chairperson is to be selected from one of the clinical 'users of blood' on the advisory committee. The department, in consultation with the chairperson will appoint a deputy chairperson.

Length of membership

The term of membership for committee members, including the chairperson, shall be for three years. After three years, membership will be reviewed with the aim to ensure continuity of knowledge and expertise.

The committee membership will be reviewed annually.

Mid-term vacancies

Nominations will be invited and an appointment made by the department in consultation with the chairperson.

Inability to attend will not ordinarily be replaced by proxy and only be replaced by prior arrangement with the department.

Quorum

A quorum will consist of half the membership plus one.

Reporting arrangements

The advisory committee is accountable to the Department of Human Services, Victoria through the Quality Improvement Unit, the Quality and Safety Branch, Rural and Regional Health and Aged Care Services.

Sub-committees

Sub-committees or working groups will be formed as required to ensure that the momentum of the advisory committee's activities is maintained between meetings.

Frequency of meetings

Quarterly and as required

Other working arrangements

A secretariat, which includes a project officer experienced in quality improvement and one or more transfusion nurses will support the advisory committee.

4. Program components

The BeST strategic plan 2004 identifies four key priority areas for the program. Working parties for each area designed and implemented activities to enhance transfusion safety (see Appendix 2 for membership).

Area 1—Improve awareness and knowledge of transfusion practice within hospitals (Group 1)

The **aims** of this group are:

- to improve patient and health care professionals' knowledge of better, safer transfusion practice, through education and training on transfusion of blood and blood products at both undergraduate and postgraduate levels
- to advance the transfusion nurse role as a key nursing role in health service organisations for the promotion of better, safer transfusion practice.

The chair of this group was Dr Erica Wood.

Area 2—Implement appropriate and best transfusion practice for clinician decision making and administration (Group 2)

The **aims** of the group are:

- to improve the appropriateness of transfusion in accordance with the National Health and Medical Research Council/Australian & New Zealand Society of Blood Transfusion (NHMRC/ANZSBT) guidelines by measuring both the appropriateness of transfusion and compliance with the guidelines
- to improve administration of blood and blood products by implementing guidelines and clinical best practice tools for administration.

The initial chair of this group was A/Prof Larry McNicol. More recently, Dr Helen Savoia has chaired this working group.

Area 3—Develop and implement a haemovigilance system for blood product use (Group 3)

The **aim** of the group is:

- to develop a haemovigilance system that measures and monitors errors and adverse events during blood product use and makes recommendations to decrease errors and adverse events associated with blood product use.

The chair of this group was Dr Peter Bradford.

Area 4—Engage and support the private and rural sectors for better, safer transfusion practice (Group 4)

The **aims** of the group are:

- to engage the private and rural sectors for the delivery of better, safer transfusion practice
- to develop and implement a central resource for outreach in education and training for the private and rural sectors.

The chair of this group was Prof Miles Prince.

5. Achievements to date

At a planning workshop in February 2006, it was agreed to revise the focus of the work of the program. This report provides a summary of the work of the working groups in BeST to December 2005.

5.1 Area 1—Improve awareness and knowledge of transfusion practice within hospitals (Group 1)

Aim 1:

to improve patient and health care professionals' knowledge of better, safer transfusion practice, through education and training on transfusion of blood and blood products at both undergraduate and postgraduate levels.

Patient education

Strategies:

- To develop key patient education messages and incorporate them into one tool that is available to patients. The website will be a portal for consumers to access the tool but primarily it will be taken to identified groups to promulgate.
- To engage with identified groups that can deliver/promote patient education about transfusion risks and benefits, such as self-help groups and hospital consumer advisory committees, hospital clinical staff and risk/quality and scientific staff.

Tools:

- Consumer brochure: *Blood transfusion: Have all your questions been answered?*
- Consumer leaflet: *Frequently asked questions by consumers regarding transfusion.*

Progress against plan:

Tools were developed in consultation with consumer groups and then made available for use. Consumer advisory committees in metropolitan health services were advised.

Educating hospital staff

Strategy:

- To deliver transfusion education through academic programs for nurses, doctors and scientists (and potentially perfusionists) and hospital education programs for the above groups.

Progress against plan (including tools):

Nurses

Short term:

- Developed and disseminated material on the key transfusion messages that need to be on the hospital graduate nurse education programs (there are many messages and these need to be prioritised).
- For hospitals with no transfusion nurse, packaged information has been provided for other staff to use within their health service. A pilot train-the-trainer model of delivering transfusion improvement was conducted in one Victorian region and this model is being considered for further use.
- Provided education directly to interested hospitals. While this is not sustainable in the long term as it is beyond the program scope, this approach was used to initially raise awareness and knowledge of best transfusion practice.

Long term:

- Commenced engagement of Victorian nurse undergraduate programs to include transfusion on the curriculum for 2006 and beyond.

Scientists

Short term:

- Transfusions can occur at any time and clinical staff may require access to transfusion administration information to safely transfuse patients. Scientists are part of the transfusion team, however some are not familiar with clinical transfusion issues, and training them to understand transfusion administration issues will assist in providing accurate advice 24 hours a day, seven days a week. A scientist laboratory reference pack for transfusion administration has been developed so that messages are consistent. This tool, *Blood product administration: laboratory reference*, is available on the BeST website.

Long term:

- Consideration was given to advocating for inclusion of clinical transfusion information on undergraduate scientific programs, however this is beyond the current scope of BeST.

Medical staff

Short term:

- Key messages on transfusion were delivered via the hospital orientation programs at health services where there are transfusion nurses using a key messages pack.

Long term:

- Consideration was given to advocating for inclusion of transfusion on the undergraduate curriculum for 2006, however, this is beyond the current scope of BeST.
- Three documents with key transfusion messages for laboratory, medical and nursing staff were developed for use within health services and are available via the BeST website.

For a summary list of education provided see Appendix 3.

BeST website analysis

www.health.vic.gov.au/best

The BeST website was an initial priority and has been online since late 2004. It continues to provide a primary information source for individuals and agencies seeking to improve their transfusion processes or educate consumers about transfusion. This is a summary of the performance and a brief evaluation of website use as at end of 2005.

Definition of page views

A view occurs when a user opens a page. Each time the page is opened, a view is counted. BeST uses the count of views to provide information on traffic through the website and for each web page.

The BeST website

The BeST home page is the entrance to the website. The site contains a number of links that are purely **informational**, such as the advisory committee members, the history of BeST, policy and future directions. Informational links are usually 'low traffic' areas and are often considered poor indicators of site use. In addition, BeST has a number of pages that are largely **resource stores**. Users access the pages and download resources for their own use. Such pages are usually considered important and should be 'high traffic' if effective. Transfusion tools web pages are considered resource stores.

Newsletters

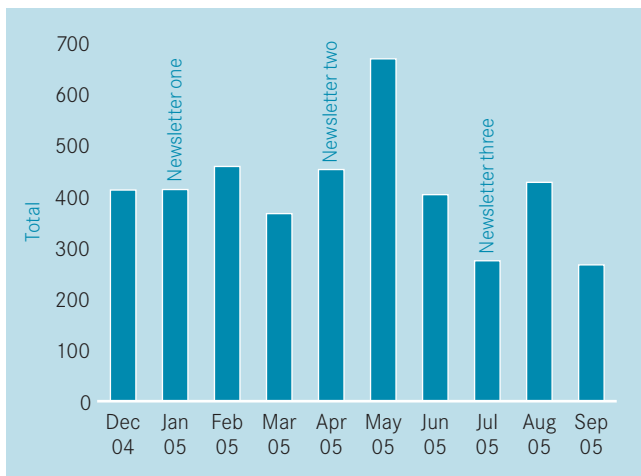
BeST has produced three newsletters to date. Each contained articles that highlighted resources on the website, as well as an update on the program.

Results

The home page was viewed extensively during the first three months of operation, indicating that users were interested in the concept of better transfusion processes. Support increased marginally after the first newsletter was produced, then declined slightly. The second newsletter coincided with a steep spike in views (16 per cent of all views for the entire period occurred in the 30 days after the newsletter was produced). The third newsletter resulted in a slight rise in view activity.

The first newsletter introduced the scope of the BeST project and provided contact details and website address. After the newsletter circulated, there was a moderate rise in activity viewing both the home page and the transfusion tools pages.

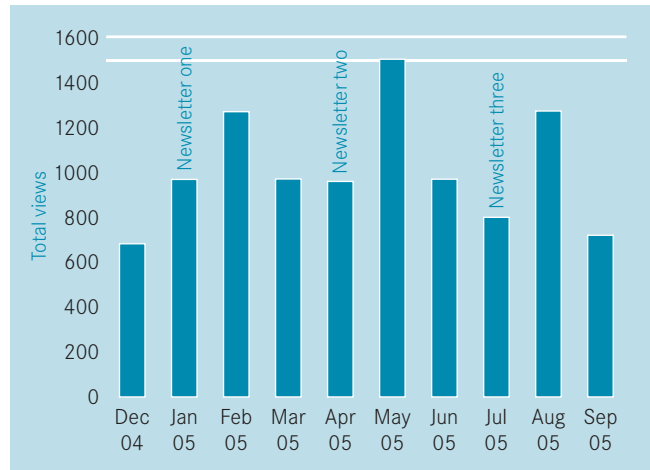
Figure 1: Home page views by month



The second newsletter contained more specific details on website resources and generated a considerable spike in activity for views of the transfusion tools pages.

The third newsletter was largely information, concentrating on updating details in the low traffic web pages. In this case, the total activity spiked again but off a lower base number. Perhaps many of the information resources once accessed had been saved for local use, not requiring a revisit to the website.

Figure 2: Transfusion tool views



In summary, the website traffic demonstrates a healthy use pattern. In the early operational phase, there was evidence of steady access to the site but resource page views were low. For every view of the home page, there were 1.7 views on average of the resource pages. As the resource pages were highlighted in the newsletters, especially the second newsletter, the average rose to a high of 3.1. Every user who accessed the home page to enter the site also accessed about three of the resource pages in the same visit.

Overall, the relationship between home page views and resource views was moderate and positive ($r=0.78$). Increases in home page access usually had increases in resource page access. However, in the months directly after a newsletter release, any increase in home page views was almost certain to have a corresponding increase in resource views ($r=0.92$), whereas for months other than post-newsletter, the relationship was weak ($r=0.44$). In summary, it appeared that, in the period to date, the combination of website and newsletter was far more valuable than just the website alone.

A review and upgrade of the website commenced in April 2006 to ensure that it remains a useful resource to health services.

Aim 2:

to advance the transfusion nurse role as a key nursing role in health service organisations for the promotion of better, safer transfusion practice.

Strategy:

A distance education course was provided for the first time in 2004 based on the Blood Matters project face-to-face course developed to train the 15 new transfusion nurses. The BeST program strategy was to continue this course to provide education to transfusion improvement practitioners, particularly transfusion nurses.

Progress against plan:

BeST has ensured that the Certificate of Transfusion Practice course has been offered each year for nurses, scientists and doctors. National and international enrolments have been received with strong participation from Victoria. Other education formats are to be investigated for future years.

Information is available at

<http://www.mdhsonline.unimelb.edu.au/best>

Evaluation:

An 81 per cent satisfaction rating was recorded by students in 2004 and 2005, covering areas such as content, formatting, teaching and ease of navigation in the online environment. The evaluation data has formed the basis of improvements to the course each year, including a new learning management system (Moodle) in 2006.

5.2 Area 2—Implement appropriate and best transfusion practice for clinician decision making and administration (Group 2)

Aim 1:

to improve the appropriateness of transfusion in accordance with the NHMRC/ANZSBT guidelines by measuring the appropriateness of transfusion and compliance with the guidelines.

Strategies:

- To conduct a clinical audit of red blood cell use in orthopaedic surgery (22 private and public services).
- To conduct a clinical audit of fresh frozen plasma use (23 public and private services).
- To develop a statewide prescription form to prompt documentation of standardised information by clinical staff.
- To develop blood management information for use in elective surgery.
- To monitor and promote best product use in cardiac surgery.
- To conduct a clinical audit of platelet use.

Tools:

- Audit tool and information sheets for red cell use in orthopaedic surgery.
- Audit tool and information sheets for fresh frozen plasma use.
- Prescription form (draft).
- Platelet audit form (draft).

Progress against plan:

- Red blood cell audit in orthopaedic surgery—a database to manage the data has been developed, data entered and analysis is being finalised. Return rates are 91 per cent.
- Fresh frozen plasma audit—as for red blood cell audit.
- Statewide prescription form—a BeST form has been drafted as an attachment to the standardised national inpatients medication chart. The form has been referred to the Victorian Medications Advisory Committee at the department to seek comment from the relevant stakeholders.
- Blood management information—a generic information brochure is being developed.
- Product use in cardiac surgery—this project is being conducted initially at the Austin Hospital. The agreed aim is to establish current practice relative to existing Austin protocols for management of fresh blood products in cardiac surgery patients for admission, intra-operative and postoperative surgery phases. This data will be used to engage in dialogue with the clinicians about the importance of documenting reasons for decisions to transfuse that are off-protocols/guidelines and provide assistance for the review of existing protocols at Austin to ensure they are up to date and relevant. The data from this process is to be used to design a pilot at other cardiac surgery hospitals in 2006. The cardiac surgery database information will be compared with the data collected in this project. The team for this project is being formed and audits tools will be developed.
- Platelet audits—a tool has been drafted and supporting information and documentation is being drafted. This audit is planned to commence after the reports on the red blood cells and fresh frozen plasma audits are released in mid-2006.

Evaluation:

The number of audits returned was a measure of sector engagement. Data analysis and reporting back to the sector are currently being finalised, with reporting and practice improvement strategies to be completed in mid-2006.

Aim 2:

to improve administration of blood and blood products by implementing guidelines and clinical best practice tools for administration.

Strategy:

To conduct a statewide audit of administration policy and practice in public and private hospitals.

Tools:

- A desk audit tool of hospital administration policy.
- Tool for an observational audit of administration practice (at the bedside) and instruction sheets.

Progress against plan:

Progress as per red blood cell in orthopaedic surgery and fresh frozen plasma audit processes, with return rates of 61 per cent.

Evaluation:

The relatively high numbers of audit returns are a very strong measure of sector engagement. Data analysis and reporting back to the sector are currently being finalised, with reporting and practice improvement strategies to be completed in mid-2006.

5.3 Area 3—Develop and implement a haemovigilance system for blood product use (Group 3)

Aim 1:

to develop a haemovigilance system that measures and monitors errors and adverse events during blood product use and makes recommendations to decrease errors and adverse events associated with blood product use.

Strategies:

- To design a haemovigilance system based on the United Kingdom's Serious Hazards of Transfusion (SHOT) reporting system. The principles of the system are that:
 - a minimum data set is requested from hospitals on a regular basis
 - near misses are included in the data set
 - an expert group reviews the data received and prepares an executive summary with recommendations for improvements and corrective actions.
- To plan and implement a trial of the system in 2006. This incorporates an assessment of the practicalities of collecting and analysing data collected from rural, private, metropolitan and public hospitals.

Tools:

- Report forms to capture defined data sets: initial form and secondary forms.
- Instructions and guidelines for reporting an event.

Progress against plan:

- Conducted a system desktop pilot exercise (October 2005) with stakeholders (private/public representatives, clinical staff, scientists, and management). The system is to be piloted for three months in several willing organisations commencing July 2006.
- The system is expected to go live across the state on 1 January 2007. This will be confirmed pending feedback from pilot activities and identification of resourcing requirements.

Evaluation:

The system is to be monitored using several indicators which include:

- per cent of hospitals reporting into the system (monitored as trends over time)
- number of total incidents reported (monitored as trends over time)
- number of incidents reported by category (monitored as trends over time).

5.4 Area 4—Engage and support the private and rural sectors for better, safer transfusion practice (Group 4)

Due to the new and broader statewide scope of BeST, a short term working group was set up to identify issues and strategies to best understand and engage these sectors.

Strategies:

- To identify rural and private stakeholders for correspondence and specific projects.
- To develop links between private and public hospitals (focusing on transfusion committee involvement initially).
- To develop a regionalisation strategy to facilitate transfusion improvement by discussion within existing or new regional forums and action for transfusion improvement.
- To identify issues in the private sector for other BeST working groups to address.
- To investigate blood product storage and handling issues.

Progress against plan (and tools):

- Identifying stakeholders—gathered information and created rural and private stakeholder maps.
- Develop linkages between private and public hospitals—investigated affiliation of members of private hospitals into transfusion committees of public hospitals, where appropriate.
- Regionalisation strategy—investigated and linked with some formed regional groups such as risk and quality managers meetings. Also investigated establishing regional meetings focused on transfusion, however it was resolved not to do so because issues to be discussed would be site-specific rather than region specific.
- Storage and handling issues—a survey was conducted of storage and handling practices. Thirteen of 16 surveys were returned from private and rural hospitals. Storage posters were developed and are available on the BeST website.

Summary of BeST achievements to date

Against agreed performance measures, BeST has:

- provided data on blood transfusion practices within hospitals in Victoria
- monitored trends and provided data on use of blood and blood products in compliance with clinical/best practice guidelines
- facilitated and reported on transfusion performance audit at hospital and statewide levels
- delivered education programs and quality improvement programs to enhance transfusion practice in Victoria
- maintained and updated a register of practical strategies to enhance the quality and safety of transfusion practice and the dissemination of relevant strategies to users of blood.

As yet, we have not been in a position to provide data on patients' experiences of the provision of transfusion services.

6. Hospital transfusion teams

Successful implementation of improved hospital transfusion practice requires local staff to undertake a range of performance monitoring, education and improvement initiatives aimed at ensuring that blood and blood components are used to best effect.

Transfusion nurses can only operate effectively when they have the support and direction of a local senior 'champion' for improving transfusion safety. This person is the 'leader' of a local 'transfusion team'. Ideally, this person is a senior manager in the hospital's quality and safety program. The leader will ensure that transfusion practice improvement is championed locally and will provide guidance and support for the transfusion nurse and the transfusion team.

The transfusion nurse, a representative of the hospital blood bank and a clinician with knowledge of blood transfusion issues, completes the team. These individuals work as the effector arm of the hospital's local transfusion committee (or equivalent).

The challenge of coordinating a program of this nature should not be underestimated. The required knowledge needs to be delivered to a wide range of staff and mechanisms to collect transfusion performance data need to be devised and implemented.

7. Work program for 2006–07

During 2006–07, the program will work with hospitals to deliver sustainable transfusion education and provide information to hospitals and clinicians about their use of blood and blood products.

Under the theme of clinical governance, development of the transfusion nurse role within the health service transfusion team will continue. In addition, the role and activities of transfusion committees within a hospital's quality structures will be promoted.

Transfusion practice improvement in hospitals can only be implemented using a range of locally developed protocols, based on national guidelines. BeST will take every opportunity to identify and share best practice approaches to local transfusion practice improvement across Victoria and will support the establishment of transfusion standards across the state in cooperation with the Australian Council on Healthcare Standards.

To enable clinicians to review their blood prescribing practice and, where possible, to optimise their use of blood and blood products, performance data will be linked to patient data and fed back to local clinical teams.

Having successfully concluded a comprehensive review of existing policies, protocols and practices in 2003–05, BeST will continue to develop a highly energised and supportive infrastructure across Victoria to advance the transfusion safety and quality agenda.

Local trainers need to be identified in a number of hospitals and they need to receive education and support from existing trained transfusion nurses and BeST. To support delivery of transfusion education across Victoria, BeST will explore the use of self-directed and e-learning packages based on the existing system of continuing transfusion education from Scotland.

Progress stems from an understanding of the likely challenges to be faced and the establishment of robust programs of consultation, collaboration and cooperation with a broad range of organisations and individuals within and outside Victorian health care.

The BeST program will work across a partnership involving blood donors, blood and blood product suppliers, funding and governing bodies and clinicians in our hospitals to make the transfusion process, not just blood, as safe as possible. The aim is to ensure that patients can be transfused safely when they need to be, and only when they need to be.

Other key areas of focus for 2006–07 are ensuring that in everyday practice clinicians decisions to prescribe blood products make use of the best available evidence; blood ordering and administration processes are best practice; and management of this precious community resource made available by volunteer blood donors is effective.

Appendix 1 Better Safer Transfusion Advisory Committee members

A/Prof Larry McNicol

Director of Anaesthesia
Austin Health
Chair: BeST Advisory Committee

Dr David Beilby

Director of Anaesthesia &
Perioperative Medicine
Box Hill Hospital

Ms Karen Botting

Project Officer, BeST

A/Prof Neil Boyce

Transfusion Medicine Specialist
Australian Red Cross Blood Service

Dr Peter Bradford

Executive Director Medical Services
Peninsula Health

Mr Wallace Crellin

Consumer representative

Mr Ashley Eccles

Blood and Pharmaceutical Programs
Programs Branch
Department of Human Services

Mr Twanny Farrugia

Consumer representative

Dr Craig French

Director of Intensive Care Unit
Western Health

Dr Chris Hogan

Consultant Haematologist
Royal Melbourne Hospital

Miss Annette Holian

Trauma Surgeon
The Alfred Hospital

Prof Anne-Marie Kelly

Director of Emergency Medicine
Western Health

Mr Geoff Magrin

Senior Scientist
Blood Bank
The Alfred Hospital

Prof Miles Prince

Head, Haematology Department
Peter MacCallum Cancer Centre

Dr Helen Savoia

Consultant Haematologist
The Royal Children's Hospital,
And The Royal Women's Hospital

Dr Carole Smith

Consultant Haematologist
Austin Health

Ms Lisa Stevenson

Transfusion Nurse
Barwon Health and BeST

Ms Libby Wilson

Executive Director, Nursing and Community Participation
Peninsula Health

Dr Erica Wood

Transfusion Medicine Specialist
Australian Red Cross Blood Service

Past members 2004–05

A/Prof Marcus Kennedy (inaugural *Chair*)

Director Emergency Medicine
Melbourne Health

Ms Sue Graham

Associate Nurse Unit Manager
Knox Private Hospital

Ms Tania Nallathamby

Programs Branch
Department of Human Services

Ms Nadine Gilby

Transfusion Nurse, BeST

Appendix 2 BeST Advisory Committee working group members

Working group 1

Dr Erica Wood (chair), Transfusion Medicine Specialist, Australian Red Cross Blood Service

Ms Janine Carnell, Transfusion Nurse, Eastern Health

Mr Twanny Farrugia, Consumer representative

Ms Judy Forsyth, Nurse Educator, Peter MacCallum Cancer Centre

Ms Mary Gaskell, Senior Scientist, Pathology, St Vincent's Health

Ms Libby Wilson, Executive Director, Nursing and Community Participation, Peninsula Health

Working group 2

Dr Helen Savoia, Consultant Haematologist, The Royal Children's Hospital and The Royal Women's Hospital (*Chair*, replaced A/Prof Larry McNicol, Director of Anaesthesia, Austin Health)

A/Prof Neil Boyce, Transfusion Medicine Specialist, Australian Red Cross Blood Service

Mr Ashley Eccles, Blood and Pharmaceutical Programs, Department of Human Services, Victoria (replaced Ms Tania Nallathamby)

Dr Craig French, Director of Intensive Care Unit, Western Health

Ms Sue Graham, Associate Nurse Unit Manager, Knox Private Hospital

Ms Annette Holian, Trauma Surgeon, The Alfred Hospital

Working group 3

Dr Peter Bradford (chair), Executive Director Medical Services, Peninsula Health

Dr David Beilby, Director of Anaesthesia and Perioperative Medicine, Box Hill Hospital

Dr Chris Hogan, Consultant Haematologist, Royal Melbourne Hospital

Mr Geoff Magrin, Senior Scientist, Haematology Department, The Alfred Hospital

Dr Carole Smith, Consultant Haematologist, The Austin Hospital

Mr Neil Waters, Transfusion Medicine Scientist, Australian Red Cross Blood Service, Victoria

Mr Deane Wilks Program Manager, Clinical Risk Management, Department of Human Services Victoria (replaced Ms Maureen Willson)

Working group 4

Prof Miles Prince (chair), Head, Haematology Department, Peter MacCallum Cancer Centre

Ms Lisa Stevenson, Transfusion Nurse, Barwon Health

Ms Marg Watts, Director of Nursing, Shepparton Private Hospital

Mr Neil Waters, Transfusion Medicine Scientist, Australian Red Cross Blood Service

Mr Richard Rogers, Senior Scientist, Immunohaematology, Cabrini Health

Dr Ellen Maxwell, Haematologist, Melbourne Pathology

The BeST secretariat were members of each working group:

Ms Karen Botting, BeST Project Officer and

Ms Nadine Gilby, BeST Transfusion Nurse.

Appendix 3 Education and awareness raising sessions provided by BeST in 2004–05

This is a summary of the education or information forums provided by the BeST secretariat over 2004–05. It involved nurses, medical, scientific and quality/risk management personnel in both metropolitan and regional areas.

Date	Name of forum	Attendees	Location	Metro (M) or Regional (R)
14 Dec 04	Australian Red Cross Blood Service (ARCBS) Scientists Forum	Scientists from across the state	ARCBS Southbank	M and R
15 Feb 05	Graduate Nurse Program	Graduate nurses	St Vincent's Private Hospital	M
23 Feb 05	Graduate Nurse Program	Graduate nurses	Melbourne Private Hospital	M
24 Feb 05	Graduate Nurse Program	Graduate nurses	Goulburn Valley Hospital	R
24 Feb 05	Hospital Nurse Forum	All available operational nurses	Shepparton Private Hospital	R
15 Mar 05	Graduate Nurse Program	Graduate nurses	St Vincent's Private Hospital	M
17 Mar 05	Victorian and Tasmanian Biannual Transfusion Nurse Workshop	Transfusion nurses	Royal Melbourne Hospital	M and R
21 Mar 05	Gippsland Regional Directors of Nursing Meeting	Directors of Nursing	Traralgon	R
31 Mar 05	Barwon-South Western Regional Quality Network Meeting	Risk and quality managers mainly	Geelong	R
7 Apr 05	Quality and Risk Management Group (QuARM)	Risk/quality managers	Werribee	M and R
11 Apr 05	Barwon-South Western Region Continuing Nurse Education Meeting	Directors of Nursing, nurse educators	Warrnambool	R
15 Apr 05	Loddon-Mallee Regional Directors of Nursing Meeting	Directors of Nursing	Bendigo	R
3 May 05	Epworth Hospital	Graduate nurses	Epworth Hospital	M
17 May 05	Commonwealth Serum Laboratories	Staff	Broadmeadows	M
18 May 05	Epworth Hospital	Nursing staff	Epworth Hospital	M
19 May 05	Werribee Mercy Hospital staff forum	Nursing, laboratory and quality staff	Werribee	M

Date	Name of forum	Attendees	Location	Metro (M) or Regional (R)
2 Jun 05	Grampians Regional Quality Forum	Quality and risk managers	Ararat	R
3 Jun 05	Victorian Medical Postgraduate Foundation, Country Education Program, Hamilton	Medical staff, laboratory and nursing attendees	Hamilton	R
17 Jun 05	Transfusion education day	Nursing and laboratory staff	Hobart	M
30 Jun 05	Transfusion education session	Nursing staff and junior medical staff	Warrnambool	R
12 Jul 05	Transfusion education session	Medical and laboratory staff	Werribee	M
13 Jul 05	Victorian Medical Postgraduate Foundation, Country Education Program, Portland	Medical staff, laboratory and nursing staff	Portland	R
14 Jul 05	ARCBS Scientists Forum	Scientists from across the state	ARCBS Southbank	M and R
5 Aug 05	Hume Regional Directors of Nursing Meeting	Directors of Nursing	Wangaratta	R
19 Aug 05	Transfusion education day	Nursing and laboratory staff	Hobart	M
29 Aug 05	Transfusion education day	Nursing and laboratory staff	Launceston	M
6 Oct 05	Half-day transfusion information session by BeST to hospitals within organised clusters in the Loddon Mallee Region	Nursing and laboratory staff	Echuca host hospital	R
12 Oct 05	Half-day transfusion information session by BeST to hospitals within organised clusters in the Loddon Mallee Region	Nursing and laboratory staff	Mildura host hospital	R

Date	Name of forum	Attendees	Location	Metro (M) or Regional (R)
12 Oct 05	Transfusion information session	Medical staff	Mildura	R
14 Oct 05	Half-day transfusion information session by BeST to hospitals within organised clusters in the Loddon Mallee Region	Nursing and laboratory staff	Castlemaine host hospital	R
25 Oct 05	Half-day transfusion information session by BeST to hospitals within organised clusters in the Loddon Mallee Region	Nursing and laboratory staff	Swan Hill host hospital	R

