NI Transfusion Committee
Draft Minutes of Meeting 5 June 2015
Date of issue: 12 June 2015

Apologies:
Alison Geddis, Quality Manager, BHSCT
Dr Sheena Gormley, Consultant Anaesthetist, BHSCT
Bronagh O'Neill, HP WHSCT
Patricia Mackey, HP, SEHSCT
Elma McLoughlin, HP, SEHSCT
Dr Philip Windrum, Consultant Haematologist, NHSCT
Carmel McCaughern, HP, NHSCT
Tom McFarland, BMS SHSCT
Dr Elizabeth Reaney, DHSSPS
Audrey Savage, BMS, BHSCT
Graham Scott, BMS, SHSCT

1. Present:
Dr Susan Atkinson, Consultant Anaesthetist, BHSCT (Chair) - SA
Catriona Briers, Lead Nurse CNRRS, SEHSCT
Dr Damien Carson, Cons Anaesthetist, SEHSCT (Audit & Implementation Lead) – DC
Sinead Carty, BMS, SEHSCT
Adrian Crawford, BMS, WHSCT
Helen Gilliland, Consultant Anaesthetist, BHSCT
Carol Anne Henry, BMS, NHSCT
Dr Don Hull, Consultant Haematologist, SHSCT - DH
Kathryn Maguire, Consultant Haematologist, NIBTS
Jo Monaghan, HP, WHSCT
Veronica McBride, WHSCT
Aine McCartney, Regional HP Coordinator - AMcC
Mary P McNicholl, HP, WHSCT
Patricia Watt, HP, SHSCT

2. Minutes of NITC Meeting 23 January 2015
Amended minutes, previously circulated. Additional amendment request:
5.3 Regional Kleihauer request form: "Several Trust representatives expressed an interest in pilot participation"
6. 2nd Action point: SA to circulate flowchart produced by SHSCT", not WHSCT

3. Matters arising
3.1 BBT3 (NI) Revision to account for updated risk assessment of transfusion transmitted vCJD
A letter has been drafted for CMO issue to Trusts. The BSO Laboratory system, which is used in all Trusts except for BHSCT, allows determination of cumulative patient donor exposure for all transfusions in one Trust. It can therefore alert users when a patient has received blood components and products from 300 or more donors. There was discussion about investigating the possibility of including an alert on a patient's ECR in such a circumstance.

4. Standardization of Transfusion related documentation
4.1 Regional Kleihauer request form pilot
Four Trust Maternity Units and Transfusion Teams have accepted the opportunity to participate on this pilot, which will run for a 4-6 week period in June-July 2015.

4.2 Regional Bloodless Pathway documentation

SA has forwarded to DHSSPS Legal Team for final approval, at the request of the Advisory Committee on Blood Safety.

4.3 Updated Regional Transfusion Request form
Martin Chadwick has informed SA that Regional Supplies has a stock of the revised request form. A total of 8,000 pads of this version should be sufficient for approximately 18 months.
Action: A.McC to set up a meeting of BMS and HPs to review transfusion history information.

4.4 Transfusion record
All Trusts now have a transfusion record. Some Trusts have audited the use of these records and found compliance in entry of a minimum dataset to be very good.
Action: A regional audit of use of transfusion records is to be coordinated by the NITC in approximately 6 months time, looking particularly at patient consent and patient information sections.

Lynne Charleton, Head of Nursing, Quality Safety and Patient Experience has enquired about the possibility of a regional transfusion record for the Quality 2020 initiative. Fionnuala Lennon has informed Lynne of all the transfusion related documentation which has already been standardized regionally.
Action: The NITC will agree a regional template for Trust based transfusion records and work towards regional standardization of this documentation.

5. Audit subgroup – report given by DC
5.1 NITC Regional audit of platelet transfusions
HPs are distributing the 4-page audit summaries during educational sessions in their own Trusts. The final full report of this audit is in the final proof reading stages before printing.

5.2 NITC Regional Audit of appropriate use of Anti-D Immunoglobulin
DC stated that substantial data cleaning has been required due to a number of key questions being left blank, requiring back filling from later answers when possible. Data analysis is now well underway. Key themes for improvement will be in the areas of documentation, dosing, timing of dose and consent. The timelines for the progress of the audit were outlined and a draft report of the live births and still births section is to be circulated in July for consultation and final drafting in October.
It is anticipated that a 4-page summary report will be available for the NITC's educational conference in November and a full 30-page report, highlighting the key themes will follow soon after. A full data report on the 150+ questions across the two audit groups will also be made available in a pdf type format to inform all of the data return.

5.3 National Comparative Audit (NCA)s
Three NCA audits have recently been published on the NCA website. There are links to these and all other NCA audits from the nitransfusion.com website.

5.4 START (Supporting Trust Audit Related to Transfusion)
The NITC START initiative continues to progress with 8 projects so far across the region. Four of these have completed at least one audit cycle, three others are progressing well and there has been one new start in the last month. This activity is in addition to other transfusion audits which are being overseen by haemovigilance, laboratory and medical staff. The sum total represents a healthy state of audit activity and interest in transfusion practice throughout the region.
The NITC is prepared to assist with advice on additional projects – particularly those concerning transfusion practice in Obstetrics or Paediatrics, ahead of the upcoming regional conference in November 2015.

5.5 Blood component and product issues

Red cell use continues to fall with the launch of each new NITC initiative; the 12-month moving average is now below 27 units per 1000 of the population. FFP use also continues to decrease yearly and is currently 2.4 units per 1000, while cryoprecipitate remains steady between 0.5 and 0.6 units per 1000.
Immunoglobulin use: there was an average yearly 13.8% rate of increase in the 4 years before the NITC was founded. After the NITC Audit there was a 2-year period of stabilization in 2011/12 and 2012/13 when the increase was only 2% and 0.1% respectively.
In the last two years regional issues of Ig G have climbed, with a 5.7% regional increase in 2013/14 and 17.4% increase in 2014/15. This increased use is of concern and the NI Healthcare Commissioners have indicated a need to ensure that this product is being used appropriately.

6. Education in Transfusion Practice

6.1 Anaemia posters and 4-page leaflets for Pre-assessment Clinics, Endoscopy Suites and Primary Care

SA thanked Members and other stakeholders for feedback on these. Amended versions are being sent to the GAIN printers. They will also be located on the NITC and GAIN websites.
Action: SA to apply to pcintranet.east@hscni.net to request 4-page leaflet and Primary Care poster are loaded onto http://primarycare.hscni.net/

6.2 E learning in Blood Transfusion and RPRB Competencies

Following consultation with the regional Haemovigilance Team, AMcC has identified the inter Trust variances in requirements for NPSA RPRB knowledge and competencies in transfusion practice.
Members agreed that it would be beneficial to have dedicated E- learning modules for staff only involved in sampling or prescribing; these may be produced by the Learn Blood Transfusion Editorial Board (AMcC represents NI on this). At present it is recommended that Prescribers complete clinical module 2 and Samplers complete part of module 1.
Currently nurses undertake e-learning module 2 and doctors complete module 2 +/- 1.
AMcC's proposal for each Trust to have a designated HP with administrative access to Learn Pro was considered a positive step, to ensure that Healthcare Professionals who move between the Trusts have only one current registration on the Learn Pro site and that locum medical staff are registered.
It was agreed that changing from 18-month to 3 yearly knowledge updates, along with relevant 3-yearly competency assessments would facilitate staff compliance and administrative monitoring and that NPSA Assessors should recertify at least every 3 years. NITC members agreed that relevant 3-yearly competency assessments should continue in NI, (in contrast to England and Wales) since there will always be local Trust differences in transfusion practice procedures and regional request forms will continue to be updated.
AMcC also proposed that the competency assessments should be standardized and that a generic certificate of competency should be produced.
Members present discussed the current Trust mechanisms for issuing temporary desist from practice notices following repeated minor or single serious sampling errors. Regional consensus on this would be beneficial.

Action: AMcC to send out a table of recommendations for regional standardization of RPRB knowledge and relevant competencies for different Healthcare Professional groups to NITC Members for feedback.

AMcC and SA met one of the Safe2Care Directors on 29th May about the provision of mandatory NPSA RPRB knowledge and competency training for Nursing Agency staff. A number of options were discussed and a response from Safe2 Care is awaited. A mechanism for similar training of locum medical staff has not yet been standardized regionally.

6.2 Education conferences

The next regional one-day conference Transfusion Practice in Obstetrics and Paediatrics is being organized for November 2015 in the Quality Improvement and Innovation Centre on the Ulster Hospital site. Short presentations and posters on local audits or surveys relating to Transfusion practice in

Obstetrics and Paediatrics are welcome. SA requested suggestions for a venue and theme for the following conference in Spring 2016.

6.3 NITC Web page: www.nitransfusion.com
This web site continues to expand in content. Past and current NITC agendas and minutes are now available to review, in addition to presentations and posters from NITC educational conferences. AMcC is planning to produce a Haemovigilance Team section. The platform is available on desktop, tablet and smartphone. There have been 2228 visitors to date in 2015 – averaging over 440 per month.

7. Haemovigilance Team – report given by AMcC
AMcC reported a temporary HP staffing shortage in BHSCT: 2 out of 3 Band 7 on Maternity leave, an interview process for a temporary Band 7 post is pending. Funding for the unfilled 0.5 WTE Band 7 post has been identified, which may be utilized to provide administrative support for the BHSCT HP team.
AMcC is currently providing the only HP input for NHSCT; a Band 7 post is to be replaced and the remaining staff are on sick or maternity leave. The other 3 Trusts have full HP compliment.
An internal business case for funding for administrative support for the HP team in WHSCT has not been approved due to unavailability of funding.

AMcC represents NI on the UK Cell salvage Action Group and the Learn Blood Transfusion Editorial Board. She also reported that the JPAC Transfusion Guidelines are being updated and that the latest "Transfusion Practitioner" Newsletter includes an article on the regional Transfusion Practice for Healthcare Teams educational symposium, which took place in SEHSCT in February 2015.

8. NITC report for Advisory Committee meeting 17 April 2015
AMcC, DC and SA attended this meeting on behalf of the NITC and the Regional HP Team.
DC gave a report of the findings of the regional platelet audit and an update on the regional Anti D audit, the START initiative and the nitransfusion.com website.
SA reported on the NITC progress to standardize regional transfusion related documentation, including the updated transfusion request form, a new Kleihauer request form, hospital transfusion records and the bloodless pathway.
The Advisory Committee was also informed of the NITC work to promote education in transfusion practice, including conferences, 4-page leaflets and posters on the management of anaemia and appropriate use of platelet transfusions.
The proposed NITC work plan for 2015/2016 includes completion and launch of the Anti D audit report and supporting a regional audit of the use and traceability of Prothrombin Complex Concentrate.
Additional agenda items discussed were hospital patient identification policies and procedures, regional use of Immunoglobulins and the NITC recommendation for a second blood sample to confirm patient blood group prior to transfusion.
NITC Members cited recent examples of duplicate and multiple electronic identification records for given patients, which could result in delays in provision of blood components.

9. Regional use of Ig G
Dr Kieran Morris, Dr Kathryn Maguire, DC and SA have had meetings with the recently appointed Immunoglobulin Pharmacist, BHSCT Pharmacy Manager and the Chair of the BHSCT based IgG Independent Assessment Panel (IAP), following a request from the NI Commissioners to review appropriateness of use of this expensive blood derived product. It is anticipated that BHSCT Pharmacy Department will take over the dispensing for BHSCT, since it is a medicinal product. This will facilitate medicinal governance procedures and monitoring of appropriate use by the IAP. The future dispensing of IgG by Pharmacy Departments in the other Trusts is under consideration.
DH pointed out that it would be essential that any new systems brought in to control the use of IgG should continue to allow 24/7 dispensing for patients with an acute requirement for this product.

10. Blood Bank aspects of transfusion practice

10.1 Blood sampling for transfusion (BCSH Guidelines 2012)

All Trusts have either implemented or are implementing the BCSH recommendation to take a second blood sample to confirm blood group for first time patients, prior to transfusion. The forthcoming BCSH guidelines on transfusion in neonates and children may influence whether or not these patient groups are transfused Group O Rh negative red cells rather than have repeated blood sampling.
Dr Corrigan, Commissioner has recommended that Trusts submit a business case if additional Blood Bank staffing or equipment is required to implement this change in practice.

10.1 Emergency transfer of blood components between Trusts

Different cool boxes are being used to maintain the cold chain for blood components when they are being transported with patients between Trusts. These boxes differ in the duration of cold chain validation and in durability.
Action: AMcC to convene a meeting of stakeholders to develop a regional cold chain process, which meets the approval of all Trust blood banks.

10.2 Paediatric sample tubes. For discussion at a future meeting.

10.3 24/7 Cover for Hospital Blood Banks. The Advisory Committee on Blood Safety was informed (17 April 2015) that some Hospital Blood Banks anticipated problems in provision of BMS cover out of normal working hours, in light of the new Royal College of Pathologists recommendations which increase accreditation and experience requirements for independent working of Biomedical scientists. NHSCT has produced a business case to seek an increase in BMS staffing levels, to cover this change in practice. The closure of an "out of hours" service for 2 of the 4 blood banks in BHSCT may facilitate compliant working practice without additional resource.

11. Correspondence

"Visit Belfast" has contacted the NITC to enquire how the NATA organizing committee can be contacted to ascertain whether NATA would like to hold a future annual conference in Belfast.

12. Any other Business

12.1 Draft NICE guidelines on Transfusion are accessible on the NICE website for consultation until 13 July 2015. Comments and suggestions can be forwarded to the NICE Working Group via SA (NITC) or DC (GAIN).

12.2 NITC Financial Matters.

DC highlighted that the NITC does not have a mechanism to deal with any funds itself or to sit under a parent body that could administer funds on its behalf. This significantly impedes NITC activities such as running and liability costs of educational conferences, paying expenses of overseas speakers, organizing printing of audit and educational publications, platform and registration costs of the NITC website. Currently fundraising for each educational event is unpredictable, with the NITC acting as a negotiator between multiple funding sources and multiple creditors. This in turn creates considerable barriers for efficiency, planning and future productivity.
In order to ensure that the NITC has reliable access to funding to run its education programme properly the NITC has investigated the possibility of having a voluntary body to operate alongside the NITC, which would be solely designed and aligned to support the NITC education programme. A registered community interest company (CIC) designed for the specific social purpose of furthering health professional transfusion education for the benefit of patients may be the optimal solution. Further information will be mailed to members over the coming month.

13. Date of next meeting:

NIBTS Lecture Room, Friday 2 October 2015 14.00 – 16.00 hr.