

Reducing Inappropriate Blood Transfusion in Stable CKD Anemia: Management Stewardship

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ABSTRACT

Background: Inappropriate transfusions in patients with stable anemia due to chronic kidney disease (CKD) pose serious safety and resource concerns. This study aimed to evaluate and implement a transfusion stewardship program to reduce unnecessary transfusions while maintaining patient safety.

Objective: To evaluate the effectiveness of a structured transfusion stewardship program in reducing inappropriate blood transfusions among patients with stable CKD anemia while maintaining clinical safety.

Methodology: A prospective interventional quality improvement study was conducted in the Department of Nephrology at Ayub Teaching Hospital, Abbottabad, Pakistan, over 12 months from January 2025 to December 2025. A total of 150 adult patients with CKD stages 3–5 and stable anemia (hemoglobin 8–10 g/dL) were enrolled using stratified random sampling. Baseline transfusion practices were assessed before implementing a stewardship intervention comprising clinician education, audit and feedback, and electronic decision support tools. Data were analyzed using SPSS version 26.0. Continuous variables were expressed as mean $\pm$ standard deviation, while categorical variables were presented as frequencies and percentages. Pre- and post- intervention outcomes were compared using paired t- tests and chi- square tests, with $p < 0.05$ considered statistically significant.

Results: Among 150 participants, 88 (58.7%) were male, and the mean age was 49.6 ± 12.8 years. At baseline, 120 (80.0%) patients received blood transfusions, of which 50 (33.3%) were considered inappropriate. Following implementation of the stewardship program, inappropriate transfusions decreased significantly to 15 (10.0%) ($p < 0.001$), while appropriate transfusions increased from 46.7% to 60.0%. The average number of transfused units per patient declined from 2.25 ± 0.9 to 2.1 ± 0.7 , without compromising hemoglobin stability (8.8 ± 0.4 vs. 8.9 ± 0.3 g/dL, $p = 0.18$).

Conclusion: The transfusion stewardship program was an effective intervention that led to greater transfusion appropriateness, fewer unnecessary transfusions, improved resource utilization, and greater hemoglobin stability. Education, audits, and decision support are key interventions that can improve patient safety in the management of stable CKD anemia.

INTRODUCTION

Chronic kidney disease (CKD) is a significant public health issue worldwide, characterized by high morbidity and mortality, as well as progressive loss of kidney function. One of the most prevalent complications of CKD is anemia, caused mainly by low levels of erythropoietin, iron deficiency, chronic inflammation, and a shortened lifespan of red blood cells. If left untreated, anemia leads to fatigue, diminished quality of life, cardiovascular events, frequent hospitalizations, and poor clinical outcomes [1]. Iron replacement and erythropoiesis- stimulating agents (ESAs) are key components of anemia management in CKD. In the absence of severe anemia with symptoms, and when clinically necessary for rapid hemoglobin correction, blood transfusion is restricted to selected patients [2]. However, over- and/or inappropriate transfusion can cause patient transfusion reactions, iron overload, all immunization, transmission of infectious diseases, and added healthcare costs. Additionally, multiple transfusions can increase the risk of future kidney

transplantation failure due to HLA sensitization [3,5]. International guidelines, including those from the Kidney Disease: Improving Global Outcomes (KDIGO) and the Association for the Advancement of Blood and Biotherapies (AABB), recommend restricted transfusion policies and caution against using hemoglobin concentration alone as the basis for transfusion decisions [6]. Despite these recommendations, many healthcare settings continue to use inappropriate transfusion practices due to poor compliance, limited clinician awareness, and a lack of standardized transfusion protocols [7,9]. Transfusion stewardship programs have become successful quality improvement initiatives that encourage evidence- based practices by providing clinician education, periodic audits and feedback, and clinical decision support systems. These interventions have been shown to minimize unnecessary blood transfusions, enhance patient safety, optimize blood product use, and reduce healthcare expenditures. However, the practice and effectiveness of transfusion stewardship in the specific context of patients with stable CKD anemia are not well

documented, especially in low- resource healthcare environments [10]. A structured transfusion stewardship program was therefore implemented, and this Quality Improvement Project (QIP) was undertaken to assess its effectiveness in reducing inappropriate blood transfusion rates among patients with stable CKD anemia while ensuring patient safety and adherence to evidence- based transfusion guidelines.

METHODOLOGY

Study Design

A prospective interventional Quality Improvement Project (QIP) was conducted to evaluate the effectiveness of a structured transfusion stewardship program in reducing the rate of inappropriate blood transfusion among stable, anemic patients with chronic kidney disease (CKD).

Study Setting and Duration

The study was conducted in the Department of Nephrology at Ayub Teaching Hospital, Abbottabad, Pakistan, over 1 year from January 2025 to December 2025.

Study Population

Adult patients with CKD stages 3-5 who had stable anemia and were receiving routine nephrology outpatient care were included in the study.

Sample Size

The sample size was calculated using the WHO Sample Size Calculator assuming a 95% confidence level, 80% study power, and an anticipated 20% reduction in inappropriate blood transfusions following implementation of the stewardship intervention. Based on these assumptions, a minimum sample of 150 participants was required.

Sampling Technique

Patients were recruited using stratified random sampling to ensure adequate representation across CKD stages and treatment groups.

Inclusion Criteria

1. Adult patients (18 years old and above).
2. Has been diagnosed with CKD stages 3 – 5.
3. Stable levels of anemia (Hb 8-10g/dl).
4. Conservative Management, Iron Therapy, or Erythropoiesis-Stimulating Agent (ESA) Therapy.
5. Willingness to take part and written informed consent.

Exclusion Criteria

1. Bleeding/hemorrhage.
2. Emergency blood transfusion needed due to hemodynamic instability.
3. Acute Infection or Sepsis.
4. A blood malignancy that needs to be treated with multiple blood transfusions.
5. Pregnant women.

6. Patients who did not accept participation.

Intervention

The intervention included clinician education sessions, dissemination of KDIGO and AABB transfusion guidelines, audit and individualized feedback, and electronic clinical decision-support reminders (CDSRs) integrated into routine transfusion practice.

Data Collection

Standardized data collection proforma was used to gather data. Patients' medical records and the hospital electronic health record system were used to obtain baseline demographic data, CKD stage, hemoglobin level, usage of an erythropoiesis-stimulating agent (ESA), iron therapy, transfusion history, number of blood units received, and transfusion indications. The appropriateness of each transfusion episode was evaluated using the Kidney Disease: Improving Global Outcomes (KDIGO) and the Association for the Advancement of Blood and Biotherapies (AABB) transfusion guidelines. The same variables were reassessed after the stewardship intervention to assess changes in transfusion practices.

Statistical Analysis

All data were input and analyzed with IBM SPSS Statistics version 26.0 (IBM Corp., Armonk, NY, USA). Data were continuously presented as mean $\pm$ standard deviation (SD) for continuous variables and as frequencies and percentages for categorical variables. Continuous variables were compared before and after the stewardship intervention using a paired t-test, and categorical variables were compared with a chi-square test. A p-value < 0.05 was considered statistically significant.

Results

A total of 150 patients with stable anemia due to chronic kidney disease (CKD) were included in the study. Baseline demographic and clinical characteristics are presented in Table 1. Among the participants, 88 (58.7%) were male, and 62 (41.3%) were female. The majority of patients were aged 46–60 years (41.3%), followed by 31–45 years (32.0%). Regarding CKD severity, 62 (41.3%) patients had Stage 4, 55 (36.7%) had Stage 3, and 33 (22.0%) had Stage 5. Baseline transfusion practices are summarized in Table 2. Before implementation of the transfusion stewardship program, 120 (80.0%) patients received blood transfusions. Of these, 70 (46.7%) were considered appropriate, whereas 50 (33.3%) were classified as inappropriate. The mean number of blood units transfused per patient was 2.5 ± 0.9 . Factors associated with inappropriate blood transfusions are shown in Table 3. The most common contributing factor was lack of awareness of transfusion guidelines (35 cases), followed by hemoglobin level >9.0 g/dL (28 cases), clinician decision without laboratory review (22 cases), and absence of erythropoiesis-stimulating agent therapy (15 cases). Post-intervention transfusion practices are presented in Table 4. The proportion of patients receiving transfusions decreased to 105 (70.0%), while appropriate transfusions increased to 90 (60.0%) and inappropriate transfusions declined to 15 (10.0%). The mean number of blood units transfused per patient decreased to 2.1 ± 0.7 . Comparison of pre- and post-intervention outcomes is shown in Table 5. Inappropriate transfusions were significantly reduced from 33.3% to 10.0% ($p < 0.001$), while the mean pre-transfusion hemoglobin remained stable (8.8 ± 0.4 vs. 8.9 ± 0.3 g/dL; $p = 0.18$). The reductions in inappropriate transfusions and in the mean number of blood units transfused per patient are illustrated in Figures 1 and 2, respectively.

Table 1. Baseline Characteristics of Study Participants

Variable	Frequency (n)	Percentage (%)
Male	88	58.7
Female	62	41.3
18–30 Years	15	10.0
31–45 Years	48	32.0
46–60 Years	62	41.3
>60 Years	25	16.7
CKD Stage 3	55	36.7
CKD Stage 4	62	41.3
CKD Stage 5	33	22.0

Baseline demographic and clinical characteristics of patients enrolled in the transfusion stewardship Quality Improvement Project (QIP).

Table 2. Baseline Transfusion Practices

Variable	Frequency (n)	Percentage (%)	Average Units per Patient
Total Patients Transfused	120	80.0	2.5 ± 0.9
Appropriate Transfusions	70	46.7	-
Inappropriate Transfusions	50	33.3	-

Baseline blood transfusion practices before implementation of the transfusion stewardship program, including the number of patients receiving transfusions, transfusion appropriateness, and the mean number of blood units transfused per patient.

Table 3. Factors Associated with Inappropriate Blood Transfusion

Factor	Inappropriate Transfusions n (%)
Hemoglobin > 9.0 g/dL	28
Absence of ESA therapy	15
Clinician decision without lab review	22
Lack of guideline awareness	35

Clinical and practice-related factors associated with inappropriate blood transfusions among patients with stable CKD anemia before the implementation of the stewardship intervention.

Table 4. Post-Intervention Transfusion Practices

Variable	Frequency (n)	Percentage (%)	Average Units per Patient
Total Patients Transfused	105	70.0	2.1 ± 0.7
Appropriate Transfusions	90	60.0	-
Inappropriate Transfusions	15	10.0	-

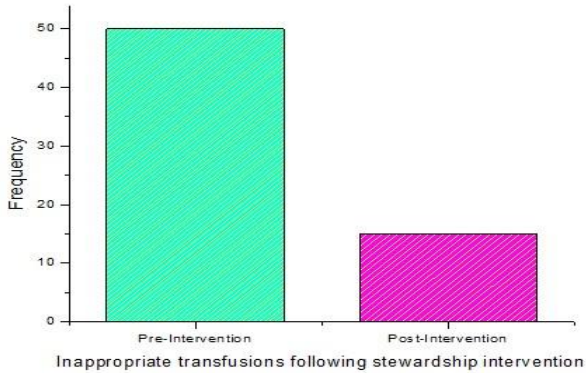
Blood transfusion practices following implementation of the transfusion stewardship program, including the frequency and appropriateness of transfusions, and the mean number of blood units transfused per patient.

Table 5. Comparison of Pre- and Post-Intervention

Outcome	Pre	Post	p-value
Patients receiving transfusion	120 (80%)	105 (70%)	0.041
Inappropriate transfusion	50 (33.3%)	15 (10%)	<0.001
Hb	8.8±0.4	8.9±0.3	0.18
Units/patient	2.5±0.9	2.1±0.7	0.02

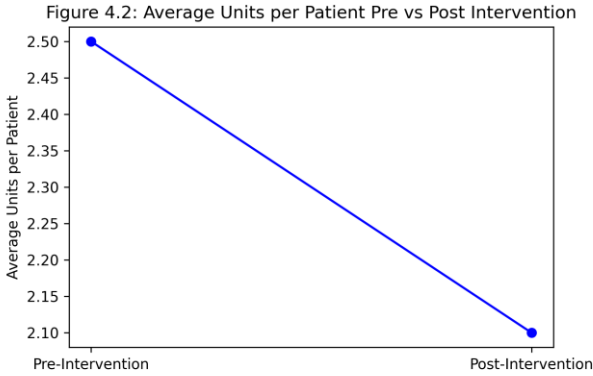
Comparison of transfusion-related outcomes before and after implementation of the transfusion stewardship program, including transfusion rates, inappropriate transfusions, pre-transfusion hemoglobin levels, and mean number of blood units transfused per patient.

Figure 1. Comparison of inappropriate blood transfusions before and after implementation of the stewardship program.



Comparison of inappropriate blood transfusions before and after implementation of the transfusion stewardship program among patients with stable CKD anemia.

Figure 2. Comparison of the mean number of blood units transfused per patient before and after implementation of the transfusion stewardship program.



Comparison of the mean number of blood units transfused per patient before and after implementation of the transfusion stewardship program.

Discussion

This Quality Improvement Project (QIP) demonstrated that implementation of a structured transfusion stewardship program significantly improved blood transfusion practices among patients with stable chronic kidney disease (CKD) anemia. Inappropriate transfusion rates decreased significantly after the intervention, and both the transfusion rate and the average number of blood units per transfusion fell. Importantly, these improvements were achieved without reducing pre-transfusion hemoglobin levels, allowing restrictive transfusion strategies to be safely implemented in appropriately selected CKD patients. These findings support previous research showing the benefits of transfusion stewardship programs to support evidence-based clinical practice. Structured stewardship programs (SWP) involving clinician education and the use of decision-support tools resulted in improved transfusion appropriateness and optimized blood utilization, as reported by Napolitano et al. [11]. Likewise, Singh et al. found that patients with CKD anemia had inappropriate transfusion practices and recommended changes in transfusion strategies in line with guidelines to improve outcomes [12]. The observations reflect the value of multi-disciplinary stewardship interventions in optimizing transfusion practices in various healthcare settings. This decrease in inappropriate transfusion observed in this study also aligns with the Kidney Disease: Improving Global Outcomes (KDIGO) clinical practice guideline, which recommends avoiding transfusion and optimizing iron therapy and ESA before initiating transfusion in patients with CKD [13,14]. Improved compliance with these recommendations following the implementation of the stewardship program may have contributed to the reported decrease in unindicated transfusion. One of the main findings of this study was that no adverse effect on hemoglobin stability was observed with reduced transfusion frequency. This discovery indicates that a substantial percentage of baseline transfusions could have been avoided and that evidence-based stewardship can reduce unnecessary exposure to transfusion-related complications without affecting anemia management. The recommendations of the UK Kidney Association and the AABB International Guidelines have reached the same conclusion, urging more restrictive transfusion criteria and a clinical evaluation of the individual patient to ensure safer transfusion practice and minimize unnecessary blood use [15,16]. The results of this project have significant implications for clinical practice, especially in resource-constrained healthcare environments where blood products are limited. Implementation of clinician education, regular audit and feedback, and electronic decision-support systems can help increase adherence to transfusion guidelines, reduce unnecessary healthcare costs, and improve patient safety. These results also align with patient blood management recommendations, which include stewardship-focused strategies to improve transfusion utilization and the use of healthcare resources [17]. There are several limitations of this study. It was performed at a single tertiary care center, and the sample size was relatively small, so the results may not be generalizable. Long-term clinical outcomes (e.g., mortality, hospital readmission, patient satisfaction, and cost-effectiveness) were not assessed during the follow-up period, as this period was limited to the duration of the QIP. In addition, it would not have been possible to assess the individual contribution of each stewardship component without the other. The results of this study warrant further multicenter, large-cohort studies to confirm these findings and establish the long-term sustainability of transfusion stewardship programs in the management of CKD. In summary, this quality improvement initiative demonstrates that a well-designed transfusion stewardship program can significantly reduce inappropriate transfusions while still ensuring patient safety. The results demonstrated that stewardship strategies should be integrated into standard care in the nephrology setting to maximize blood utilization and enhance the quality of care for patients with CKD anemia.

Limitations

The study has several limitations that should be acknowledged. First, this

study was conducted at a single tertiary care hospital, which may limit the generalizability of the results to other hospitals with different patient populations, clinical practices, and resource utilization. Second, some of the data were from a routine EMR, which may have introduced documentation bias and led to missing data. Furthermore, the Hawthorne effect could have influenced clinicians' behavior during the intervention period, potentially increasing adherence to the transfusion guidelines for a short time.

CONCLUSION

Implementation of a structured transfusion stewardship program improved adherence to evidence-based transfusion guidelines, reduced inappropriate blood transfusions, and optimized blood utilization without compromising patient safety. These findings support incorporation of transfusion stewardship into routine nephrology practice.

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AUTHORS' CONTRIBUTION(ICMJE)

Kainat Bibi: Conceptualization, data collection, data analysis, manuscript drafting, and interpretation of results.

Salman Sher: Study conception and design, supervision, critical revision of the manuscript for important intellectual content, and data interpretation.

Sayed Aisha Bahar: Data interpretation, critical review of the manuscript, and methodological input.

All authors reviewed and approved the final version of the manuscript and agree to be accountable for all aspects of the work in accordance with the **ICMJE authorship criteria**.

Ethical Approval: This project was conducted as a Quality Improvement Project (QIP) designed to evaluate and improve routine clinical practice. According to institutional policy, formal Institutional Review Board approval was not required because no experimental intervention was introduced and patient care was not altered. Patient confidentiality was maintained through anonymization of all collected data, and the project was conducted in accordance with the ethical principles of the Declaration of Helsinki.

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