

SOUTH THAMES TRANSFUSION SCIENCE TA(D)G.

DRAFT

Minutes of meeting 29th November 2012

Dining Room, Euan Keet Medical Education Centre
Princess Royal Hospital, Hayward's Heath

Sponsors— Tutela and Arena Instrumentation

Present:

Name	Based at	E-Mail
Malcolm Robinson (MR)	Chair	malcolm.robinson@wsht.nhs.uk
Shirley Hannam(SH)	Secretary	sbh2555@yahoo.co.uk
Richard Whitmore (RW)	NHSBT Tooting	Richard.Whitmore@nhsbt.nhs.uk
Sally Procter(SP)	NHSBT Tooting	sally.procter@nhsbt.nhs.uk
Malcolm Needs (MN)	NHSBT Tooting	Malcolm.Needs@nhsbt.nhs.uk
Jenny Linkins (JL)	Eastbourne DGH	Jenny.linkins@esht.nhs.uk
Emma Clenshaw(EC)	Darent Valley Hospital	emma.clenshaw@dvh.nhs.uk
Alison Davis(AD)	Medway Hospital	alison.davis@medway.nhs.uk
Rashmi Rook (RR)	East Surrey Hospital	Rashmi.Rook@sash.nhs.uk
Bob Slater (BS)	Pembury Hospital	robert.slater@nhs.net
Wendy Bonnert(WB)	Maidstone Hospital	wendy.bonnert@nhs.net
Kirsten King(KK)	Spire Gatwick Park	kirsten.king@spirehealthcare.com
Jayne Barmby (JB)	Epsom General	Jayne.barmby@esh.nhs.uk
Lorna Toward(LT)	Spire Gatwick Park	lorna.toward@spirehealthcare.com
Susan Mitchell	William Harvey Hospital	smitchell13@nhs.net
Pam Glinski(PG)	Hayward's Heath	pamela.glinski@bsuh.nhs.uk
Samantha Sadu(SS)	NHSBT Tooting	Samantha.sadu@nhsbt.nhs.uk
Julie Cole(JC)	Royal Sussex, Brighton	Julie.cole@bsuh.nhs.uk
Zoe Sammut(ZS)	St. Richards, Chichester	zoe.sammut@wsht.nhs.uk

1. Chair's opening remarks:

The Chair welcomed everyone to the meeting and suggested around the introductions as there were 'new faces' present. Main focus of this meeting to be the new BCSH Guidelines, pre-transfusion compatibility procedures in Blood Transfusion Laboratories, but a joint meeting with the London TADG has been proposed at either Charing Cross Hospital or St Mary's Hospital.

The Chair thanked the Sponsors for today meeting; from Tutela and Arena Instrumentation

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Contact details of Sponsors are;

Sally Towle <i>Tutela National Sales Manager</i>	<i>Tutela Medical Tel: 07909 751427</i>	stowle@tutelamedical.com
Gary Moseley Business Development Manager	Arena Instrumentation T; 01452 720740 M; 07967619640	gary.moseley@arena-instrumentation.com



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Feedback on this presentation back by those present to Gary Moseley please

2. Apologies

Name	Based at	E-Mail
Matthew Free (MF)	Kings College Hospital	matthew.free@nhs.net
Leslie Delieu(LD)	Darent Valley Hospital	leslie.delieu@dvh.nhs.uk
Bob Goddard (BG)	Margate Hospital	robert.goddard@ekht.nhs.uk
David O'Connor (DO)	Eastbourne	oconnor.david@esht.nhs.uk
Tim Maggs (TM)	St. Thomas' Hospital	tim.maggs@gsts.com
Sue Rudd (SR)	St Helier	Sue.rudd@esth.nhs.uk

3. Minutes of previous meeting and matters arising (not on agenda elsewhere)

Minutes accepted.

Discussion about where the TADG future lies. Should we consider being affiliated to the SECRTC as not many people from London attend this meeting. Also whether we should consider joining with the Transfusion Practitioners as they struggle with sponsorship for their meetings.

Update on hospital exchange with NHSBT staff, this has started on both sides.

4. Treasurer's Report

Only 2 of the 3 sponsors from the last meeting paid money into the account, MR to chase up. Balance as of end of August £1516.32
LD and SH to arrange with the bank the other signatories on the account. The TADG has been asked to support the Education Day in January 2013, it was agreed to give £1000 in support.



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5. New BCSH Guidelines on pre-transfusion testing: Tools, GAP analysis and risk assessments: Where next?

Discussion on BCSH guidelines and outlined the RAG rating done by MR. RAG rating to be sent out with the minutes.

MN drew attention to the algorithm on P18 “when/when not to test for weak D”



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6. Interesting Cases

MN to send interesting cases to MR to embed. No other interesting cases reported



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7. No Name, No Blame

(i) A unit of blood out of the fridge for 33 minutes (OTC). The expiry date on the bag did not match with the expiry date on the paper work. Returned to the lab, expiry date corrected on the computer system and blood put back into stock fridge despite being OTC. Selected for another patient, issued and used. Reported to MHRA

(ii) Sample from long term transfused patient with autoantibodies sent to RCI for investigation of possible allo antibodies. None detected, RCI suggested Immediate Spin(IS) crossmatch. Hospital blood bank computer had recorded presence of anti-K previously detected by RCI therefore should not do IS. All records search at the hospital and RCI, no previous report found with anti-K. Further investigation found the report from RCI had been mis-reported, patient did not have anti-K.

(iii) Took over from day staff on the late session, units up on crossmatch were crossmatched against the wrong sample, two samples out on bench BMS had picked up the wrong sample, discovered as the blood groups didn't match

(iv) On call staff, emergency crossmatch for patient with anti-C^w couldn't find any C^w antigen negative blood so ordered 4 units to be sent from NHSBT on 'blue light' delivery. No blood was required for the patient. BMS re-trained

(v) Two units of blood issued for patient but labels were transposed, staff collecting the blood noticed the error and it was corrected by BMS staff

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8. E-Mail questions: feedback



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9. LUNCH

10. Chair and Secretary for the group

No change MR and SH to continue for another year

11. Feedback from other meeting:

TP Education Event in Maidstone: November 8th Feedback

BMS Education Day in Brighton 31st January 2013: Cost to TADG group (discussed in item 4)

London RTC (RW)

London TADG (RW)

General feedback from the meeting in Maidstone was all positive, excellent meeting.

Also suggested MR adds the Chair of the London TADG to the e-mail list so they receive the minutes of our meetings.

12.NHSBT business

RCI Report: Please telephone RCI when sending urgent samples, **including** coming through to the **RCI on-call BMS (via Issues)** during on-call hours.

RW to send to MR to embed

Other matters:

Long dated platelets ordered via Issues (OBOS) will have an expiry date of 48 hours, maximum, now as there is a problem supplying platelets with a longer expiry date as more wastage on the short dated platelets at NHSBT.

If **orders are changed on OBOS** after NHSBT has received it you must phone to let them know the order has been changed.

HLA matched platelets are not on OBOS and will not be in the foreseeable future.

Very important to record the increment in platelet count when HLA platelets are transfused. H&I do not always receive this information and are willing to talk to the group about the importance of the incremental

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data. Studies have shown the post transfusion sample can be taken 10 minutes after the transfusion, do not need to wait 1 hour as previously thought.

Please do not send samples less than 1ml to RCI for testing, this is insufficient for all the tests required and delays the results as the patients have to be recalled for bleeding when the report has been sent back from RCI to the hospital as insufficient, also make sure samples are correctly labeled.

13. RTC Committee report

MR to embed

14. TP Group

LD not present no report given

15. AOB and Future Meetings

MN -- two new books out: 3rd Edition Blood Group Antigens facts Book
IBMS Fundamentals of Biomedical science: Transfusion and Transplantation
Science edited by Robin Knight

New edition of Mollison is out now or due out now. New Jeff Daniels book due out next year.

New private hospital open in Brighton, MHRA not interested in compliance as they have never received blood and products. NHSBT had to inspect.

Suggested future meeting dates:

Thursday 21st March 2013 at Hayward's Heath: Room booked so Wednesday 20th March 2012 suggested.

Thursday 20th June 2013 Worthing

Thursday 19th September 2013 TBC

Thursday 5th December 2013 East Surrey?

Copy of the minutes to:

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Aman Dhesi; NBTS: Hosting minutes on RTC website	NHSBT	Amanpreet.Dhesi@nhsbt.nhs.uk