NI Transfusion Committee
Minutes of Meeting 19 May 2017
Date of issue: 6 June 2017

Apologies:
Adrian Crawford, Blood Bank Operational Manager, WHSCT
Don Hull, Consultant Haematologist, SHSCT
Stephen Kane, Blood Bank Manager BHSCT
Alan McKinney, Chair of HTC, WHSCT

1. Present:
Monique Abela, Registrar in Transfusion Medicine, NIBTS
Susan Atkinson, Consultant Anaesthetist, BHSCT (Chair) – SA
Louann Birch, HP SEHSCT
Damien Carson, Cons Anaesthetist, SEHSCT (Medical Audit & Implementation Lead) – DC
Sinead Carty, BMS SEHSCT – SC
Patricia Dunlop, Ass. Specialist in Medicine SEHSCT
Matt Gillespie, Blood Bank Operational Manager, NHSCT
Helen Gilliland, Consultant Anaesthetist and Chair of HTC, BHSCT – HG
Sheena Gormley, Consultant Anaesthetist BHSCT
Aine McCartney, Regional HP Coordinator - AMc
Mary P McNicholl, HP, WHSCT – MP
Jo Monaghan, HP WHSCT
Kieran Morris, NIBTS - KM
Lorna Palmer, HP SEHSCT
Lyndsey Parker, for Stephen Kane, Blood Bank Operational Manager, BHSCT
Shonagh Reilly, HP NHSCT
Graham Scott, Lead Biomedical Scientist SHSCT
Patricia Watt - HP SHSCT

2. Minutes of NITC Meeting 27 January 2017
Approved.

3. Matters arising
Covered in Agenda items.

4.1 Audit sub-group
DC presented the findings of the recently completed regional audit of red blood cells - "Where Does the Blood Go in Northern Ireland?" which has been sponsored by GAIN. The overall number of units transfused (1528) in a 2-week period was 14.5% fewer than predicted from the ongoing downward trend in use of this component. Although the audit design was such that the number of 2-unit transfusions was underestimated it was evident that many patients are still being transfused 2 units and without haemoglobin check before the second unit in 91% of cases. The most common indication for transfusion was anaemia in patients with non-haematological cancer. Most transfusions for gastro-intestinal bleeding were administered to patients with acute rather than chronic blood loss. This audit has set the groundwork for the planned "TRUST" project by demonstrating that there is scope to reduce or avoid transfusion, particularly in orthopaedic and general surgical specialties and in medical patients with iron deficiency anaemia. The draft report of this audit will be sent out to NITC Members for comment and feedback before the final version is shared with Trusts.
Funding of the proposed "TRUST" project has not yet been identified and GAIN has no budget available for 2017/2018 projects.

Action: DC to produce separate audit reports for each Trust.
DC to meet with GAIN to discuss "TRUST" project funding.

4.2 National Comparative Audits

Blood Transfusion in Haematology 2016 report is available on the NCA website.

Data collection has been completed for:

Re-audit of Patient Blood Management in adults

Red cell transfusion in Palliative Care

Data collection is in progress for:

TACO audit

Planned audits:

Re-audit of Red Cell & Platelet transfusion in adult haematology patients – July 2017

Audit of O negative red cells – Autumn 2017

4.3 Audit of Octaplex usage in BHSCT

Collected data is being analyzed.

5. Blood component use

5.1 Component issues

Red cell issues have decreased further, currently at 23.8 per 1,000 head of population. It is difficult to predict whether the current downward trend in demand for platelets will continue, since there were year-on-year increases in platelet issues between 2011/2012 and 2015/2016 financial years and the UK and Ireland Medical Directors consensus is that platelet demand will increase by 2-4% per year until 2022. It may be necessary to increase the proportion of platelets obtained by plasma apheresis (currently 85%) if the supply of buffy coat derived platelets is affected by the ongoing reduction in red cell donations.

The monthly rate of fresh frozen plasma issues is being monitored to see if the recent increase in demand is leveling off.

5.2 HEV negative components

KM stated that routine HEV screening of blood donations will commence on 29 May 2017. Allowing for maximum 35–day storage this means that all red cells issued to Trusts on or after 4th July will have been screened for HEV. In the interim only red cells marked, as being HEV negative, should be transfused to at-risk patients. NIBTS will notify Trusts, NITC Members and Consultants who require HEV negative red cell units for their patients.

5.3 Blood sampling for pregnant patients

KM reported that he has discussed the 72-hour vs. 7-day sampling to transfusion interval with the authors of BSH guidelines (2012) for Pre-transfusion Compatibility Procedures in Blood Transfusion Laboratories. Although the risk of development of atypical antibodies during or pregnancy or following a recent pregnancy is lower than following transfusion the NITC consensus is that Trusts should undertake a risk assessment if they wish to hold Blood Bank samples for pregnant women for 4-7 days instead of 72 hours. The only BSH approved exception is for women with placenta praevia when blood samples can be stored for up to 7 days, unless they have been transfused or have confirmed atypical antibodies. SEHSCT has already changed practice to adopt the 72-hour sampling – transfusion interval during pregnancy or within previous 3 months of a pregnancy.

5.4 Confirmation blood sample prior to transfusion

This BSH 2012 recommendation has now been adopted in all NI Trusts. SA reported that BHSCT theatre teams have expressed concern about emergency provision of red cells when the local MSBOS indicates "Group and Screen" without cross match. In this circumstance clinicians have the option to transfuse Group O negative red cells, take responsibility for transfusing red cells without sending a confirming Blood Bank sample or wait until a second sample has confirmed blood group before transfusing a bleeding patient.

Clinicians in BHSCT have requested that preoperative blood group confirmation should be undertaken for "Group and Screen only " as well as for "Group and Cross match" patients, to simplify recommendations and to reduce the risk of incompatible or delayed transfusion in the event of unexpected major bleeding.

BHSCT Blood Banks differ from other Trusts since they can issue red cells electronically, provided a patient's blood group has been confirmed on a second or a historic sample and there are no atypical antibodies.
NITC members debated this topic and the requirement to revise MSBOS charts, so that they include guidance on blood ordering for patients with low preoperative haemoglobin levels or atypical antibodies.
DC reported that SEHSCT is currently auditing how many "Group and Screen" samples result in red cell transfusion to inform decision-making on changing Trust practice.
Action: Trust Transfusion Committees and Teams to consider undertaking an audit of "Group and Screen" to Red Cell Transfusion in their own Trusts.

6.0 Management of Major Blood Loss protocols – Presentation by KM
KM gave a presentation on the key steps in the management of massive transfusion, including definition, activation protocols, red cell: FFP: platelet packs, doses and transfusion ratios, emergency use of group O positive red cells for males and possibly females post child-bearing age. He also discussed the merits of pre-thawed group A FFP for trauma, tranexamic acid, cell salvage and cryoprecipitate vs. fibrinogen concentrate. Trusts have protocols and local guidelines in place for the management of major haemorrhage, on the recommendation of NPSA rapid Response Reports and BBT3 (NI) but there is variation in the terminology used in these protocols and in the initial provision of multicomponent packs. It was agreed that standardization of protocol terminology would be advantageous for staff working between Trusts; however requirement for red cells, plasma products and platelets is likely to differ for each patient specialty.
The BHSCT Blood Bank and Transfusion Team have been working with RVH Emergency Department to introduce red cells with pre-thawed FFP for major trauma patients.
Action: SA to coordinate subgroup to standardize terminology used in major haemorrhage / massive transfusion protocols.

7.0 Haemovigilance Team - AMc
7.1 Haemovigilance Staffing
AMc reported that all Trust Haemovigilance teams are fully staffed, except for NHSCT with a 0.5 WTE vacancy and SHSCT, which is short of 1WTE. Other haemovigilance items covered in meeting agenda.

8.0 Education and Staff Training
8.1 Course on Non-Medical Authorization of Transfusion
AMc reported that the face-face component has been successfully completed and participants are now required to undertake work-based training with mentors. Candidates are employees in BHSCT (4), NHSCT (1), SEHSCT Home Transfusion (2) and SEHSCT (1), all of whom work with Haematology patients. AMc has been exploring course accreditation options. Trusts are required to ensure that details of accountability and maintenance of competency in authorizing blood by staff completing this course are included in their own policies.

8.2 Right Patient, Right Blood Training and Desist Notices
The regional Haemovigilance Team has reviewed inter Trust implementation of Temporary Desist from Practice Notices (TDPN) against the most recent NITC recommendations. The updated consensus of NITC members is that a TDPN should be issued to a healthcare practitioner if he/she has made 3 minor errors in a 3-month period or 1 major error, following which the individual must repeat knowledge training and relevant competencies before resuming transfusion practice. The healthcare practitioner should be advised after committing 2 minor errors that a 3rd minor error within a 3-month period or 1 major error will result in immediate issue of a TDPN. Following a major (Wrong Blood in Tube) error a healthcare practitioner must demonstrate that they have undertaken additional corrective and preventative action to avoid another major error.

8.3 SAI Learning Letter re TACO
AMc and SA have had meetings with Dr Sartaj and most recently with Dr Carolyn Harper, Medical Director of the Public Health Agency, to discuss what actions should be recommended for Trusts to reduce the risk

of TACO, following the reporting of TACO –related SAIs to SHOT. The lack of a satisfactory national or international definition of TACO, limited evidence base on the recognition and management, likelihood of other confounding factors including non-blood fluid management and pre-existing co morbidities means that it would be difficult to produce regionally standardized guidelines. It was agreed that staff awareness of transfusion-related pulmonary complications should be increased and that SHOT tools to assess and manage patients at risk of TACO should be implemented in Trusts. Dr Harper has requested that the NITC develops a regionally standardized Transfusion Record, which should incorporate a patient assessment tool and advice on the monitoring of patients with increased risk of TACO.
The NC TACO Audit, currently in progress may provide additional information on patient assessment and prevention of TACO.
Action: SA & AMc to coordinate development of a regionally standardized Transfusion record.

9 Standardization of Transfusion related documentation

9.1 Kleihauer Request Form

SA thanked NITC Members who have already provided feedback on the 4th draft version, which has been updated since meeting with Eilish Meehan of NIECR and Denise Boulter, Midwifery Consultant. The NIMATS (regional maternal electronic record) software programme is currently being revised and will now include the term "INFANT" instead of "INFANTA" for singleton deliveries. This will enable Blood Bank staff to determine whether a cord blood sample pertains to a singleton or one of a multiple birth of an Rh-negative mother. It is recommended that the cord / newborn hospital number for a singleton will still be the mother's hospital number prefixed with an "A" (e.g. RMH15/A1234), as is currently the case in all Trusts except for WHSCT. However the use of H&C numbers for mothers and newborns is being considered as the primary identifier by the NIMATS working group and BHSCT HCN group.

9.2 NICE NG 24 Transfusion

On 18 May 2017 SA contacted Jonathan Houston in Public Health Agency, which monitors Trust implementation of NICE guidelines. He acknowledged the last NITC progress report on NG 24, which was submitted to the PHA in January 2017 and advised that the NITC could submit a request for Trust funding to facilitate implementation of NG 24. The NITC consensus at this time is to await an outcome from the GAIN application for sponsorship of the proposed "TRUST" project.
The NITC intends to take account of recent research and NG24 in a review of the NI recommendations on red cell transfusion thresholds. AMc has highlighted that despite national concerns the more restrictive NG red cell transfusion thresholds have already been included as standards in UK training packages (LearnPro e-learning and associated software applications) and in National Comparative Audits, affecting inter-regional comparisons.

10 Registration of unknown patients

AMc and SA coordinated a successful workshop with Eilish Meehan of HSC Demographics Service and Denise Lynd, Director for Medical Records in BHSCT on 31 March 2017. Managers from all Trusts with responsibility for electronic patient record systems, including PAS, Symphony and NIECR attended and agreed that there should be a regionally standardized naming convention to register patients of unknown identity to expedite emergency medical care.
Action: SA to coordinate a second workshop of managers once naming convention has been agreed.

11 National / regional networking

NITC is coordinating BBTN meetings this calendar year; the next face-to-face meeting is planned for September at the BBTS conference in Glasgow. Work is in progress to update evidence and recommendations on the JPAC website. However the JPAC editorial Board and the UK Cell Salvage Action Group will require a new chair following the retirement of Karen Shreeve.
SA congratulated KM and Lisa Eaton on coordinating a very successful ESTM conference, which was held in Belfast on 22-24 March 2017. SA thanked DC for managing the expenses payments via the NITC EFTP account.

12. National Transfusion Guidelines

Re BSH Guideline on Administration of Blood Components – final version has been submitted to the BSH

editorial Board. The main changes are a recommendation that the 30-minute rule for commencing transfusion of red cells has been updated and RPRB training requirements in each Country have been specified.
Action: SA to coordinate updating of NI regional guideline on the Administration of Blood Components.

13. Any other business

13.1 Future conferences:

SHOT Conference: 12 July 2017, Harpendon, Herts. Deadline for abstract submissions 1 June 2017.
BBTS Conference: 13-15 September 2017, Glasgow.

NITC Members have proposed that the next NITC regional transfusion conference be held in November 2017, possibly on the theme "Red Cells in Perspective", to include a presentation of the latest NITC coordinated regional audit of red cells.
Action: NITC Members invited to suggest and/or provide presentation topics.

13.2 Small sample draw volume – a Patient Blood Management project.
AMc informed the NITC that a long-term project, which commenced in September 2016, is in progress in RICU in BHSCT to reduce blood-sampling volumes. This has already been achieved for blood gas analysis sampling. The project team is working with local laboratories and sample tube suppliers to identify smaller sample volume options for biochemistry and haematology tests. A regional tender for blood sample tubes is in progress.
Action: SA to contact Regional Procurement manager to request that the new tender includes provision of sample tubes for smaller draw volume.

14. Date of next meeting:

Friday 29 September 2017 14.00 – 16.30 hr. NIBTS Seminar room.