NI Transfusion Committee
Minutes of Meeting Friday 25 January 2019
Date of issue: 8 February 2019

Present:
Susan Atkinson, Consultant Anaesthetist, BHSCT (Chair) – SA
Louann Birch, HP SEHSCT
Damien Carson, Cons Anaesthetist, SEHSCT (Medical Audit & Implementation Lead) – DC
Patricia Dunlop, Assoc. Specialist, SEHSCT
Helen Gilliland, Cons. Anaesthetist, BHSCT
Megan Glass, BMS, NHSCT
Sheena Gormley, Cons Anaesthetist, BHSCT
Carol-Ann Henry, Biomedical Scientist, NHSCT
Stephanie Hill, HP, NHSCT
Kathryn Maguire, Cons Haematologist, NIBTS
Sara Martin, HP, SHSCT
Aine McCartney, Regional HP Coordinator – AMcC
Mary P McNicholl, HP, WHSCT - MP
Josephine Monaghan, HP, WHSCT
Kieran Morris, Medical Director, NIBTS – KM
Lois Neill, HP, BHSCT
Lorna Palmer, HP SEHSCT
Lynsey Parker, Blood Bank Operational Manager, BHSCT
Kenzi Potter, BMS, NHSCT
Mairead Richmond, HP, NHSCT
Graham Scott, Lead Biomedical Scientist SHSCT- GS
Trevor Thompson, Blood Bank Manager, SHSCT
Patricia Watt - HP SHSCT – PW

SA welcomed and congratulated Stephanie Hill, recently appointed Haemovigilance Practitioner in NHSCT. SA also welcomed 2 visiting Biomedical Scientists (Megan Glass and Kenzi Potter) from NHSCT who are completing their Higher Specialist portfolio.

Dr Don Hull has recently retired as Consultant Haematologist in SHSCT. Patricia Watt is retiring as Senior Haemovigilance Practitioner in SHSCT. SA thanked and acknowledged Patricia for her significant input in the Regional Transfusion Team and her long-standing contribution to the NITC work plan.
Action: SA to write to thank Dr Hull for his major and long-standing contribution to transfusion practice and the NITC.

1. Apologies:
Sinead Carty, Blood Bank Operational Manager, SEHSCT
Beverley Craig, Head of Laboratory Services, BHSCT
Adrian Crawford, Blood Bank Operational Manager, WHSCT
Amanda Malone, SEHSCT
Bronagh O'Neill, HP, WHSCT
Tracey Steenson, Coordinator of Rapid Response Team, SEHSCT
Fionnuala Walker, HP, BHSCT
Phil Windrum, HTC, WHSCT

2. Minutes of NITC Meeting on 25 September 2018
Approved.

3. Matters arising
Covered in Agenda items below.

4. Education and Staff Training – report by AMcC. Please see Haemovigilance report for NITC 29 January 2019 for additional information.

4.1 Minor errors in blood sampling for transfusion

The BHSCT HP Team reported that minor errors are most commonly due to human error in the clinical environment rather than lack of knowledge about safe transfusion practice. In a 3-monthly rolling audit it is proving more beneficial to have fact-finding discussions with staff about these incidents than to desist them from the transfusion process. The NITC recommends that HPs and Hospital Transfusion Teams should use their own discretion to identify which sampling errors have been due to lack of knowledge or poor clinical practice and therefore warrant desisting from transfusion practice until re training and competency assessment have been completed.

Action: BHSCT Trust Transfusion Team is requested to report findings of a 3-month (December – February 2018 inclusive) look-back of the different types and relative frequency of minor sampling errors.

Action: Other Trust Transfusion Teams to consider undertaking similar reviews.

Action: NITC letter to all Trusts regarding update in management of sampling errors, once 3-month review of minor sampling errors has been examined.

4.2 Labelling of blood sample tubes

NITC Members reported how difficult it can be to handwrite and read all patient identification details on sample tube labels, one factor in the occurrence of minor errors.

Action: NITC to contact Company that provides sampling tubes for NI Healthcare Trusts, to request enlargement of sample tube labels.

4.3 Course on Non-medical Authorization of Blood

AMcC has received multiple requests for this successful course to be run again, particularly from Nurse Practitioners working in Adult and Paediatric Haematology. Staff with 3 years of relevant clinical caseload experience are eligible to attend this course, which will probably run in May / June 2019.

Action: AMcC to prepare and disseminate an expression of interest to Trust Nursing Departments, copying Haemovigilance Teams for information. All applicants will require a Mentor from their specialty, who may be requested to participate in one of the classroom days.

4.4 RPRB and Introduction to Transfusion Practice for Undergraduates

AMcC informed the NITC that an Introduction to Transfusion Practice is in place for final year Medical Undergraduates, 2nd year Nursing Undergraduates in University of Magee, 2nd year Nursing and Midwifery at Queens University and during Induction in the Open University. Final Year Medical students will undertake Safe Transfusion Practice training in March 2019, after they sit their final examinations. Competency assessments are being arranged for the F0 Work Shadowing apprenticeship.

4.5 Auditing compliance in RPRB Training and Competencies

Hospital Transfusion Teams (HTTs) currently undertake comprehensive 6-monthly (February & September) audits of blood sampling and transfusion to assess staff compliance in RPRB training, as recommended in BBT3 (NI). However this process is labour-intensive and HTTs have found that it may be more beneficial and time-efficient to concentrate on checking RPRB compliance of staff involved in transfusion sampling and administration errors.

Action: NITC to recommend that compliance in RPRB staff training should be monitored by following up on sampling errors and that 6-monthly audits are no longer required.

5. Review and Implementation of National Guidelines in Northern Ireland

5.1 Guidelines on red cell transfusion in NI

The NITC has sent out an invitation to clinical staff in all NI Healthcare Trusts to participate in a consultation on the updating of regional guidelines for the use of red cells. This invitation was emailed to Trust Medical Directors, Directors of Nursing, and Chairs of Trust Transfusion Committees and to Hospital Transfusion Teams. SA thanked DC for setting up a webmail address for collation of all responses. At a meeting in November 2018 BBTN Members reported that NICE guidelines (NG24) on the indications for red cells transfusion have not yet been fully implemented in other regions of the UK.

Action: SA to re-send consultation email in a few weeks time to increase the number of responses.

6. Standardization of Transfusion related documentation

6.1 Kleihauer request form

SA thanked Sinead Carty for collating additional feedback on 3rd printers' proofs. The estimated annual number of request forms required is 3,500; although this is likely to decrease when fetal DNA testing for D status is introduced.

Action: SA to forward final changes concerning use of EDTA sample tubes for Kleihauer and Cord samples to the printing company.

Action: SA to request printing of a 6-month supply of this request form.

6.2 NI Transfusion Record (TR)

SA has discussed changes to layout for TACO assessment with HP Team, i.e. before authorization of individual blood components. The aim would be to ensure assessment or re-assessment of the patient, including recent blood tests, before another unit is authorized. An option to separate essential documentation for bedside use from additional useful guidance for staff information was also discussed. The guidance for staff, e.g. indications for transfusion, recognition of acute transfusion reactions could be held in a booklet of TR forms and on Trust intranet sites to reduce the number of pages per TR.

Action: SA to make further revisions to draft regional TR V7, taking account of draft V6 regional TR.

6.3 NI Transfusion Request form

It was agreed that work could begin on updating of this form, in parallel with updating of Northern Ireland Guidelines on the indications for red cell transfusion.

Action: SA to send out an email to NITC members to request suggested changes to this form.

Action: SA to invite Trust representation on a working group to update this regional request form.

6.4 Accessibility of policies on Trust websites

A recent Trust Learning Letter advised that Trusts should ensure that the Regional Bloodless Pathway should be readily accessible on Trust intranet sites, using multiple keywords (search terms). NITC Members reported that this recommendation has been fulfilled in NI Healthcare Trusts. It was agreed that it would be beneficial to have regional policies available on the www.nitransfusion.com website to facilitate access by other stakeholders.

Action: DC requested to upload regional transfusion policies on NITC website.

7. Blood component use – trends – report by DC

Monthly issue of red cells has plateaued in the last six months - around 22 units per 1,000 head of population. Monthly issues of platelets have increased in the last

quarter to 4.2 units per 1,000 head of population, while NIBTS issues of FFP and cryoprecipitate continue to fall to 1.9 and 0.46 units per 1,000 head of population respectively.
Blood component use is discussed at Hospital Transfusion Committee meetings. DC has offered to provide individual Trusts with their own red cell and platelet issues to compare against regional monthly issues. Additional information on Trust component usage and wastage is available on the Blood Stocks Management database. KM highlighted the current narrow margin between supply and demand of blood components in Northern Ireland.

8. Audit subgroup – report by DC

8.1 Where does the blood go in Northern Ireland? (WDBG)

The final audit report is available on the RQIA website.

8.2 National Comparative Audit (NCA) Projects

DC attended an NCA working group meeting in London, November 2018.
2017 Audit of patient assessment for TACO: A secondary report and educational tools are in production following report publication. A follow-up NCA on TACO is planned.
Audit of use of O negative red cells: DC discussed summary of initial results.
One recommendation is to maintain O negative red cell stocks at 12.2% instead of 12.6%. The NITC consensus is that transfusion of uncross matched O positive red cells in emergency situations should not be the first option for men, unless they are unlikely to be transfused in the future. There is a significant risk of D sensitization with every O positive red cell unit transfused to an O negative male or female.
Audit of major haemorrhage: initial results to be presented at Association of Anaesthetists in Great Britain and Ireland conference in January 2019. One aim of this audit is to produce a better working definition of major haemorrhage.
Audit of maternal anaemia: data collection nearly completed. A number of health organizations are being contacted to increase stakeholder engagement and adoption of report recommendations, including RCGP, RCOG, Public Health England and National Childbirth Trust.
Audit of FFP and Cryoprecipitate in Neonates and Children: Preliminary reports have been sent to participants.
Vein-to-Vein audit: to be piloted in NW England. The aim of this project is to provide Healthcare Trusts with a number of quality improvement tools to facilitate local audits of the different steps involved in the blood donation, patient sampling and transfusion processes.
AFFINITIE Research programme: results should be available in the near future following a meeting of Programme Steering Group in November 2018.

NCA Schedule for 2019/2020:
Autumn 2019: Re-audit of Medical use of blood
Spring 2020: Audit of PBM in Perioperative patients
Audit of FFP and Cryoprecipitate use in adults

9. NITC work plan and funding

9.1 Funding for NITC work plan

Feedback from meetings with NI Healthcare Commissioners and Medical Leaders Forum in 26 July 2018 and 3 September 2018 respectively concerning past and future NITC proposals to improve on the regional use of red cells was very positive. However funding has not yet been secured for the 5-year TRUST project. SA has contacted Healthcare Commissioners to request an update on funding options.

9.2 Anaemia Strategy for Northern Ireland

SA gave an outline of the main aims and desirable outcomes for a regional strategy to improve on the detection and management of anaemia, especially when due to haematinic deficiency. Such a strategy should involve engagement with healthcare professionals in hospital and primary care, public organizations and ideally it would be led by the Department of Health.
SA has made preliminary contact with the Public Health Agency about this proposal.
NITC Members discussed aspects of Patient Blood Management (PBM) that would require additional resources to promote and implement.
Action: SA to liaise with NITC Members in collation of evidence for a new business case for the regional provision of PBM, including an Anaemia Strategy.

10. Review of Haemovigilance Practitioner Role
KM acknowledged the excellent and ongoing work of the Regional Haemovigilance Practitioner Group. The NITC discussed at length how the HP role has evolved in the last decade.
Action: The Regional HP Team is requested to examine current HP roles in the different Trusts to see if any aspects should be revised.
Action: Regional HP Team requested to inform NITC if any changes to job plans might be required.

11. Registration of Unknown Patients
The RVH Emergency Department computer system in Belfast Trust has been successfully revised so that a 4-digit instead of a 2-digit date of birth is included in patient identification addressograph labels. The requirement for implementation of a 4-digit date of birth on systems in other Trusts is to be checked out.

12. Future National / Regional Conferences
4-5th April 2019 - NATA, Berlin
Annual SHOT Symposium – 9 July 2019 – Harpenden. Deadline for abstract submissions 26 April 2019.
BBTS 18 - 20 September 2019 - Harrogate
Action: SA to confirm date of next NITC Regional one-day conference in Oct / Nov 2019

13. National / Regional Networking
The NITC has completed a 2-year period of chairing BBTN Meetings. The next BBTN meeting in Birmingham will be chaired by England on 1 May 2019.

14. Any Other Business
<u>14.2 Development of a regional Blood Tracking System to link in with a new regional LIMS.</u>
Funding has been secured for a regional Blood Tracking System, in conjunction with the development of a regional LIMS. GS informed the NITC of preliminary work on this project, including an invitation for the appointment of NIBTS and NITC representatives to sit on the Project Board, Project Team and Project Assurance Group. AMcC agreed to help determine HP involvement through the Regional Haemovigilance Group.

<u>14.3 Annual SHOT conference</u>
SHOT is keen to recruit speakers from outside England to give presentations at future annual SHOT conferences. Sharon Hart, a Cardiac Nurse from BHSCT has agreed to participate in a debate on the nurse's responsibility for compatibility testing in the pre-administration checking process at the SHOT conference on 9 July 2019.

15. Date of next meeting
Friday 17 May 2019: 2 – 4.30 pm. Venue: NIBTS Lecture room