NI Transfusion Committee
Revised draft Minutes of Meeting Tuesday 25 September 2018
Date of issue: October 2018

Present:
Susan Atkinson, Consultant Anaesthetist, BHSCT (Chair) – SA
Louann Birch, HP SEHSCT
Emma Carley, HP, BHSCT
Damien Carson, Cons Anaesthetist, SEHSCT (Medical Audit & Implementation Lead) – DC
Sinead Carty, Blood Bank Operational Manager, SEHSCT
Beverley Craig, Head of Laboratory Services, BHSCT
Sheena Gormley, Cons Anaesthetist, BHSCT
Jeremy Hamilton, Cons Haematologist & HTC Chair, SHSCT
Zona Kelly, HP, BHSCT
Kathryn Maguire, Cons Haematologist, NIBTS
Sara Martin, HP, SHSCT
Aine McCartney, Regional HP Coordinator – AMc
Mary P McNicholl, HP, WHSCT - MP
Kieran Morris, Medical Director, NIBTS – KM
Lorna Palmer, HP SEHSCT
Lynsey Parker, Blood Bank Operational Manager, BHSCT
Shonagh Reilly, HP NHSCT
Mairead Richmond, HP, NHSCT
Graham Scott, Lead Biomedical Scientist SHSCT
Trevor Thompson, Blood Bank Manager, SHSCT
Patricia Watt - HP SHSCT - PW

1. Apologies:
Mark Bridgham, Consultant Haematologist, NIBTS
Adrian Crawford, Blood Bank Operational Manager, WHSCT
Carol-Ann Henry, HP, Biomedical Scientist, NHSCT
Don Hull, Consultant Haematologist, SHSCT
Josephine Monaghan, HP, WHSCT
Fearghal McNicholl, Consultant Haematologist, WHSCT
Bronagh O'Neill, HP, WHSCT
Tracey Steenson, HP, SEHSCT
Patrick Stewart, Cons Anaesthetist & Chair of HTC, WHSCT

2. Minutes of NITC Meeting on 18 May 2018
Approved.
SA welcomed Beverley Craig, recently appointed Head of Laboratory Services, BHSCT and Emma Craig, recently appointed Haemovigilance Practitioner, BHSCT.
Dr Patrick Stewart, Consultant Anaesthetist is now Chair of HTC in WHSCT and Dr Gary Benson is Clinical Lead of BHSCT HTT, following Dr Robert Cuthbert's retirement.

3. Matters arising
3.1 (5.3) Confirmation blood sample prior to transfusion
AMcC stated that BHSCT is advising staff that a confirmation blood sample should only be taken when requested by the hospital blood bank, in keeping with 2012 BSH Guideline.
3.2 (6.1) Leadership and Change Workshop

NITC Members found this study day very useful and informative; the most useful learning being the use of change models to implement new projects in transfusion practice.
Action: DC to circulate certificate of attendance to attendees.

4. Review and Implementation of National Guidelines in Northern Ireland

4.1 Key recommendations in 2017 SHOT Report

SHOT has written to all Trusts to inform them about the three key recommendations in the 2017 SHOT report. NITC Members have expressed concerns about adopting the first key recommendation, which was based on one incident – to include additional training and competency assessment in ABO and D blood group principles for clinical staff. The inclusion of an ABO/D component compatibility table for recipients in the regional transfusion record has been considered as a reminder for clinical staff but it could cause confusion when a blood bank has to issue components that are compatible even though they do not "fit" the table recommendations.
The NITC consensus is that the current basic knowledge in ABO and D grouping is sufficient and that more in-depth education could result in confusion, delays in transfusion and potentially increase wastage of components.
The second key recommendation states that all available IT systems and electronic blood management systems should be "considered". The new regional LIMS and blood tracking systems planned for NI Laboratory Services will facilitate implementation of this recommendation.
Pre-transfusion risk assessment for TACO (third key recommendation) is currently being implemented in NI and will be included in the regional transfusion record.
Action: SA to inform SQAT /PHA of this NITC consensus on the SHOT 2017 report key recommendations.

4.2 Red cell transfusion triggers in NI

NI guidelines on red cell transfusion were last updated in 2009, with a reduction in transfusion threshold to < 90 g/L for patients with bone marrow failure or chemo/radiotherapy. Although NICE guidelines on transfusion were published in 2015 no national standards have been set for red cell transfusion thresholds. There has been concern about the use of haemoglobin < 70g/L threshold for vulnerable patient subgroups, including non-ACS cardiac disease and elderly postoperative patients. There is however an increasing evidence base of no additional harms with restrictive versus more liberal transfusion thresholds in elderly postoperative, post cardiac surgery and hip fracture patients. Recent National Comparative Audits have used NICE transfusion guidelines as audit standards, which conflict with current indications in the NI regional transfusion request form. The NITC intends to consult clinical staff from all relevant specialties in NI Healthcare Trusts to determine whether they would or already have adopted NICE guidelines on red cell transfusion and whether they have any particular concerns about implementation of a < 70 g/L trigger in their patients.
Action: SA to invite clinical staff to participate in consultation process by writing to Trust Medical Directors and Chairs of Trust Transfusion Committees.

Action: SA to include as an agenda item for discussion at BBTN Meeting in November 2018.

4.3 Special requirements for blood components

Healthcare Trusts complete a Community Referral Form to request Community Transfusion Teams to administer home transfusions, with advice on any special transfusion requirements. There is currently no mechanism for Blood Banks to access this information, to confirm patient-specific special requirements. It is anticipated that this problem will be resolved when patient transfusion alerts and requirements are added to the NIECR (work in progress) and when the latter connects with the new LIMS. In the meantime it should be possible for hospital administration staff to add special requirements to a patient's ECR.

5. Standardization of Transfusion related documentation

5.1 Kleihauer request form

SA thanked NITC members for recent feedback on the first printer's proof.
Action: SA to make recommended changes and request 2nd proof for final checking before printing.

5.2 NI Transfusion Record including pre-transfusion bedside checks, TACO risk assessment and component compatibility

WHSCT have recently completed an audit of an old (no prompt for TACO risk assessment) versus a recently introduced (formal TACO checklist) Trust Transfusion Record (TR), which demonstrated pre-transfusion patient assessment for risk of TACO improved from 0 to 100% of transfused patients when the new TR was used. A higher proportion of patients had slower transfusions (87.5% vs. 30%) and prophylactic diuretic (30% vs.15%) when the new TR was employed, compared to the old TR. If prophylactic diuretic was not administered, the reason was documented in 85.7% of instances when the new TR was used. Frequent observations were undertaken during transfusion in 66.7% of patients identified to be at risk of developing TACO.
DC highlighted that 89% of patients in the National Comparative Audit of TACO risk assessment had at least one additional risk factor for TACO, apart from age over 70, which is also a risk factor for TACO (SHOT 2017 report). More than 70% of red cell transfusions are given to individuals over 60 years of age; in other words the vast majority of patients for whom transfusion is considered, are likely to have one or more risk factors for TACO. There has been a 20% increase in over 60 year olds in Northern Ireland in last 12 years or so. There is a risk that red cell use may increase in Northern Ireland, as the over 60 age population doubles in the next 20 years.
SA thanked the Haemovigilance Team for producing a draft regional TR following the regional consultation in June 2018. The NITC consensus is that a blood component compatibility table should not be included in the regional TR (see 4.1 above) to avoid confusion and possible delays in transfusion.
Action: Haemovigilance Team requested to update this draft and re-format for circulation to NITC Members for additional feedback.
Action: SA to update SQAT on progress in production of Regional Transfusion Record by early 2019.

5.3 NI Transfusion Request form
NITC Members have submitted some suggested changes to this form, which requires revision of content and format.
Action: SA to set up a working group of Trust representatives to update and revise this form.

6. Education and Staff Training – report by AMcC
6.1 Locum agencies for non-medical staff have been advised that they are responsible for ensuring that locum staff have up to date mandatory Right Patient, Right Blood (RPRB) training and relevant competencies to work in NI Healthcare Trusts. Haemovigilance Practitioners can provide agency staff with transfusion practice training for a charge, paid by the respective locum agency.
6.2 RPRB E-learning certificates in transfusion practice are now available from an increasing number of new companies. LearnPro RPRB e-learning certificates issued from E-learning for Health, eLearnPro and National Learning Manager are the only accredited platforms with licenses to use LearnPro. E-learning certificates from any other source are not acceptable unless a staff member has evidence that corresponding e learning has been undertaken on LearnPro.
6.3 GDPR changes in e-learning Healthcare staff can now update their own passwords. LearnPro administrators will no longer be able to edit staff details from 1 October 2018.
Action: AMcC to clarify whether LearnPro administrators will still be able to update passwords for staff, e.g. if they have changed email addresses or contact details.
6.4 Introduction to Blood Transfusion. This module is now provided on Open University, University of Ulster Magee, Queens University Nursing and Midwifery courses. Student nurses must also complete LearnPro Safe Transfusion Practice and Blood Component modules by the end of their second undergraduate year.

7. Blood component use – trends – report by DC
Monthly issue of red cells has leveled off - around 22 units per 1,000 head of population. Platelet and FFP use has plateaued, around 4 and 2.2 per 1000 head of population respectively. Month on month issues of cryoprecipitate have fallen in the last year.

8. Audit subgroup – report by DC
8.1 Where does the blood go in Northern Ireland? (WDBG)
The audit report has been published on the RQIA website; DC advised it could be disseminated in Trusts after the RQIA have corrected a number of corruptions in the new format.
Proposals for new NITC audits with potential to make further improvements in clinical practice include the following, based on results of the WDBG and single Trust pilot audits:
- Audit of anaemia and transfusion in medical patients
- Post transfusion haemoglobin checking
- Perioperative use of Tranexamic acid
- Factors influencing transfusion across Northern Ireland
- Appropriateness of transfusion with new guidelines

Funding has still to be identified to undertake any new audit proposals. Furthermore job plans of Haemovigilance Practitioners may need to be revisited, unless other Trust-based staff can be trained to undertake data collection.
Action: Trust Transfusion Committee audit representatives to be invited to attend an ad hoc meeting to consider which new audit proposals should be prioritized.

8.2 National Comparative Audit (NCA) Projects

2017 Audit of patient assessment for TACO - report published. This audit demonstrated that 89% of patients had at least one risk factor for TACO, with hypoalbuminaemia, concomitant intravenous fluids and positive fluid balance being the most common risk factors after age. Haemoglobin checking after the first unit was undertaken in only 12% of cases.
Audit of massive haemorrhage – data collection planned for Autumn 2018
Audit of maternal anaemia – data collection by midwives & obstetricians in Autumn 2018.
DC has submitted NITC Members' feedback to the NCA working group to amend and clarify proformas for these new audits but insufficient time has been allowed for incorporation of these suggestions prior to data collection.
Action: DC to request a longer time interval between stakeholder feedbacks on new proposals and start date of data collection.

9. NITC Work plan and funding

SA discussed the presentations given to NI Healthcare Commissioners and Medical Leaders Forum on behalf of the NITC on 26 July and 3 September respectively. The main focus was on the 43.2% reduction in red cell use in Northern Ireland following NITC coordinated regional audits and implementation plans between 2005 and 2017. Both parties were very supportive of new NITC proposals to make further improvements in use of blood components and to develop a regional strategy for the management of anaemia. NI Healthcare Commissioners complemented the NITC on successfully sustaining improvement in transfusion practice and are currently exploring funding options for future NITC proposals.
Action: SA to map out a regional strategy to improve on the management of anaemia.

10. Registration of Unknown Patients

A new naming convention has been tested successfully to register unknown patients on a hospital PAS and to generate 395 H&C numbers on NIECR. Stakeholders are now working with BSO and Link Labs software systems to see if a 4-digit instead of a 2-digit year of birth can be used to avoid confusion of 1901 with 2001.
Action: SA to discuss implementation plan with stakeholders

11. Future National / Regional Conferences

3-5th October 2018 - BBTS Annual Conference, Brighton
24th October 2018 - NHO Conference, Dublin. 'Haemovigilance, its many dimensions'
4-5th April 2019 - NATA, Berlin
DC proposed a study day on Systems Training in 2019 to up skill NITC Members to reduce repetitive errors in transfusion practice.

SA invited suggestions for a regional conference on transfusion practice next Autumn, which could include recent NITC and individual Trust projects on patient blood management.

12. National / Regional Networking

The NITC is hosting the next BBTN Meeting in Belfast on 6 November 2018. The BBTS Transfusion Practitioner group is setting up a group online forum.

13. Any Other Business

13.1 Infected blood and blood products public inquiry

KM advised that preliminary hearings of this UK inquiry commenced this week. It concerns the deaths of individuals infected with hepatitis C and/or HIV following the administration of blood products for the treatment of haemophilia and other conditions from 1970. It is anticipated that this inquiry will last two and a half years.

13.2 Electronic patient information leaflets on transfusion. PW informed the NITC that SHSCT has translated the NHSBT leaflet "Will I need a Blood Transfusion?" into the ten most commonly used additional languages in Northern Ireland and that electronic versions are available for other Trusts to download.

13.3 Pilot of single person pre-transfusion checking

MP informed the NITC that WHSCT introduced single person checking for blood component administration on 20 August 2018. Staff feedback has been positive for this 3-month pilot, which has been undertaken in the Rapid Response Clinical Intervention Centre and Haematology Day Unit in WHSCT. WHSCT is considering further pilots in other clinical units.

14. Date of next meeting

Friday 25 January 2019: 2 – 4.30 pm
Venue: NIBTS Lecture room