2013

Blood Transfusion in Elective Total Hip and Total Knee Arthroplasty Patients

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Plan

In January, 2012, the Bone and Joint Center leadership and surgeons from the Disease Specific Care Core Team discussed blood utilization in total hip arthroplasty (THA) and total knee arthroplasty (TKA) patients. Transfusion rate seemed high and standard of care seemed inconsistent between providers. This resulted in further discussion with orthopedic surgeons and nursing staff to get insight from their practice.

Common variation in practice included transfusing one unit at times and two at others, not transfusing with a consistent hemoglobin goal (some providers would order blood transfusion with a hemoglobin of 9.0 and some would not order a transfusion with a hemoglobin of 7.6, with patient symptoms also differing).

Autologous blood donation was common, and patients would sometimes receive the blood during their inpatient stay, regardless of their hemoglobin or symptoms which may or may not have warranted a transfusion.

Review of evidence, along with a multidisciplinary approach of directly involving the pathology department demonstrated a recommendation of <3% blood utilization for this patient population.

Do

A protocol was created, which included a transfusion based on patient symptoms, transfusing one unit instead of two, and a hemoglobin threshold of 7.0 or less. This protocol was initiated with the intent of providing structure to the providers and nurses, with clinical rationale and a standardized approach to blood transfusion in a mostly elective patient population.

Staff and provider education started in January with discussions of evidence, and formal education completed prior to initiation of protocol.

Initiate protocol August, 2012

Check

Total Joint Specialist and core team evaluated specific patients who did receive blood, to determine whether or not protocol was used, to address our performance improvement goal of providing standardized care for these two patient populations.

Costs of blood transfusion evaluated

Indirect cost of preparation and storage, nursing time, retrieval time along with evidence discussing introduction of blood from external source, increases risk of reaction and error.

Direct cost

- $495.00 each unit of autologous blood “handling fee”, $1346.38 autologous storage fee, $474.25 transfusion fee (total of $2315.63 per unit of autologous blood direct cost, when given to a patient, who may not necessarily need it)
- $474.25 transfusion fee for blood bank unit direct cost
- 50 autologous blood units for elective THA and TKA patients for FY 2012 = $115,781.50 direct unit cost, $305 supply cost. Our last autologous unit transfused was in June, 2012.
- 202 non-autologous blood units for elective THA and TKA patients for FY 2012 = $95,798.50 direct unit cost, $1232.20 supply cost. FYTD 2013 through March, 2013 = 92 units, projection for FY 13 end of 122 units when modeled from first three quarters, 80 units less.

Discussions with surgeons, hospitalists at follow up meetings and individual meetings.

Few minor changes made and communicated to all nursing staff, providers and same meeting groups.

Act

Bone and Joint Clinical Utilization committee evaluates transfusion rate on a monthly basis, results shared quarterly with Department of Orthopedics and Total Joint Steering Committee.

Rate for TKA patients has consistently averaged 5%, rate for THA patients has decreased from an average of 23.3% to <10%.

Protocol initiated for all other orthopedic order sets November, 2012

References


PROJECTED DIRECT COST SAVINGS FOR FY 2013

$116,086.50 IN AUTOLOGOUS BLOOD USAGE

$40,088 IN BLOOD BANK PRBCs

TOTAL $156,174.50

*indirect costs of nursing and pathology staff time not included