Confirmed Minutes of the South Central RTC Meeting
Held on 28 February 2019
Regency Park Hotel, Thatcham

Attendees		
Diana Agacy	Transfusion Practitioner	Southampton Hospital
Simeon Ariola	Nurse Practitioner	Southampton Hospital
Neil Bailey	Assoc Practitioner	Queen Alexandra Hospital
Jenny Bodkin	Transfusion Practitioner	Hampshire Hospitals
Pushkar Dadarkar	Consultant Anaesthetist	Wexham Park Hospital
Anwen Davies	PBMP	NHSBT
Alison Davies	Transfusion Laboratory Manager	Queen Alexandra Hospital
Kerry Dowling	Transfusion Laboratory Manager	Southampton Hospital
Kim East	Transfusion Practitioner	Wexham Park
Pedro Gamito	BMS	Southampton Hospital
Joshna Gopal-patel	Transfusion Laboratory Manager	Milton Keynes Hospital
Sharon Greasley	Director of Nursing	BMI Hospitals
Anita Haines	BMS	Queen Alexandra Hospital
Tanya Hawkins	Transfusion Practitioner	Royal Berkshire Hospital
Tracey Hay	BMS	Queen Alexandra Hospital
Lucy Jerrum	BMS	Queen Alexandra Hospital
Acy Joji	Ward Manager	Horton Hospital
Steven Le Prevost	BMS	Queen Alexandra Hospital
Cathy Lim	CSM	NHSBT
Caroline Lowe	Transfusion Practitioner	Milton Keynes Hospital
Gwynn Matthias	Consultant Haematologist	Queen Alexandra Hospital
Peter McQuillan	Consultant ICU	Queen Alexandra Hospital
Subir Mitra	Consultant Haematologist	Milton Keynes Hospital
Nicola Mundy	Transfusion Laboratory Manager	Royal Berkshire Hospital
Jacky Nabb	RTC Administrator	NHSBT
Thea Pawley	Assoc Practitioner	Queen Alexandra Hospital
Terrie Perrie	Transfusion Practitioner	Milton Keynes Hospital
Beverley Phillips	BMS	Southampton Hospital
Kate Priest	BMS	Southampton Hospital
Jon Ricks	Transfusion Practitioner	Southampton Hospital
Chris Robbie	Speaker	MHRA
Julie Ryder	Transfusion Practitioner	Swindon Hospital
Nigel Sargant	Consultant Haematologist	Hampshire Hospitals
Dipika Solanki	Transfusion Practitioner	Oxford University Hospital
Julie Staves	Transfusion Laboratory Manager	Oxford University Hospital
Charyline Steele	BMS	Southampton Hospital
Michael Terry	Surgeon	St Mary's IOW
Angelika Themessl	BMS	Southampton Hospital
Howard Wakeling	RTC Chair SEC	
Dana Williams	Captain	Royal Centre for Defence Medicine

10.00	Meeting Opens	Action
1	**Electronic Sample Labelling – Pros and Cons** Presentation given by Kerry Dowling, Transfusion Laboratory Manager, Southampton Hospital, and Julie Staves, Transfusion Laboratory Manager, Oxford University hospitals available on http://www.transfusionguidelines.org/south-central Discussion included: • 789 Wrong Blood in Tube (WBIT) event were reported in 2017 to SHOT (Serious Hazards of Transfusion) Haemovigilance scheme • BCSH guidelines for pre-transfusion sampling (2012) states unless a secure electronic patient identification system is in place, a second sample should be taken to check the ABO group of a first-time patient before transfusion • Not all electronic systems are the same • A bedside electronic system allows the user to print labels in the sample circle • Audit data at John Radcliffe shows a big reduction of WBIT events using a bedside electronic system • Interface with IT systems limits the number of characters available • Wrist band audits are carried out at John Radcliffe, this includes phlebotomy • Southampton have a two-sample rule, this can result in more samples being taken. The second tube is supplied by the lab for a group check, to stop both samples being taken at the same time • Southampton have changed practice, trollies are used for labelling samples at the bedside. They are introducing an electronic system for all samples, not just transfusion • The two-sample rule also applies to Trauma patients, labelling is carried out by a code red nurse • Southampton surgical patients have two wristbands, one on the wrist and one on the ankle, if one is removed to insert a line it is applied to the forehead • Conclusion – Human factors mean that no process is infallible. Whichever method is used, adherence to protocol is key, we should make it easier for users to do the right thing	
2	**Using incident reporting as a tool** Presentation given by Chris Robbie, Higher Haemovigilance Specialist, MHRA available on http://www.transfusionguidelines.org/south-central Discussion included: • There has been an increase over the last 2 years in categories relating to human factors • Trusts are not recording staffing and workload as an issue. Reporting it would back up anecdotal evidence, the data currently only records this at 8% • Trusts are finding it difficult to recruit trained staff, levels may be right but staff are not experienced. Need for training puts pressure on experienced staff • People are not reporting staffing issues and workload as a problem as there is a fear of inspector visits. Chris explained that the inspectors are there to help identify the issue and provide support • Issues should be escalated to the Trust Risk Register • Mike Dawe is the Haemovigilance Team Manager at MHRA, who visits Trusts as part of his role and provide advice and guidance on addressing problems. Southampton have been visited by Mike Dawe and Chris Robbie and found it very useful. Mike Dawe will share capacity plans which will help the Trust to produce their own • Trusts should contact Mike Dawe to arrange a visit if required • There are now flow diagrams available to facilitate hospitals to identify true root causes and effective corrective and preventative actions when investigating adverse events.	

3	**Centre of Defence Path – Human Factors** Presentation given by Captain Dan Willis Royal Centre for Defence Medicine available on http://www.transfusionguidelines.org/south-central Discussion included: • The way we perform as individuals and as teams is not exclusive to the military • Question 'How does QMS manage the uncertainty in the field?' Answer 'Try to create SOPs with flexibility for people to make decisions. If not escalate to change the SOP or equipment' • Question 'How do you approach / challenge hierarchy?' Answer 'There is a flatter hierarchy based on specialities and deployment' • Audit for deployment 6 monthly • Transfusion labels are handwritten	
4	**What is the regional picture?** Presentation given by Anwen Davies PBMP NHSBT This presentation was sent to HTTs in the South Central Region prior to the meeting. If you would like any further information on this presentation please contact jacky.nabb@nhsbt.nhs.uk Discussion included: • Queen Alexandra hospital have moved from O D neg to O D pos • Southampton have implemented emergency O D pos into all of their remote fridges. They have just finished a project to address problems with wastage relating to the air ambulance and hope see an improvement next year • Cathy Lim to contact Mike Terry to discuss platelet stock • Investigate availability of data pro capita per Trust	**CL** **AD/JN**
5	**Workshop sessions** The meeting split into four groups to review four case studies: 1. Group A – Elaine Bromiley Case – Routine Sinus Surgery 2. Group B – Baby transfused with mum's blood 3. Group C – Sample Validity Case 4. Group D – Specific Requirements Not Met Case The feedback from these sessions is attached to the minutes Also attached is the Patient's Safety First document 'Implementing Human Factors in Healthcare' as mentioned at the meeting	
8	**Minutes of the previous meeting** The minutes of the meeting held in June 2018 were approved.	
9	**Hospital Update** **Queen Alexandra** • MSoft go live is still awaited **Milton Keynes Hospital** • UKAS inspection December • Electronic care system not ready for transfusion yet • New Cancer Centre being built in Milton Keynes due to be opened in November **Hampshire Hospital** • Putting together a business case for a change of Blood track system **Wexham Park Hospital** • Have moved from A D neg Platelet stock to A D pos • New reporting system being introduced	

	Royal Berkshire Hospital • Trial of Rotem machine in maternity, will not communicate with LIMS • Working with maternity to reduce Hb level to 70, currently 75 • Still experiencing issues with electronic prescribing • Introducing new analysers • New IT system being introduced. **Southampton Hospital** • Working on a single unit red cell project • Platelet usage and wastage reduction project on going • Preparing for Blood track upgrade • Working on electronic ordering and prescribing • UKAS inspection upcoming **Oxford University Hospitals** • Revamped blood fridge training • Developed in house e learning due to go live March/April **Question re transfusion training for doctors as to whether consultants are also trained** • OUH - TP provide training for FYI doctors each year • Milton Keynes and Wexham Park have training updates for consultants who like to attend separate sessions **NHSBT** Update given by Cathy Lim, CSM, NHSBT **Leaking blood packs** • If a leaking blood pack is discovered contact Hospital Services (HS) and do not discard the unit. • HS will ask you to complete a pack defects form, return the leaking pack to NHSBT in a bio-hazard container and will also take further details relating to any contaminated packs. Providing NHSBT have details of any contaminated packs they do not need returning. • Please ensure all leaking red cell and platelet packs are reported to NHSBT. • Only submit a credit request for these units if they have been reported to NHSBT. **Sample Tracking** • Continuous Improvement Event planned to look at tracking of samples within NHSBT **Credits** • Please submit credits within 3 months of the expiry date of the component • Please add a comment to any “MIS” (miscellaneous) credits requests **Investigation of possible transmission of non-bacterial transfusion-transmitted infection** • If a patient is suspected of having possible non-bacterial transfusion-transmitted infection, the case will be investigated by NHSBT clinicians working within microbiology services. Telephone: 0208 957 2988 Secure fax: 0208 957 2884 Email: nhsbt.transfusionmicrobiology@nhs.net **CEO for NHSBT** • Betsy Bassis will take up the role on a permanent basis from 4th March 2019	
10	**Regional update**	

	Budget ○ Sponsorship gained has enabled us to stay within budget despite the cancellation charge for the March 2018 meeting being charged to this financial year. The budget for 2019/20 will be reduced by approx. 15%. Sponsorship to be gained **Next meetings** ○ RTC meeting and Education Symposium June 19th 2019, Transfusion Bites November 6 2019 both meetings to be held at the Regency Park Hotel, Thatcham	
15.30	**Meeting Close**	