NI Transfusion Committee
Minutes of Meeting 26 January 2018
Date of issue: 7 February 2018

Apologies:
Adrian Crawford, Blood Bank Operational Manager, WHSCT
Helen Gilliland, Consultant Anaesthetist and Chair of HTC, BHSCT – HG
Sheena Gormley, Consultant Anaesthetist BHSCT
Jeremy Hamilton, Consultant Haematologist, SHSCT
Carol Ann Henry, BNS Blood Bank / haematology NHSCT
Claire Hewitt, BMS, blood Bank SEHSCT
Don Hull, Consultant Haematologist, SHSCT
Stephen Kane, Blood Bank Manager BHSCT
Josephine Monaghan, HP WHSCT
Bronagh O'Neill, HP, WHSCT
Lorna Palmer, HP SEHSCT
Lynsey Parker, Biomedical Scientist, BHSCT
Patricia Watt - HP SHSCT
Philip Windrum, Consultant Haematologist and Chair of HTC, NHSCT

1. Present:
Susan Atkinson, Consultant Anaesthetist, BHSCT (Chair) – SA
Louann Birch, HP SEHSCT
Mark Bridgham, Consultant Haematologist, NIBTS - MB
Catriona Briers, Lead Nurse, SEHSCT
Damien Carson, Cons Anaesthetist, SEHSCT (Medical Audit & Implementation Lead) – DC
Sinead Carty, Blood Bank Operational Manager, SEHSCT
Sharon Hope, HP, NHSCT
Sara Martin, HP, SHSCT
Aine McCartney, Regional HP Coordinator - AMc
Mary P McNicholl, HP, WHSCT – MP
Kieran Morris, NIBTS – KM
Shonagh Reilly, HP NHSCT
Asma Sadiq, Specialty Doctor, NIBTS
Graham Scott, Lead Biomedical Scientist SHSCT
Trevor Thompson, Blood Bank Manager, SHSCT

2. Minutes of NITC Meeting 29 September 2017
Approved.
SA congratulated Sara Martin and Sharon Hope on their recent appointments as Haemovigilance Practitioners of SHSCT and NHSCT respectively.

3. Matters arising
Covered in Agenda items.

4. Audit sub-group
4.1NITC projects and RQIA applications
DC is meeting the RQIA next week to discuss the final report of "Where does the blood go in NI?" before publication. DC reported that the RQIA has not yet given an outcome to the most recent NITC application (7 October 2017) for funding. There are currently no other funding sources to facilitate the NITC work plan. NITC members expressed concern that the current improvements in blood component use in Northern Ireland may not be sustained, unless new regional projects are initiated.
Action: SA to request a meeting of the HSC Advisory Committee on Blood Safety to discuss how NITC activity can be resourced.

4.1 National Comparative Audits

DC attended NCA working group meeting in November 2017; the resource implications for UK regions participating in future NCAs was discussed.

Audit of Patient Blood Management in adults undergoing elective scheduled surgery audit – final report published.

Audit of Red Cell &Platelet transfusion in adult haematology patients - data collection has been completed.

TACO (patient risk assessment) audit – data collection has been completed.

5 Blood component use

5.1 Trends in NIBTS issues

Red cell issues have decreased to around 22.5 per 1,000 head of population. The overall demand for platelets has decreased to approximately 4.25 per 1,000 head of population. AMcC reported an 11% reduction in platelet use in Haematology in Belfast City Hospital (BHSCT); the explanation for this dramatic reduction is to be investigated. Fresh frozen plasma monthly issues had increased in the last 12 months but have now decreased and the demand for cryoprecipitate is essentially unchanged. NITC Members considered whether the recent reduction in fresh frozen plasma issues could in part be due to a recent increase in Octaplas usage.

Action: AMcC and KM to investigate cause of decrease in platelet transfusions in BHSCT.

Action: KM to see if Octaplas usage can be included in monthly NIBTS issue reports.

5.2 Emergency use of Group O RhD negative / positive red cells

Standard NI blood bank practice in cases of major haemorrhage, when a patient's blood group is unknown, is to issue the first 4 units of red cells as group O Rh D negative and then O RhD positive red cells thereafter, until the patient's blood group has been identified. The use of group O RhD positive red cells as first line transfusion for major haemorrhage/trauma in adult males attending BHSCT Emergency Department has been discontinued due to concerns about the development of atypical antibodies and transfusion reactions if future transfusions are required. The current BSH Guidelines on the haematological management of major haemorrhage (2015) state that O RhD positive red cells can be considered for males in this circumstance. KM is a member of a national working group, which is writing new BSH Guidelines on the emergency use of group O red cells.

Action: NITC to consider a regional audit of emergency use of group O red cells.

5.3 Blood Transfusion in a Mass Casualty situation

The HSCB launched a regional project in mid 2017 to prepare for mass casualty situations in Northern Ireland. MB outlined the preparatory work being undertaken by NIBTS, which includes a review of the donation supply chain, stock management and staff training. Overall stocks of red cells in Northern Ireland have recently been decreased from 5 to 3.5 days supply in NIBTS and 8 to 4 days supply in hospitals. In the event of a mass casualty situation when numerous patients require transfusion it is likely that NIBTS would have to boost stocks from mainland UK and or Ireland.

A NI mass casualties exercise in December 2017 included only one request for blood components from NIBTS. No Trust –based Blood Bank staff were in attendance to ascertain whether Trust Blood Banks should have been contacted during this exercise. NITC members agreed that the regional project would benefit from more involvement of NIBTS, hospital blood banks, hospital transfusion committees and transfusion teams with Trust-based Disaster Planning Teams. The introduction of a new regional LIMS should facilitate the inter-hospital transfer of blood components in the event of mass casualties.

Action: SA to write to Chairs of Trust Transfusion Committees about increasing the engagement of local blood banks, transfusion committees and transfusion teams with Trust-based Disaster Planning Teams.

Action: Trust Blood Bank Managers to update regional protocol for the inter hospital transfer of blood components with patients.

5.4 Confirmation of patient blood group sampling prior to transfusion

BSH guidance recommends that hospital blood banks request that a second blood sample is taken when blood components are requested for a patient that does not have a historic blood group. This only applies to approximately 20% of patients in each Trust, since hospital blood banks already have blood group and/or transfusion history for the majority of patients requiring a new transfusion. BHSCT is currently the only NI Healthcare Trust, which provides red cells by electronic issue for suitable patients - an additional indication for a second sample to confirm a patient's blood group. It has been noted in BHSCT

that taking two blood samples is commonplace for "Group and Hold" requests, with or without blood component orders, regardless of historic record on Link Labs. BHSCT Transfusion Team has been investigating the implications of this recent increase in clinical and laboratory workload and resources, in addition to variances in the blood sampling process. This change in practice is to be escalated to BHSCT senior management team. NITC Members considered that solutions to ensure best practice in pre transfusion blood sampling might differ between different clinical units and so local stakeholders should be encouraged to work with transfusion teams to develop their own protocols.

6.0 Education and Staff Training

6.1 NI SQAT SAI Alerts on transfusion practice

The NI Public Health Agency issued SAI alerts to Trusts concerning patient risk assessment for TACO (Transfusion Associated Circulatory Overload) (2017) and pre-transfusion bedside checking (2017), which reflect key recommendations in 2015 and 2016 SHOT reports. The NITC was only consulted on the former notification prior to publication. NITC Members discussed the importance of having a clear-cut evidence base of benefit prior to the introduction of a change in clinical practice. There is currently no reliable definition or clinical criteria for the diagnosis of TACO. SA is attending a meeting of the Safety and Quality Alert Team on 5 February 2018, on behalf of the NITC to discuss these notifications.

Action: SA to attend SQAT meeting on 5 February 2018, to request that the NITC is consulted prior to the issue of future SQAT alerts on transfusion practice. SA is also to recommend that the regional project to prepare for mass casualty situations should include greater involvement of NIBTS and Trust-based transfusion services.

6.2 One-day course on Change Management in clinical practice

This one-day course, which is being funded out of the NITC EFTP account, is being held in the Leadership Centre at the Beeches in Belfast on 23 May 2018 (09.30 – 16.30). It is anticipated that Haemovigilance Practitioners will derive greatest benefit from attending this course; however there will be sufficient spaces available for one Blood Bank Manager (or designated alternative representative) fro each Trust.

Action: Trust Transfusion Committee Members to forward names of interested and available Haemovigilance Practitioners and Blood Bank member from each Trust.

6.3 NITC conference: Red Cells in Perspective, 9 February 2018.

Final preparations are in progress for this conference, which is being held in Riddel Hall, Queens University. SA thanked DC for setting up the link to an electronic delegate registration system, which has greatly facilitated the administration process. To date more than 90 delegates have registered to attend this conference. NITC Members agreed that a reduced registration fee of £25 should be available for undergraduate students in Nursing and Medicine.

7.0 Standardization of Transfusion related documentation

7.1 Kleihauer Request Form

SA informed the NITC that the 11th draft of this form has been forwarded to a printing company. Blood Bank Managers (or nominated representatives) present agreed that it would be useful to standardize to 4 ml purple-topped sample tubes for Kleihauer tests, to distinguish from 6 ml pink-topped sample tubes for cord blood samples.

Action: NITC Members and other stakeholders requested to forward any additional amendments.

Action: SA to share printer's proof with all stakeholders.

Action: Blood Bank Managers' Forum requested to inform SA of decision concerning regional standardization of sample tubes for Kleihauer (4 ml purple-topped EDTA) and cord blood (6 ml pink topped EDTA) samples.

7.2 Regional Blood Transfusion request form

A number of suggested updates to current request form have been raised, such as the inclusion of "currently pregnant" option, which limits storing of group and antibody screening samples to 72 hours before anticipated transfusion and location of signatures for blood samplers and component authorizers. Members recommended that the current undergo major re-design to facilitate completion by clinical staff, including simplification (where feasible) and colour coding of entries that must be recorded to avoid sample rejection.

Action: SA to coordinate revision of this regional request form.

Action: NITC Members requested to forward additional suggested amendments to SA.

7.3 NI Policy on the Administration of Blood Components

This NI policy was last updated in 2009, although Trusts have updated local policies to include more recent recommendations, such as those contained in BBT3 (NI). The new BSH Guidelines on the administration of blood components (November 2017) recommends a change from the 30-minute rule to 60-minute out of controlled temperature storage, when red cells can potentially be re-issued after a quarantine period in a blood bank fridge. It was agreed at the recent NITC Strategy meeting (9 January 2018) that this change in practice would only be feasible with electronic blood tracking.

Action: SA to coordinate updating of NI regional transfusion policy.

7.4 Regional Transfusion Record

Two Trusts (NHSCT, WHSCT) are going to pilot Transfusion Records, one with a TACO risk assessment as a tool, the other with a TACO risk assessment checklist for every blood component. The pilot forms will also contain different versions of a pre-transfusion bedside checklist. The results of this pilot will inform final production of a regionally standardized Transfusion Record. WHSCT is also undertaking a trial of single-person pre-transfusion "bedside checking" in Haematology.

Action: SA to coordinate revision of update this form.

8.0 Registration of unknown patients

A regional stakeholder meeting of managers responsible for regional (NIECR) and Trust-based patient electronic records was held on 25 January 2018. A regional naming convention for the registration of unknown patients that require transfer between hospitals or Trusts and/or blood transfusion during an episode of emergency treatment was agreed in principle. It is to undergo further consultation with Administrative staff and be tested on electronic patient record systems before a tabletop exercise with clinical staff.

9.0 NITC Strategy meeting

SA presented a resume of this one-day meeting, which was well represented by NITC Members on 9 January 2018. The NITC is keen to move forward with the resultant work plan, although resources will need to be identified for some items.

Action: SA to circulate minutes of this meeting to all NITC Members.

10 National / regional networking

10.1 BBTN

NI is chairing BBTN meetings for the calendar years of 2017 and 2018. The next meeting is scheduled for 20 February 2018 in the Jack Copeland Transfusion Service building in Edinburgh. All Regional Transfusion Committees in UK and Ireland have been invited to provide feedback on the design of a national survey of Learn Blood Transfusion (LBT) e learning. LBTS users will be requested to complete a questionnaire to ascertain whether they it fulfills transfusion training requirements.

10.2 JPAC website

Updating of the transfusion practice pages on this website is on hold, due to lack of staffing and resources.

Post NITC meeting note: Dr Gormley has informed the NITC that the UK Cell Salvage Action Group is updating national guidelines on the use of cell salvage.

11.0 Any Other Business

11.1 Future National Conferences

NATA conference: 12, 13 April 2018 in Lisbon, Portugal

The Royal College of Nursing Annual Congress 12 – 16 May 2018, Waterfront, Belfast. Patricia Mackey, NIBTS, has applied to run a fringe event on the role of the nurse - from donation to the administration of blood.

SHOT Annual conference – 12 July 2018, Lowry Building, Manchester.

11.2 Associate Physicians

NHSCT has enquired about standardized minimum transfusion practice training for recently appointed Associate Physicians. Haemovigilance Practitioners (HPs) are recommending LearnPro Safe Transfusion Practice / Blood Components: Indications for use, in addition to competency assessments by HPs; i.e. similar to training for Foundation Year QUB students.

11.3 Future NITC Meetings

Members discussed whether the day of the week and the venue of future NITC meetings should be varied to facilitate attendance by some Members.

Action: NITC Members requested to identify possible venues outside Belfast.
12.0 Date of next meeting: 14.00 – 16.30 Friday 18 May 2018. Venue to be confirmed.