NI Transfusion Committee
Minutes of Meeting 23 January 2015
Date of issue: 12 February 2015

Apologies:
Adrian Crawford, Lead Blood Bank Manager, WHSCT
Dr Sheena Gormley, Clinical Lead for Cell Salvage, BHSCT - SG
Irene Griffin, Blood Bank Operational Manager, BHSCT
Veronica McBride
Elma McLoughlin, HP, SHSCT
Mary P McNicholl, HP, WHSCT
Dr Liz Reaney, DHSSPS
Dr Philip Windrum, Chair Transfusion Committee, NHSCT

1. Present:
Dr Susan Atkinson, Cons Anaesthetist, BHSCT (Chair) - SA
Dr Damien Carson, Cons Anaesthetist, SEHSCT (Audit & Implementation Lead) – DC
Sinead Carty, Blood Bank Manager, NHSCT
Patricia Dunlop, HP, SEHSCT
Dr Helen Gilliland, Chair, Transfusion Committee, BHSCT – HG
Claire Hewitt, Blood Bank Section Head, SEHSCT
Dr Don Hull, Cons Haematologist, SHSCT – DH
Fionnuala Lennon, HP, BHSCT – FL
Patricia Mackey, HP, SEHSCT
Aine McCartney – HP, NHSCT – AMc
Tom McFarland, Blood Bank Operational Manager, SHSCT - TMc
Dr Bridgin Merron, Haematology registrar, NIBTS
Dr Kieran Morris, Medical Director, NIBTS – KMo
Bronagh O'Neill, HP, WHSCT
Audrey Savage, Blood Bank Manager, BHSCT - AS
Patricia Watt, HP, SHSCT - PW

2. Minutes of NITC Meeting 16 September 2014
Amended minutes, previously circulated, were approved.

3. Matters arising

3.1 Patient Information Leaflets

Standard NHSBT "Will I need a blood transfusion?" and "Information for patients needing irradiated blood" leaflets are now available in all Trusts. KMo stated that this supply could continue to be funded and ordered through NIBTS.

3.2 BBT3 (NI) Revision to account for updated risk assessment of transfusion transmitted vCJD

SA presented proposed amendment to wording in BBT3 (NI). KM recommended that the wording should include a qualification for exposure to non UK plasma and plasma products from 1999 – highlighted in italics:

"Patient Participation in Transfusion Practice
Risk of contracting variant Creutzfeldt-Jakob disease (vCJD) after being transfused donated blood components (January 2015)
In 2012 the Transmissible Spongiform Encephalopathy (TSE) Risk Management Sub Group of the Advisory Committee on Dangerous Pathogens (ACDP) reassessed the risk of contracting vCJD following transfusion of donated blood components [(1)].
The actual number of recorded cases of vCJD has fallen short of the number previously predicted. In the revised prediction model, a patient should now be considered to have an increased risk of contracting vCJD from donated blood components or blood products, if the transfusions have resulted in exposure to 300 or more donors since 1990. *This excludes plasma and plasma products manufactured since 1999, which*

are sourced outside the UK. Additional risk factors [2] for contracting vCJD apply to individuals who:

- Have received blood or blood components from another individual who has subsequently developed vCJD
- Have donated blood to an individual who subsequently developed vCJD
- Have received blood or blood components from an individual who has also donated blood to a patient who subsequently developed vCJD

It is often difficult to ascertain when an individual has been exposed to 300 or more donors, since blood derived plasma products are pooled from multiple donors and the patient may have been administered transfusions in more than one hospital. However when it is possible to confirm this level of donor exposure following multiple transfusions, a Medical Practitioner should inform the patient of the increased risk of contracting vCJD and offer counseling in this respect.

Reference:

1. vCJD and Transfusion of Blood Components: an updated risk assessment, April 2013. www.gov.uk/government/publications/vcjd-and-transfusion-of-blood-components-updated-risk-assessment
2. Annex J14. Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection, January 2013."

Action: SA to inform the Chair of NI Blood Safety Advisory Committee (CMO) of this NITC recommendation.

4. Haemovigilance Staffing

Shirley Murray and Catherine Howell (NHSBT) were awarded the Oliver Memorial Award on 21 November 2014 for their work in transfusion medicine. This is the first time that this award has been made to Haemovigilance Practitioners.

The Committee congratulated Aine McCartney on her appointment as NI Haemovigilance Coordinator, following an interview process on 2 Dec 2014. Aine will officially commence this post on the 1 May 2015, which has 0.5 WTE regional and 0.5WTE BHSCT commitment.

BHSCT continues to have a shortfall in haemovigilance staffing, despite additional hours being worked by existing HPs. This shortfall is due to:

- 0.5WTE Band 8b post vacancy until 1 May 2015
- Resignation of 1.0 WTE Band 6 post (replacement post has been shortlisted for interview)
- Secondment of 0.5WTE Band 7 post for implementation of the remote blood fridges project (staff are currently backfilling these hours)
- 1WTE Band 7 on maternity leave from Dec 2014
- 0.5WTE Band 7 not yet allocated

There will be an additional 1 WTE Band 7 deficit due to maternity leave from May 2015.

In NHSCT:

There will be 0.5WTE deficiency due to maternity leave from April 2014 and a 1WTE Band 7 vacancy from 1 May 2015.

All other Trusts are currently fully staffed with Haemovigilance Practitioners.

5. Standardization of Transfusion related documentation

5.1 Regional Bloodless Pathway documentation

Approved by NITC Members.

Action: SA to forward to BHSCT Legal Team for final approval.

5.2 Revision of Regional Transfusion Request form

SA circulated proof of updated request form and booklet covers. Additional amendments to be made:

- Removal of line " Never had a transfusion" in the table entitled "Patient Transfused. "
- Under "INDICATION FOR TRANSFUSION" – amend box entitled "Surgery: state Operation …" to "State Procedure or other indication for red cell request"

- Kleihauer test prompt to remain until final version of regional Kleihauer request form is available.

The residual stock of existing request form will last until end of April 2015.
Action: SA to advise printer company to proceed with production of 1-year order of revised form and booklet covers.
Action: SA to convene a subgroup to consider revisions for next version of Regional Request Form.

5.3 Regional Kleihauer request form
SA thanked NITC Members for feedback and comments on the circulated draft form. It was agreed that this request form should be piloted before mass production; all Trusts expressed an interest in pilot participation.
Action: SA to make further amendments before this request form is piloted.
Action: AS to investigate funding for pilot.

6. Blood sampling for transfusion (BCSH Guidelines 2012)
After detailed discussion, the NITC consensus is that the BCSH recommendation to undertake a second blood sample for confirmation of blood group in "new patients" should be implemented in NI. This recommendation has already been adopted by SHSCT and SEHSCT.
There has been a significant reduction in sampling errors and wrong blood in tube events (WBIT) in NI Healthcare Trusts since the introduction of NPSA: SPN 14 Right Patient, Right Blood training programme, although WBIT events still occur.
It was agreed that Blood Bank Biomedical Staff should when appropriate, request a second blood sample to confirm a patient's blood group when a cross match order has been made; not for every blood group and antibody screen request. This change in practice would increase sample workload for hospital blood banks by approximately 4-6 %.
An exception to the above would apply to neonates, small children and vulnerable adults, when the responsible Clinician must consider the risks and benefits of a second venipuncture and blood sample to confirm blood group. NITC Members emphasized that this blood group confirmation process must not cause any delay in emergency provision of blood components, in keeping with the 2012 BCSH Guidelines. The issue of blood components to the clinical unit could proceed during the blood group confirmation procedure. Clinicians would be advised to withhold transfusion if clinically feasible, until the blood group has been confirmed.
Action: SA to write to Dr Corrigan of the NITC recommendation for implementation, with details of the associated resource implications.
Action: SA to circulate flowchart produced by WHSCT, which clarifies implementation process.

7. Audit subgroup – report given by DC
7.1 NITC Regional audit of platelet transfusions
DC and SA have discussed the audit report amendments following review by the External Assessor, Professor Mike Murphy. It is estimated that the final report will be completed by the end of February 2015. There is sufficient residual GAIN funding for printing of a 4-page summary booklet and production of a smaller number of copies of the full report. DC is to present the audit report at the forthcoming one-day Symposium on Transfusion Practice for Healthcare Teams on 27 February 2015.

7.2 NITC Regional Audit of appropriate use of Anti D Immunoglobulin
DC reported that data entry onto an electronic database has been completed. Estimated date for completion of analysis and draft report is the end of June 2015.

7.3 National Comparative Audit (NCA)s
Audit of blood use in elective surgery: DC has provided feedback on the planned scope and design to the NCA Group, following comments from NITC Members. DC is undertaking a local pilot of this audit. Data collection is scheduled to commence in April 2015. This NCA will be linked to the AFFINIIE project, to ascertain how clinical audit impacts on improvement in clinical practice.

The 2014 NCA of Patient Information and Consent is in the final stages of reporting. Final reports of the 2013 NCA of Anti –D Immunoglobulin and the 2013 NCA of blood use in Neurocritical care units will be published shortly.

Data collection for the 2014 NCA of Sickle Cell Anaemia in Children was completed in Dec 2014.
A future audit of the use of blood in lower gastro-intestinal bleeding is planned.

7.4 START (Supporting Trusts in Audit Related to Transfusion)
The aim of this initiative is to promote interest and good clinical practice in transfusion medicine for trainee doctors. DC is providing advice and support in the audit process and other projects for a number of different Trust based audits including:
Overnight transfusions - WHSCT
Iron deficiency pathway – WHSCT
Cross match in neonates and donor exposure – SHSCT
Single unit transfusion - SEHSCT

7.5 Blood component and product issues
DC presented current trends in use – moving monthly average for red cell issues has decreased further to 27 per 1,000 head of population. FFP issues are still decreasing, currently at 2.35 per 1,000 population, whereas demand for platelets is still increasing (4.75 per 1,000 population).
Demand for IgG is proving costly, with a 16% year-on-year increase since July 2013; 135,000 units were issued in the last financial year, when appropriateness of use Ig G issues was assessed retrospectively.
Dr D Corrigan has written to DC and SA to request a re-audit of the use of this expensive blood product. A full-time Band 8a Immunoglobulin Pharmacist has recently been appointed to work with the BHSCT-based Immunoglobulin Assessment Panel, to prospectively oversee issues of Ig G. DC has offered to assist this Pharmacist in a re-audit, on behalf of the NITC.

8. Education in Transfusion Practice

8.1 E learning in Blood Transfusion
AMc is now the NI representative on the Learn Pro User Group.
A dedicated GP / prescriber only module will be available next year. In the meantime GPs should be advised to undertake clinical module 2.
FL and AMc have requested that NI access to the regional library on Learn Pro is removed, since it is out of date.
NI is up to date with payment of the annual license fee, through NIBTS. However an additional non-recurrent fee of £800 has been requested to facilitate mandatory confirmation of users' job role and location. This would reduce the likelihood of users having more than one registered access name and keep users' profiles up to date.

8.2 Education conferences
SA congratulated the organizers of the very successful half-day conference, which was held on 19 September 2014 in Altnagelvin Hospital on "Transfusion Safety in a Major Incident". This conference provoked discussion about communication systems and the need for a standardized method of patient identification, especially for the unknown patient.
A one-day Symposium on Transfusion Practice for Healthcare Teams will be held in the Quality Improvement and Innovation Centre on the Ulster Hospital site on 27 February 2015; the main themes being platelet transfusion, perioperative anaemia and management of major haemorrhage.

8.3 NITC Web page: www.nitransfusion.com
DH thanked DC on behalf of the NITC for setting up this successful web site, which is being accessed by approximately 10 new individuals per day. It was agreed that agendas and minutes of NITC meetings should be added to this web site.

9. Blood Bank aspects of transfusion practice

9.1 Emergency transfer of blood components between Trusts:

A subgroup is to be formed to standardize this process.

Action: AMc requested to ascertain how many inter hospital transfers of blood components with patients took place in the last year.

9.2 Paediatric sample tubes:

At the NITC subgroup meeting on 26th Aug 2014 it was agreed that paediatric sample tubes and labels should be standardized in NI. Regional Procurement has informed SA that purchase of a standardized sample tube could be incorporated into the existing blood sample tube tender, if the total cost is below a particular threshold.

Action: Trust Blood Bank Managers requested to provide SA with an estimate of annual usage and cost per item of currently used paediatric sample tubes.

10. Haemovigilance aspects of transfusion practice

10.1 Identification of the unknown patient

SA has written to Dr G Lavery, Clinical Director of the NI Patient Safety Agency, to request that a standardized system for identification of the unknown patient is considered by the Department of Health.

10.2 Update from BBTN

DC and SA attended the last meeting, which was held during the BBTS conference in September 2014. The main current objectives of BBTN are to promote patient blood management programmes and single unit red cell transfusion.

11. Correspondence

Already referred to above

12. Any other Business

13.1 TMc highlighted the implications of the Royal College of Pathologists' recent recommendations for Biomedical Scientist staffing of Hospital Blood Banks (published in Transfusion Medicine in February 2015). It will be more difficult to provide "out of hours" cover with Biomedical Scientists who have the recommended grade, training and experience, despite recent rationalization of Blood Bank Services in NI Healthcare Trusts. This problem will be exacerbated by anticipated retirement of senior Biomedical staff.

Action: SA to write to Dr Reaney and the CMO to request that this topic be included on the agenda of the next NI Blood Safety Advisory Committee meeting.

Action: Hospital Blood Bank Managers to undertake a gap analysis, in light of the new recommendations.

13. Date of next meeting:

Fri 5 June 2015 2-4 pm, NIBTS Lecture Theatre