

TRANSFUSION UTILIZATION COMMITTEE AND PROGRAM

- 1. REASON FOR ISSUE:** This Directive provides policy for establishing blood utilization committees, polices, and procedures, which promote safe and clinically effective blood utilization thereby reducing the risk of adverse transfusion outcomes.
- 2. SUMMARY OF MAJOR CHANGES:** None.
- 3. RELATED ISSUES:** VHA Handbook 1106.01.
- 4. RESPONSIBLE OFFICE:** The Pathology and Laboratory Medicine Services (10P4D), is responsible for the content of this VHA Directive. Questions may be directed to P&LMS Program Office at 202-632-8419.
- 5. RESCISSIONS:** VHA Directive 2009-005, dated February 9, 2009, is rescinded.
- 6. RECERTIFICATION:** This VHA Directive is scheduled for recertification on or before the last working day of September 2020.

David J. Shulkin, M.D.
Under Secretary for Health

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TRANSFUSION UTILIZATION COMMITTEE AND PROGRAM

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for establishing blood utilization committees, policies, and procedures, which promote safe and clinically effective blood utilization thereby reducing the risk of adverse transfusion outcomes. **AUTHORITY:** 38 U.S.C. 7301(b)

2. BACKGROUND: Public Health and professional organizations, including The Joint Commission, AABB (formerly known as American Association of Blood Banks), and the College of American Pathologists, require ongoing monitoring of blood utilization within institutions. The goal is to aim for the comprehensive Patient Blood Management. The Patient Blood Management best practices are recommended for an interdisciplinary program of the oversight and review of patient blood management activities. This interdisciplinary program shall be patient-centered, data-driven, and outcomes-focused. Essential to effective transfusion practices are the implementation of evidence-based transfusion guidelines (see Appendix A) to reduce variability in transfusion practice, and the employment of multidisciplinary teams to study, implement, and monitor local blood management strategies.

3. POLICY: It is VHA policy that each VA medical facility must have a working Transfusion Utilization Committee and Program adhering to the mandates of this Directive.

4. RESPONSIBILITY: The VA medical facility Director, or designee, is responsible for:

a. Designating a Transfusion Utilization Committee and ensuring that the Transfusion Utilization Committee includes representation from all major departments or services that transfuse blood or blood products (see Appendix. A).

b. Establishing a written Transfusion Utilization policy (see Appendix B).

c. Establishing a formalized comprehensive process to monitor transfusion related activities.

d. Ensuring that clinicians participate in the peer review process. At a minimum, the facility must have a peer review program that monitors and addresses transfusion practices for all categories of blood and components including:

(1) Ordering practices.

(2) Blood refusal practices.

(3) Patient identification.

(4) Sample collection and labeling.

(5) Pre-transfusion testing orders.

(6) Distribution, handling and dispensing.

- (7) Blood administration policies.
- (8) Infectious and non-infectious adverse events.
- (9) Monitoring of patients for appropriate responses.
- (10) Medical errors, near-misses and sentinel events.
- (11) Appropriate utilization.
- (12) Wastage and discard rates.
- (13) Ability of transfusion services to meet patient needs.
- (14) Clinical alternatives to blood transfusion (perioperative salvage).

(15) Compliance with peer-review recommendations for an active program with evidence based metrics and clinician feedback to ensure compliance with transfusion guidelines.

e. Establishing a written process to monitor the ordering practices of each requesting physician, to include a process for defining corrective action for those ordering providers that are not in compliance with established protocols.

f. Ensuring that data needed to evaluate transfusion practices is submitted in a timely manner (see Appendix A). Data sources include but are not limited to transfusion services, quality management, nursing, medical services, and surgical services.

5. REPORT: Transfusion utilization data, defined data, determined by the National Director, Pathology and Laboratory Medicine Services (10P4D) and the Program Office, on transfusions practices is to be submitted twice a year covering 6 month intervals (January – June and July – December) to P&LMS Program Office.

6. REFERENCES:

- a. VHA Handbook 1106.01.
- b. Accreditation Standards, Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181.
- c. Best Practices for a Patient Blood Management Program. April 2012. AABB, 8101 Glenbrook Road, Bethesda, MD 20814.
- d. Standards for Blood Banks and Transfusion Services, 29th edition or latest edition, AABB, 8101 Glenbrook Road, Bethesda, MD 20814.

7. DEFINITIONS:

a. **Blood Utilization Review.** The dual purpose of blood utilization review is to 1) minimize the inappropriate use of blood components and 2) promote transfusion of the right component at the right time to the right patient. Blood utilization review touches all aspects of the transfusion process, including physician ordering, indications for transfusion, transfusion thresholds, patient identification, blood administration, monitoring for adverse effects, error reporting, the role of the Transfusion Committee or Transfusion Safety Officer, and quality improvement through physician education.

b. **Patient Blood Management.** Patient Blood Management is an evidence-based, multidisciplinary approach to optimizing the care of patients who might need transfusion.

c. **Transfusion Utilization Committee.** An active multidisciplinary participation by physicians, nurses, administrators and other interested individuals to perform blood utilization review and promote prevent adverse transfusion-related events or to take appropriate corrective actions should such events occur. The Transfusion Utilization Committee is responsible for developing its own institutional blood utilization procedures and audit criteria.

GUIDELINES FOR ESTABLISHING A TRANSFUSION UTILIZATION COMMITTEE

Transfusion utilization review is essential in promoting continual improvement in the ordering, distribution, handling, dispensing, and administration of blood components and in monitoring the effects of transfusion practices. Peer review of transfusion practices is required by the American Association of Blood Bank (AABB) and by Department of Veterans Affairs (VA) policy (VHA Handbook 1106.01). To meet these requirements, facilities form a Transfusion Utilization Committee (TUC) also sometimes known as a Blood Utilization Committee, a Blood Usage Review Committee, a Transfusion Committee, or a Tissue and Transfusion Committee. This single interdisciplinary group brings multiple clinical services and the multiple steps involved in the transfusion process into compliance with these applicable policies, accreditation standards, and any applicable regulatory requirements.

It must be understood that the format of the review process and the criteria for appropriate blood utilization must be developed by each institution and needs to be revised as new information and advances become available. Each TUC, or its equivalent, is responsible for developing its own institutional blood utilization procedures and audit criteria. These criteria, usually based on suggested laboratory values, form the framework for accepted practice based on current evidence, but do not independently establish all indications or criteria for individual transfusions. Review and approval of audit criteria by the medical staff prior to implementation is essential. The procedures and audit criteria must be reviewed and revised or updated on a regular basis.

1. Composition of the Transfusion Utilization Committee.

a. Based upon Departmental recommendations, the committee members and Chair are appointed by the hospital's Clinical Executives (Chief of Staff or Nurse Executive). Members need to be knowledgeable and experienced in one or more aspects of transfusion therapy and blood banking. The tenure on the committee needs to be of sufficient duration so that skills acquired can be used and shared.

b. The Committee must be chartered according to the institutional bylaws as a standing professional committee of the Medical Board. If the Blood Bank Director or Transfusion Services Director (if different) is a full-time or permanent part-time VA employee, he or she is required to be a member of the TUC. If the Blood Bank Director or Transfusion Services Director is a contractor or consultant to VA, the Chair of the Committee may seek input from the Director regarding matters within the scope of the contract or invite the Director to attend Committing meetings to provide information and individual advice. Directors who are not VA employees should not engage in deliberations of the Committee relating to advice or recommendations being provided by the Committee to VA.

NOTE: *It is recommended that the Committee include members from all the major departments or services that transfuse blood. Subspecialties with high blood usage need to be represented (Cardiovascular surgery, Orthopedics, Hemodialysis, Oncology, and Hematology etc.). In addition to the Blood Bank or Transfusion Service Director, members to be included, as applicable, are:*

- (1) Surgery,
- (2) Medicine,
- (3) Anesthesia,
- (4) Pathology,
- (5) Quality Assurance, Quality Management, or Risk Management,
- (6) Emergency Medicine,
- (7) Blood Bank,
- (8) Nursing,
- (9) Hospital administration,
- (10) Patient Safety Officer,
- (11) Education and Training, and
- (12) Others, as appropriate, i.e., Biomedical Engineering, Blood Supplier, a representative of nursing home transfusion services, if any.

2. Responsibilities of a TUC. The functions of the committee overseeing blood usage need to be clarified by the committee itself. To focus the committee's activities, specific objectives or charges need to incorporate The Joint Commission (JC) requirements. Sample objectives are:

- a. Follow national guidelines and/or develop local guidelines for clinical use of blood.
- b. Develop policies and procedures for blood transfusion in the facility.
- c. Monitor and clinically review (concurrently or retrospectively) selected blood transfusions per TUC to ensure appropriate and correct usage of blood thereby reducing unnecessary transfusion and avoiding wastage.

- d. Recommend corrective actions in transfusion practice.
- e. Engage in active dialogue with peer feedback on individual transfusion practice.
- f. Make arrangements for training of house and clinical staff based on policies and procedures.
- g. Establish criteria for audit of transfusion practice and review of utilization of blood/blood products in individual cases.
- h. Make periodic reports to the Medical Board.
- i. Assess blood and blood component use for ways to improve patient care
- j. Review and analyze statistical reports of the transfusion service.
- k. Assist the blood supplier(s) in blood procurement efforts, where applicable.
- l. Assess adequacy and safety of the blood supply.
- m. Promote continuing education in transfusion practices for the hospital staff.

3. Meetings. Minimally, the TUC needs to meet on a quarterly basis. Ad hoc meetings can be conducted if warranted. Minutes are required to document the items discussed and any corrective or preventative actions which were to be taken.

4. Reporting. The following are the types of data that a facility may consider for submission to the TUC Chair quarterly by the responsible office. In turn the TUC reports all such data to the Medical Board on a quarterly basis.

Data Element	Responsible Office
General statistics including, but not limited to the number of transfusions, including the number and type of components transfused.	Transfusion Services
Number of units, by component type, outdated or otherwise discarded.	Transfusion Services
Number of autologous procedures,	Transfusion Services
Number of transfusions audited or reviewed for appropriateness and the results of investigation of transfusions deemed inappropriate. Corrective and preventative actions resulting from the reviews should also be reported.	a. Initial screen – Transfusion Services b. Peer review for transfusions that fail to meet transfusion criteria – Clinical Services

Data Element	Responsible Office
Intra-operative and post-operative blood salvage statistics, including, but not limited to the number of procedures performed and the method(s) or equipment used,	Surgery
Other data and statistics as specified by the Department of Health, Center for Disease Control and Prevention (CDC), and other agencies, as required.	Transfusion Services
All patient adverse reactions attributed to transfusion of blood, blood components, or blood derivatives including suspected disease transmission with all incidents to be discussed in detail, including the results of all investigations.	Transfusion Medicine Director
Results of proficiency testing, peer review, and inspections by governmental or private (peer) entities.	Transfusion Services
Change in supervisory personnel or other significant staffing changes.	Transfusion Services
Issues that may affect quality or supply.	All Departments

Additionally, defined data, determined by the National Director, Pathology and Laboratory Medicine Services (10P4D) and the Program Office, on transfusions practices is to be submitted twice a year covering six month intervals (January – June and July – December).

5. Conducting the Peer Review or Audit.

a. The blood bank/transfusion service reviews all transfusions using stated indication and audit criteria based on guidelines established by the TUC. This can include prospective review with intervention by the Pathologist/Transfusion Medicine Physician. The TUC will audit a percentage of transfusions based on local policy which should include elements required for documentation of transfusion in the patient record and these will include all transfusions that do not meet audit criteria. The review of transfusions can be done prospectively (before blood is issued) or retrospectively (after blood is issued). Most consider the prospective review as preferable, because interventions can intercept unnecessary transfusions and correct inaccurate transfusion orders in the real time.

b. For each transfusion the following information is to be documented in the veteran’s health record:

- (1) Physician order,
- (2) Indication for transfusion,
- (3) Informed patient consent,
- (4) Patient identification checks,
- (5) Blood component issuance documentation,
- (6) Patient monitoring during transfusion,
- (7) Assessment of outcome, and
- (8) Applicable laboratory or clinical results before and after the transfusion. .

c. Trained hospital quality assurance or compliance staff, using established guidelines, can do chart or electronic record reviews. Where there are questions about the indication and results of a transfusion, the clinical record should be peer reviewed or reviewed at the transfusion committee meeting. Sample review notification process:

(1) Practitioners with transfusions failing Quality Assurance (QA) review are sent a Letter of Findings. No response is necessary, and the letter is not noted in the providers credentialing file.

(2) Repetitive or unusually serious violations are examined by medical staff service committee (i.e., a Peer Review).

(3) The attending physician is to be asked to explain or justify transfusions questioned by QA and Peer review. After a final review of all available material, the TUC submits repetitive or unusually serious incidents to clinical department chairs or to appropriate committees concerned with medical practices, credentials, etc. Conclusions may be placed in privileging file.

6. Assessment.

a. After a review of all the data (statistical and peer review), the TUC assesses the facility's performance and effectiveness in:

- (1) Blood ordering practices for all categories of blood and blood components,
- (2) Minimizing wastage of blood components,
- (3) Distribution, handling, use and administration of blood components,

(4) Evaluation of all confirmed transfusion reactions,

(5) Meeting patient's transfusion needs,

(6) Informing patients and physicians in a timely manner and confidential manner of possible infectious disease transmission, and

(7) Other assessments, as applicable:

(a) Review of policies for informed consent,

(b) Release of directed donor unit,

(c) Outpatient and home transfusion,

(d) Therapeutic aphaeresis,

(e) Use of cell-saver devices,

(f) Procurement and storage of hematopoietic progenitor cells,

(g) Perioperative autologous blood collection, and

(h) Evaluation of evolving technologies and products.

b. Corrective or preventative actions for identified issues need to be formulated and instituted. Follow-up to assess effectiveness of actions taken is critical. All actions are to be communicated to the Clinical/Medical Board.

7. Strategies to Improve Blood Utilization.

a. Educational programs for medical staff are crucial to the success of the TUC.

b. Implement computer-assisted prospective audit measures by expanding guideline, algorithms, triggers and alerts regarding appropriate ordering practices in the Ordering package.

c. On a regular basis, review and refine "Type and Screen" guideline (T/S), Maximum Surgical Blood Order Schedule (MSBOS), and Standard Blood Order (SBO) to ensure that they reflect local practices and accepted standards of care.

d. Research and implement best practices; example benchmark data on component outdating published by the National Blood Data Resource Center (NBDRC).

e. Participate in Hemovigilance Programs.

8. References.

- a. Guidelines for Blood Utilization Review. Bethesda MD; 2001. AABB, 8101 Glennbrook Rd, Bethesda, MD 20814.
- b. Practice Guidelines for Blood Transfusion: A Compilation from Recent Peer-Reviewed Literature. American Red Cross Biomedical Headquarters. May 2002. 2025 E Street NW, Washington, DC 20006.
- c. Quality Indicators of Blood Utilization. D.Novis et al. Archives Pathology & Laboratory Medicine – Vol 126, February 2002.
- d. Resurgence of the Blood Utilization Committee. Presented at 2005 AABB Annual Meeting. October 17, 2005.

SAMPLE TRANFUSION UTILIZATION COMMITTEE POLICY

Department: Medical Staff Effective Date:

Subject: Transfusion Utilization Review Committee Policy No.

1. POLICY: It is the policy of the ___(insert facility name)___ and its Medical Staff that appropriate review of utilization of blood and blood components takes place on a quarterly basis, at least.

2. PURPOSE: The Transfusion Utilization Review Committee is responsible for:

- a. Assigning oversight of the transfusion utilization review processes.
- b. Developing the policies and practices related to inventory management and blood usage review.
- c. Ensuring safe and effective blood usage based on measurable, predetermined performance criteria.

3. PROCEDURE: The Transfusion Utilization Review Committee, a peer review committee, ensures the appropriate review of utilization of blood and blood components, which must take place at least quarterly. This Committee must include a Chairperson, secretary, blood bank representative, and physician membership representative of the Hospitals Clinical Services with high blood component usage (Anesthesiology, Surgery, Medicine and Emergency Medicine), the physician director of transfusion services, a nursing services representative, a quality management representative, and a hospital administration representative.

- a. This review must be documented; and may be performed, as is appropriate, through a retrospective patient care evaluation mechanism, medical record review, or any other patient specific reviews.
- b. The Committee must review the blood bank summary on their investigation of actual or suspected transfusion reactions.
- c. The Committee must review the monthly and quarterly statistics on blood component usage, wastage and ordering practices. These data are systematically aggregated and analyzed on an ongoing basis with the focus on identifying opportunities for performance or process improvement.