GP : Transfusion Confusion
Innovation Case Study

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Background:
At UHCW in 2012, just 50% of patients who were being treated by medical specialities had the fact that they had had a transfusion communicated to their GP’s (audit, n=15). This makes it difficult for GP’s to discuss a patient’s admission, manage their ongoing care or react to complications that arise as a consequence of transfusion. Given increasingly short hospital stays patients are more likely to be transfused close to discharge back to community care making this project all the more important.

Project Details:
The simplest of interventions was completed! A space on the e-discharge pro-forma on CRRS was labelled for the inclusion of blood transfusion events and this is now highlighted in red. Teaching was delivered to new FY1’s specifically on this topic (69% of audited e-discharges were completed by FY1/2 doctors).

Impact:
Following the intervention over 80% of blood transfusions occurring in hospitals were documented in the e-discharge letters to GPs. (Identified during re-audit, n=40). Furthermore other essential information was included more commonly in the discharge regarding the transfusion eg when it occurred, why, how many units and whether any complications occurred.

This innovation is exceptionally simple but I feel delivers a meaningful improvement in patient care. (80% transfusions represents near complete inclusion on e-discharges as the remaining patients were often discharged without e-discharge letters) which is a separate issue.

Invited to present at the regional blood transfusion group meeting.

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