Confirmed

Newcastle Blood Centre User Group

Meeting at
Lecture Theatre, Newcastle National Blood Centre

Wednesday 30th January 2013.

Present:
Chris Elliott (CE) - Chair
Sue Barnes (SB)
Jonathan Boxshall (JB)
Jill Caulfield (JC)
Robin Coupe (RC)
Cheryl Kempton (CK)
Dave Lander (DL)
Michelle Lannon (ML)
Joanne Lawson (JL)
Martin Maley (MM)
Yvonne Scott (YS)
Karen Simblet (KS)
Hazel Tinegate (HT)
Russell Urwin (RU)
Karen Ward (KW)
Vanessa Winfield (VW)
Mark Williams (MW)
Janice Robertson (JR) minutes

Apologies:
Nicola Main (NM)
John Sutton (JS)

No representation from Sunderland, North Tees or North Cumbria

1.	**CE welcomed the group.**	
2.	**Presentation** **NHSBT Reagents** Presented by Michelle Weston – Unable to attend, will present at May meeting. MW asked for specific issues to be forwarded to him, these will be engaged at face to face meetings. **New Compatibility Guidelines** Group discussed summary of key recommendations. Main issues: • MHRA request for 2nd person check on manual checks The guidelines call for identification of 'critical points' within transfusion processes. Several members of the group noted that the MHRA are very interested in processes that include the second check of any manual process within the lab (group, screen or crossmatch). Two routes seem to have been developed either ensure checking takes place at time of test (even if this means calling someone in) or out of hours doing a retrospective check during the next duty session. • Running QC with every manual Crossmatch Not everyone is doing this yet but all will be looking to implement as appropriate. • Map of compatibility process Most labs have flow charts of their processes but these may not map all aspects of the entire chain so add on will be required	

	• Return of units to stock Most sites have not changed their sample availability and stock return schemes as yet, however a number are looking to do so in the future. Some will have 48hr sample viability with 24hr blood availability while others are looking to allow release of units on a sample up to 78hrs with control of blood to stop availability of units post 72hrs. • Retention of samples for 3 days post transfusion This causes more problems than almost anything else in the guidelines. Most sites are being very pragmatic and it is the pre-op assessed patients who present the most difficulty as they are often assessed two or more weeks in advanced and if samples not frozen (and most are not) then blood is allocated on samples no longer stored or viable. One solution is to get a pre transfusion sample immediately before the operation on arrival of patient (but still allocate units on old sample if necessary). Most people around the table queried the necessity of this recommendation in that it would not prevent a reaction/error however it presence was explained to be that of being compatible with GMP. • Who is permitted to issue units? This was debated and a variation was found across the region. It was clear that while staffing levels etc did play a part, it was the functionality of the local IT systems and test automation that clearly differentiated where the line was drawn with regard to support staff interaction in transfusion • Concessionary release, recalls and process deviations. Group agreed that use of concessionary release forms was a useful way of documenting component/product release outside of the normal process (although often for good reason).	
3.	**Minutes of previous meeting 09.10.12** Minutes confirmed. Can be posted onto website. **Matters arising** • Scientific & Technical Training staff within NHSBT have been informed of the demand from local hospitals for the "Practical Introduction to Transfusion Science" course to be provided at the Newcastle Centre. A survey of potential demand has been conducted and this proposal is now awaiting confirmation from NHSBT Training. Although NHSBT is keen to provide this type of training in the Newcastle Centre, at the present time no details for this provision have been confirmed. Laboratory Managers will be informed of further developments in due course and are encouraged to consider existing venues for this training until Newcastle arrangements have been confirmed. NHSBT training provision can be viewed on the "Hospitals & Science" website. • RC confirmed that the change notification for storage of frozen components (to below -25C) has been incorporated into the NHSBT Portfolio of Blood Components (available from the "Hospitals & Science" website). D Lander reported that the blood component label text will be updated through a change to the PULSE system. A date for this change is being planned but has not yet been confirmed.	JR
4.	**NHSBT Departmental Update** **Dave Lander – PTI Manager** • Euroblood pack Validations - Newcastle has been participating in validating blood collection pack systems as part of a European Blood Alliance tender process. Newcastle validated a number of packs between April and October 2012. All the data collected is now being reviewed and hospitals will be notified of the outcome in Spring 2013. • Directorate change - the Patient Services Directorate which included Manufacturing, Testing and Hospital Services has been merged with the Blood Collection directorate to form a single Directorate - Blood Supply - within NHSBT. The structure of this new directorate is currently being finalised. • It has been announced that the Brentwood and Lancaster stock holding units are under review with regard to their future. The outcomes and recommendations will be presented to the NHSBT Board in March 2013. • There is a National Consultation underway within Hospital Services in	

NHSBT which is looking to implement standardised structures, shift rotas, duties etc across all Hs departments in NHSBT.

Karen Simblet – QA Manager

- Audit next week.

Martin Maley - RCI

- RCI now part of Diagnostic and Therapeutic Services (DTS)
- CPA surveillance visit 08/02/13
- EQA results satisfactory – for BTLP (antibody identification) and AQQAS (quantitation) exercises. .
- SPICE is being used by some trusts, others awaiting administrator input. Undergoing change of software to allow selection of reports to be printed.

5. **Customer Service Update**

Report for NBCUG 300113.pdf

6. **Trust / Hospital Reports**

Hospital reports.pdf

7. **Regional Audits/ surveys**

- **Wrong Blood in Tube**
  Report to be circulated to trusts.
  Almost half of all incidents involved specimens taken by doctors, other major factor demonstrated to be labelling away from bedside. Champion 'Stand By Me'.
- **Transfer of blood with patient**
  Data analysis in progress.
  Propose policy split into two documents a) Blood components transferred between hospitals b) Blood components transferred with patient, this should only be done when appropriate level of escort in place – doctor and/or specialist nurse.
- **Where do platelets go?**
  Andrew Charlton working on draft article and reports for HTC's..
- **Massive Haemorrhage in North East**
  Planning stage, first meeting 31st January 2013.

8. **Education**

- **Quality Audit Training Workshop**
  Wednesday 6th February 2013, Newcastle Blood Centre.
  20 delegates registered, final preparations in progress.
- **Pre-assessment nurses**
  Tuesday 24th September 2013, Newcastle Blood Centre.
  2 pre assessment nurses on working group.
- **RTC Annual Education Symposium**
  One born every minute
  Tuesday 8th October 2013, The Durham Centre.

9. **NBTC Lab managers group**

Next meeting 11th February 2013.

10. **MHRA Blood Consultative Committee**

Next meeting 6th March 2013

11. **RCI On-Call Charges Consultation**

on call premium charge.pdf

12.	**AOB** None	
13.	**Date and time of next meetings** 1pm Wednesday 8th May 2013 1pm Wednesday 2nd October 2013. Lecture Theatre, Newcastle Blood Centre.	