## Self-evaluation of the implementation of Patient Blood Management



To reduce your and our effort, we ask you to fill out the self-assessment form digitally. The necessary calculations can thereby be automated.

Hospital:	
Address:	
Person of contact:	
Position:	
Email:	

This self-assessment form determines the implementation degree of the PBM measures defined in the PBM network and calculates the corresponding PBM level (e.g. silver, gold). In order to be able to make statements relative to the possibilities of the respective hospital, it is first determined whether the measure to be evaluated can be implemented locally at all.

**Measures are considered feasible** as soon as they are theoretically feasible. This also includes measures that have not (yet) been implemented for various (e.g. financial) reasons (e.g. use of point-of-care diagnostics), but which would be beneficial for the patient.

**Measures are considered unfeasible** if there is no theoretical possibility of implementation (e.g. participation of important PBM stakeholders from paediatrics if there is no paediatrics in the hospital or use of MAT in oncological interventions if no oncological interventions are performed in the hospital). Since it is impossible to treat patients of special disciplines in hospitals without corresponding areas, the non-implementation of the special measure does not result in any disadvantage for the patient. Accordingly, the measure is not included in the evaluation.

If the respective measure is unfeasible, please tick the corresponding column. If the measure can be implemented (= feasible), please rate the degree of implementation by ticking the appropriate box: 0 = none / rare (<10%), 1 = moderate (10-50%) or 2 = good / frequent (>50%) implementation. Subsequently, all points are added up and evaluated as a percentage of the maximum number of points resulting from the number of measures that can be implemented. The sum of the percentages results in the achieved PBM level (for details see page 7).

The form can be signed digitally. If you encounter any problems, you can of course also print out the self-assessment form, sign it and scan it.

Please send the completed form to: patientbloodmanagement.kgu@gmail.com

Bundle 1 – General PBM project management	unfeasible	feasible		
Involvement of key PBM stakeholders [role]	ameasible	0	1	2
Local PBM coordinator with protected time [central role for communication, networking, education, documentation, and benchmarking]				
Hospital board of directors (eg, chief medical officer, chief executive officer, chief nursing officer) [support; official decision]				
Surgeons (eg, orthopaedic/trauma, cardiac, vascular, visceral, trauma, urology, neurosurgery [interdisciplinary consensus, practical collaboration]				
Anaesthesiologist/intensive care specialists [interdisciplinary consensus, practical collaboration]				
Transfusion medicine specialists/transfusion committee [prevention of blood wastage, optimal blood use, changes in donor blood management]				
Internists/gastroenterologists/hematologists/cardiologists/nephrologists [Anaemia management, optimal blood use]				
General practitioners/family doctors [determine the necessity for elective surgery, assign patients to a hospital, preoperative anaemia management]]				
Patient`s representative [need to be informed about the different alternatives to treat anaemia/create awareness				
Paediatrics mainly refers to blood conservation strategies]				
Central laboratory/laboratory scientists [number and amount of blood sampling, smaller blood collecting tubes]				
Pharmacists/purchasing department [introduction of new drugs for the management of anaemia and coagulopathy]				
Information technology department [sampling of routine data and key performance metrics]				
Finance department [finance experience for program budget plan, initial project costs; hospital-wide cost savings]				
Quality management [project management experience; PBM as a fixed part of a quality improvement initiative]				
Public affairs [dissemination channels/marketing of the PBM project (eg, via journals/Intranet/e-mails/posters/roll-ups/press]				
Undergraduate and postgraduate education				
Undergraduate education (nursing school/medical school)				
Postgraduate education of physicians and clinicians (lectures, workshops; initial and yearly)				
Postgraduate education of nurses (intensive care unit, normal ward; initial and yearly)				
Certification (eg, by online E-learning courses) - to enhance PBM education				
Local standard operating procedures/protocols				
Standard operating procedures for PBM				
Anaemia management				
Coagulation management				
Blood conservation				
Optimal blood use/transfusion of blood products (list of index procedures for "type and screen" or "type and crossmatch (and supply)")				
Massive haemorrhage protocols (including such as damage controlled surgery, arterial				
embolization, haemotherapy algorithm)				
Massive haemorrhage (in general)				
Postpartum haemorrhage				
Trauma-associated haemorrhage				
Cardiac surgery-associated haemorrhage				
Bundle 1 – Subtotal				

Bundle 2 – First strategy: Manage the patient's anaemia		feasible		
Preoperative management of anaemia (subgroup of surgical patients)	unfeasible	0	1	2
Diagnosis of anaemia				
Identification of anaemic patients (screening), especially surgeries with relevant transfusion risk >10%				
Diagnosis of iron deficiency anaemia (eg, blood count, ferritin, transferrin saturation, calculation of the individual iron deficit)				
Diagnosis of vitamin B <sub>12</sub> or folic acid deficiency				
Extended diagnostic of anaemia (eg, consultant for gastroenterology, endoscopy; haematology, bone marrow biopsy)				
Diagnosis of anaemia ideally 3-4 weeks before surgery				
Diagnosis of anaemia although time to surgery is shorter than 3-4 weeks				
Anaemia clinic; anaemia/PBM nurse				
Treatment of anaemia				
Administration of intravenous iron				
Administration of vitamin B <sub>12</sub> and/or folic acid				
Administration of erythropoietin				
Optimizing cardiovascular and pulmonary function to improve tolerance of anaemia				
Increase of oxygen delivery (increase of inspiratory oxygen concentration); decrease of oxygen consumption				
Haemodynamic monitoring in high-risk procedures/patients (normovolaemia, optimization of cardiac output)				
Management of anaemia in hospitalized patients and/or after surgery				
Diagnosis of anaemia				
Diagnosis of iron deficiency anaemia				
Treatment of anaemia				
Administration of intravenous iron				
Administration of vitamin B <sub>12</sub> , folic acid and / or erythropoiesis-stimulating agents				
Bundle 2 – Subtotal			•	-

Bundle 3 – Second strategy: Interdisciplinary blood conservation modalities		feasible		
Reduction of diagnostic-associated blood loss	unfeasible	0	1	2
Restrictive frequency of blood collection				
Appropriate timing of postoperative blood tests and not daily judicious use / "weekend" plan				
Reduced size of blood collection tubes			<u> </u>	1
EDTA (eg, 1.8 ml), citrate (eg, 1.8 ml), lithium-heparin/serum (eg, 2.5 ml)				
BGA (eg, 1 ml)				
Type and screen tubes (z.B. 5 ml)				
Reduced sampling for blood cultures in daily routine (limit to established indications)				
Closed in-line flush devices (arterial pressure transducer systems, central venous blood				
Reduction of surgery-related blood loss (subgroup of surgical patients)				
Extreme attention to minimize blood loss (eg, diathermy for tissue dissection), haemostatic adjuncts				
Laparoscopic surgery/minimal invasive techniques/modern surgical instruments				
Controlled hypotension (if no contraindication is present)				
Autologous blood collection and retransfusion (cell salvage) – perioperatively				
Non-oncological procedures: if expected blood loss >500 mL				
Oncological procedures: if massive blood loss				
Oncological procedures: if expected blood loss >500 mL (radiation of washed blood; filtration using leukocyte depletion filters)				
Limited numbers of swabs for blood absorption/swab washing and cell salvage ("single swab")				
Cardiac surgery (as special area)				
Small extracorporeal circuits (priming volume <1.2 L; 3/8" lines; minimized extracorporeal circuits)				
Extracorporeal circuits (retrograde autologous priming; blood cardioplegia, modified ultrafiltration/haemofiltration)				
Bloodless saphenous vein graft removal/immediate wound closure/endoscopic vein removal				
Preoperative management of coagulopathy				
Questionnaire/tests of haemostasis				
Algorithm for management of patients with oral/parenteral anticoagulation and/or antiplatelet therapy				
Haemostasis management in hospitalized patients			,	,
Use of a coagulation algorithm for administration of blood products, clotting factor concentrates, tranexamic acid				
Physiological conditions of haemostasis				
Body temperature >36°C (normothermia), pH >7,2 / Ca <sub>i</sub> <sup>2+</sup> >1,1 mmol/l				
Point-of-care diagnostic in coagulopathy				
Coagulation system (eg, viscoelastic methods)				
Platelet function (eg, aggregometric methods)				
Empiric administration of tranexamic acid in certain procedures (particular in cardiac, orthopaedic, transplant surgery, massive haemorrhage)				
Empiric therapy of platelet dysfunction (eg, desmopressin)		ш	ш	

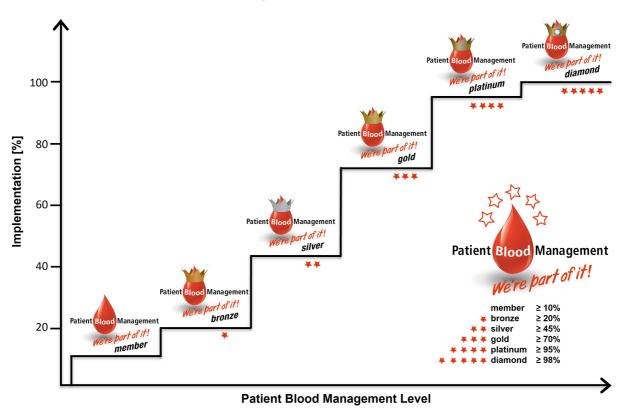
Bundle 4 – Third strategy: Optimal blood use with patient-centred decision making	unfeasible	feasible		
Patient-centred decision making		0	1	2
Individual PBM plan with transfusion triggers based on the patient's risk profile/tolerable erythrocyte deficit				
Written patient information form/informed consent for allogeneic blood products (in emergency after transfusion)				
Intelligent electronic ordering system for blood products (including patient's lab results, alert function)				
Clinician who ordered blood products can be identified (important for feedback and audit)				
Indication list for each of the following hemotherapy products (eg, pocket card, posters etc)				
RBC units				
Platelet concentrates				
FFP units				
Coagulation factors (prothrombin complex concentrate, fibrinogen, recombinant VIIa, recombinant XIII)				
Single-unit policy (RBC units, platelet concentrate)				
Documentation of the indication for each of the following hemotherapy products (eg, by paper-/electronic-based ordering				
RBC units				
Platelet concentrates				
FFP units				
Coagulation factors (prothrombin complex concentrate, fibrinogen, recombinant VIIa, recombinant XIII)				
Use of dosage for blood components instead of units				
Bundle 4 – Subtotal				

Bundle 5 – PBM-related metrics/patient's outcome/benchmark	unfeasible	feasible		
PBM-related metrics	uilleasible	0	1	2
Anaemia - itemized for each department with percentage of patients		•	•	
Preoperative anaemia				
Hospital-acquired anaemia				
Treated anaemic patients (eg, parenteral iron, vitamin B <sub>12</sub> , folic acid, erythropoiesis-stimulating agents)				
Use of blood conservation techniques - itemized for each department with number of units and percentage of patients				
Use of haemostatic agents (tranexamic acid, desmopressin)				
Use of cell salvage				
Haemotherapy product use - itemized for each department with number of units/dosage and percentage of patients				
Blood products (RBC units, platelet concentrates, FFP units)				
Coagulation factors (prothrombin complex concentrate, fibrinogen, recombinant VIIa, XIII)				
Transfusion episodes where a single unit of RBCs/platelet issued				
Indications for blood product use - mean pretransfusion levels (haemoglobin, platelet count, INR)				
Blood product use that falls outside of hospital or professional transfusion guidelines				
Blood wastage - number of units				
Crossmatch (supply) / transfusion ratio (aim: as low as possible, ratio 1.7:1)				
Discarded blood products (RBC units, platelet concentrates, FFP units)				
Report to clinicians/administrative departments about PBM-related metrics (once a year)				
Patient's outcome				
Haemovigilance (transfusion reactions, transfusion-associated cardiac overload, TRALI)				
Mortality (in-hospital)				
Morbidity (eg, ICD-10 codes)				
Infections (sepsis, pneumonia), acute renal failure, acute myocardial infarction, acute ischemic stroke				
Length of stay in hospital/intensive care unit				
Benchmarking				
Internal/external benchmarking (eg, for selected surgical procedures)				
Membership of a PBM network				
Program budget for PBM				
Initial/ongoing project costs (personnel resources, dissemination); PBM-related cost savings (reduced blood products, laboratory analyses)				
Hospital audit for PBM				
Participation in hospital audit for PBM practice and transfusion decisions in a sample of scheduled cases				
Hospital accreditation for PBM				
Participation in a hospital certification (accreditation) program				
Bundle 5 – Subtotal				

## **Summary**

	Number of measures (total)	Maximum score (total)	Number of feasible measures (local)	Maximum score (local)	Score achieved (local)	Relative degree of implementation
Bundle 1	27	54				%
Bundle 2	15	30				%
Bundle 3	25	50				%
Bundle 4	14	28				%
Bundle 5	22	44				%
Sum	103	206		_		%

## Patient Blood Management



Place, Date Name, Stamp Signature

## **Questions & Comments**