Confirmed Minutes of the South Central RTC Education Symposium & Meeting

Challenge and Change

Held on 12 February 2014

Regency Park Hotel

Attendees		
Diana Agacy (DA)	TP	Southampton Hospital
Jon Bailey (JB)	ACF,ED	John Radcliffe Hospital
Donna Beckford Smith (DBS)	TP	Stoke Mandeville Hospital
Susan Brunskill (SB)	Senior Information Scientist	NHSBT
Michael Cheung (MC)	TLM	Nuffield Hospital Hampshire
Tony Cleal (TC)	BMS	Queen Alexandra Hospital
Marie Cundall (MC)	Senior BMS	Royal Hampshire County Hosp
Pushkar Dadarkar (PD)	RTC Chair	Wexham Park Hospital
Christine Ellis (CE)	TP	Wexham Park Hospital
Maria Durkin (MD)	Senior Sister	Southampton Hospital
Edward Fraser (EF)	TP	Oxford University Hospitals
Sharon Greasley (SG)	Director of Nursing	BMI Healthcare
Kay Heron (KH)	TP	Queen Alexandra Hospital
Beverly Janes (BJ)	ITU Sister	Southampton Hospital
Liza Keating (LK)	HTC Chair	Royal Berkshire Hospital
Carolina Lahoz (CL)	Consultant Haematologist	Wexham Park Hospital
Steve Le Prost (SLP)	BMS	Queen Alexandra Hospital
Janet Martin (JM)	BMS	Queen Alexandra Hospital
Gwynn Mathias (GM)	Consultant Haematologist	Queen Alexandra Hospital
David Miles (DM)	Data Analyst	NHSBT
Jacky Nabb (JN)	RTC Administrator	NHSBT
Mark Offer (MO)	Consultant Haematologist	Wexham Park Hospital
Terrie Perry (TP)	TP	Wycombe General Hospital
Donna Rawlings (DR)	SNR S2 NICU	Southampton Hospital
Michelle Ray (MR)	CSM	NHSBT
Susan Rockley (SR)	TLM	Wexham Park Hospital
Nigel Sargent (NS)	Consultant Haematologist	Hampshire Hospitals Trust
Khuram Shahzad (KS)	Senior Transfusion	Buckhinghamshire Hosp Trust
Ben Sheath (BS)	BMS	Wycombe General Hospital
Louise Sherliker (LS)	PBMP	NHSBT
Liane Simons (LS)	HTC Chair	Buckinghamshire Hosp Trust
Dawn Smith (DS)	TLM	Southampton Hospital
Simon Stanworth (SS)	Consultant Haematologist	NHSBT
Rod Sutherland (RS)	Lead Transfusion	Spire Southampton
Anthony Stock (AS)	HTC Chair	Milton Keynes Hospital
Claire Whitham (CW	Senior Transfusion	Buckinghamshire Hosp Trust

Apologies		
Kim East	TP	Wexham Park Hospital
Tanya Hawkins	TP	Royal Berkshire Hospital
Peter McQuillan	HTC Chair	Queen Alexandra Hospital
Andy Thompson	TP	St Mary's IOW
John Travers	TLM	Hampshire Hospitals Trust
Vicky Warburton	TP	Hampshire Hospitals Trust
Catherine Wilson	TP	Hampshire Hospitals Trust
Alison Wright	TP	Milton Keynes Hospital

1) Massive Haemorrhage review of protocol – Presented by Jon Bailey

Points covered included:

- Massive Haemorrhage is analogous to Cardiac arrest, hospitals should consider one call for Massive Haemorrhage using the same telephone number as cardiac arrest i.e. 2222. At some Trusts up to six phone calls are required to activate the massive haemorrhage protocol.
- The SC audit identified that Trusts have differing components of their Massive Haemorrhage Packs; it was considered that consistent number ratios may be helpful.
- A dedicated porter for the duration of a Massive Haemorrhage episode is considered vital (to deliver blood AND collect samples for analysis)
- Uniformity across Trusts would enable consistency, familiarity, training and improve the availability of comparative data
- Wexham Park Hospital stated that Trust use the same number as Cardiac, 2222, for Massive Obstetrics Haemorrhage and they considered that it would be easy to add Massive Haemorrhage Protocol to same number
- SS advised that there is a USA trial looking at ratios of rbc:FFP. 1:1 being compared to 1:2
- BCSH guidelines for standardisation is awaited, it is thought it should be available in the next 3-4 months
- There is no firm consensus within protocols for stand down of a Massive Haemorrhage episode.
- PD asked how feasible a regional protocol is considering the significant variation in practice from each trust.
- It was agreed that the single phone call to a known number would be the thing to move on to.
- Should consideration be given to a Massive Haemorrhage Protocol Course as with ALS?

2) Multi Regional Audit of Blood Component transfusion in liver cirrhosis - Presented by Simon Stanworth

Points covered included:

- RBC – current practice is to transfuse if Hb <80, the trial suggests that Hb <70 would be acceptable
- FFP - for Bleeding or procedures. The evidence is that PT is a poor predictor. Standard dose does not improve INR
- Many are not checking INR after FFP transfusion.
- Restrictive strategy – appropriate

Recommendations:

- Separate transfusion guidelines for liver cirrhosis suggested, hard to advocate threshold in bleeders
- FFP pre-procedure evidence shows that there is no benefit, consider VTE prophylaxis.
- Check INR after FFP

3) Transfusion to women under age of 40 - Presented by Mark Offer

Retrospective audit of all transfusion episodes (>24 hours apart) in female patients < 40 years of age, over a 15 month period from January 2012 to March 2013. Excluded those patients who had the massive transfusion protocol activated, patients suffering from thalassaemia or under-going regular transfusion and children under 1 years of age.

Points covered included

- Patients were being transfused due to subjective symptoms such as feeling tired, looking pale
- Is the target too high? One third were transfused to Hb >10, therefore use only one unit. Wexham Park and Milton Keynes have a single unit policy. NHSBT are producing a poster similar to the platelet poster ‘don’t use two when one will do’
- For pregnancy consider oral iron and iv iron.

4) Systematic Reviews – Presented by Susan Brunskill

Points covered included:

- A systematic review is a literature review that has a clear defined question & follows a series of (rigorously researched) procedures
- Supports policies, arguments, justification for audits, challenges clinical practice
- The team are approached with questions to review and hold a quarterly meeting to assess whether it is a quality study
- Transfusion Evidence Library provides users with access to randomised controlled trials from 2002 to present, selected good quality systematic reviews and direct free access to Open Access articles please se : **transfusionevidencelibrary.com** website

5) Patient Blood Management Update

Following the PBM meeting in September three working groups were formed to take forward agreed objectives

5.1 Anaemia

Aims

a) Regional approach

- The South Central Priorities Committee have produced a policy statement :(no. 94 'intravenous iron for iron deficiency anaemia') and there is a more detailed commissioning report, which was reviewed in January 2013. These documents outline the circumstances in which IV iron will be funded
- Local Trusts are required to agree funding with commissioners (MAC approval etc.)

Action: the SC RTC group needs to share good practice, such as pre op iron protocols already in place

b) Top 10 tips

- Under construction

Action: produce the top ten tips for IV iron with links to relevant information behind each tip

Patient Centred approach, not cost centred

- Develop / share clinical protocols / best practice

Action: Gather information, post to RTC website

c) Patient involvement

- Patient information leaflets for oral and Iv iron
- Jehovah's Witness representative on group

Action: Use OUH oral iron PIL as an example. Search for other examples

5.2 Tranexamic Acid; results of SCRTC audit of practice

Aims:

a) Are Massive haemorrhage protocols are available?

- All Trusts that responded have a Massive Haemorrhage protocol Is Tranexamic Acid part of the Massive haemorrhage protocol?

b) Does pre-hospital care use Tranexamic Acid?

- Most of those Trust responding have Tranexamic Acid within their protocol

c) Pre hospital care

- All air ambulance services that replied gave 1g TA, although time did not permit to contact all air ambulance crews and private ambulance services. The results were not clear for Paediatrics.

d) How much are we Buying Vs Massives?

e) Fibrinogen triggers

- All Trusts that responded and have TA in their protocol have Fibrinogen Triggers

Discussion points included:

- The need to educate to use TA up front
- The risk of thrombosis not being addressed
- Should the dose be based on kg rather than standard 1G
- BCSH Guidelines may address some of these issues

5.3 Information

Aims

a) Produce a wrong blood in tube database

- The database has been distributed to all TLMs for completion of base data and 2 years retrospective WBIT incidents to enable benchmarking. Data will be collected every 6 months and reports produced

b) Regional Standard for sampling and labelling

- These have been agreed and are to be circulated

c) Form a working group within the RTC to review what is available and what would be useful

- To be taken forward

6) – RTC Chair Update

PD gave an update from the October NBTC meeting, full details can be found in appendix 1

7) HTC Update

7.1 Wexham Park

- Massive Obstetrics Haemorrhage protocol and Massive Haemorrhage protocol have been produced, the paediatric massive protocol is in progress,
- The audit on transfusions to women under 40 was completed and results presented today,
- The Trust is to be acquired by Frimley Park Hospital

7.2 Buckinghamshire Hospital Trust

- Rotem in regular use in theatres (lab took responsibility for training), will share algorithm used with the group
- Consent form and blood info leaflet being trialled
- Local retrospective consent audit
- Cell Salvage – Anti D guidelines have just come out

7.3 Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital

- NHS numbers were introduced at the beginning of January,
- Have updated massive transfusion policy
- Redesign of Transfusion webpage
- Holding a joint HTC meeting in March, they were previously two separate Trusts
- Local audit on consent for transfusion
- Question – are hospitals going to be stocking more methyline blue FFP for vCJD for 18 year olds born in 1996? Southampton use Octoplas, NHSBT looking to provide pooled product, SABTO have a confirmed position on it

7.4 Milton Keynes

- Audit showed that some nursing staff were under the impression that platelets transfusions were 'safe' with no observations required, following education and reaudit there was no improvement. This is being used as a marker for substandard care, not just in Transfusion.
- Lab data is very good, usage is going up.
- The TPs are not available to train - inappropriate usage going up, TPs need time to train
- There is no TP in place at present the current TP is going on leave until December 1st 2014

7.5 Portsmouth

- Fiona Stribling is returning as TLM
- ED have set up a streamlined process for administering octaplas, 2 doses in ED dept (like O neg)
- Have set up Transfusion intranet webpage
- Have relaunched the newsletter
- Wrong blood in tube incidents – data is collected and panels are held to investigate bad practice e.g. remote labelling (senior docs handing blood to junior) and transcription errors Found lots of issues and are not seeing any repeat offenders
- 2 years data for crossmatch in surgery collated, initial analysis shows that many do not get used, further analysis required
- Were joining SUH and IOW in consortium this has now been abandoned and would now like to look at Electronic bloodtrak

7.6 Southampton

- Root cause analysis for bloodtrack, backed by patient safety team, traceability 99.8%,
- Blood on helicopter, they will be holding blood and bloodtrak to be used,
- Remote temp monitoring of blood fridges
- Looking to move from 2 sample route to full e-sample labelling at bedside using barcode on wristband, need more PDAs,
- Local wristband audit looking at quality of band and where it is attached
- Prescription of transfusion auditing against standards,

7.7 Royal Berkshire

- Audits on who is ordering blood in ICU
- moving to ICE system in ICU
- Liza Keating and Tanya Hawkins TP are attending new consultant induction.

7.8 Oxford - SS

- Paediatric subcommittee are producing an educational Paediatric video proposing that we collaborate with them to produce a regional video, the meeting requested that the RTC has input into the content

7.9 Spire Southampton

- Moving to hub and spoke over the next one to two years,
- Audit around cardiac surgery reduced crossmatch trigger
- Gi & Liver asking for lots of blood pre op but not using it. The crossmatch to transfusion ratio is 42% Need to carry O neg for emergency use, more O neg is being used with less wastage
- Trialling 2 sample policy but if not possible then O neg used, it was stated that this is also the case in other Trusts

8) TP Feedback

- Following the SC region move to OUH the meetings are now being held at NHSBT Reading base, the majority of TPs are able to attend but not all are finding it possible.
- Participated in various audits (liver, medical) concern over the long turnaround for audits.
- New TPs are to have mentor / buddy from within the TP team
- Help to organise and promote Regional Meetings
- Attend National meetings i.e. - NPSA review group
- Attended a TP development day arranged and funded by the RTC

9) TLM feedback

- Held a Regional TLM meeting, in addition to the user group meetings which are distribution centre base data TLM development day held, very good those that attended got a lot out of it but unfortunately attendance was low.
- Working with RTC to hold a BMS Education day

10) Double Dose Platelet

- All to send update to JN for collation and distribution

Action: All

11) Blood Usage across the region

The Blood Usage data for the South Central Region sent to all HTTs prior to the meeting was reviewed.

12) Budget

The following proposals for the use of the remaining budget for 2013/14 were discussed and agreed:

- Purchase of audience voting system for use in Education Days, jointly funded by SW region
- Contribution to Paediatric Education Video being produced by Oxford, the meeting requested that if a contribution is made that the region has input into the content.
- Bursary for National meetings

Appendix 1

RTC Chair update

The last RTC Chairs meeting was held on October 21st 2013. PD provided a highlight report to the RTC Chairs for the SC region, including meetings, Education and Development and reporting. PD raised issues identified by the region, including delay in feedback from National Comparative Audits, guidelines for Major Haemorrhage and Platelets not available and TP concerns re NPSA Competencies.
Two TPs from the SC region attended a one day meeting to discuss NPSA competencies in Birmingham, EF fedback from that meeting

Feedback from the RTC Chair meeting
included:

- Transfer of Blood with patients being reviewed by East Region following concerns about wastage.
- Support agreed for Project on identification and management of pre-op anaemia
- NCA on Red Cells taking place in Feb and May 2014
- Changes being made to transfusionguidelines website
- London region have a decrease in platelet use since the implementation of the platelet champion.
- Yorkshire region have GP representation to manage anaemia.

Feedback from the NBTC meeting
Included:

Blood Components Working Group

- Extending post-thaw shelf life of FFP. No consensus to support extension beyond 24 hours
- National Commissioning Group for PBM - Proposals under consideration to allocate funding for audit, benchmarking of blood usage activity, and project below
- NW Region project - Management of pre-operative anaemia
- Meeting with Sir Bruce Keogh scheduled to plan how PBM recommendations will be implemented

Education Working Group – 1st Phase of review of Undergraduate curriculum for Medical Students and Nurses.

- Results of survey provided to Med Schools with recommendations for changes to undergrad teaching
- Director of UK Foundations School programme requested to include specific training on positive patient identification
- Core competencies for Foundation Dr in Pathology reassessed
- - Wide variation in level of content, delivery and assessment in relation to transfusion medicine
- Discussed with the NBTC reps of relevant Royal Colleges for action
- Patient Involvement Working Group - Developed Patient information leaflets, promoting transfusion awareness with other societies, providing research support

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NPSA SPN 14 Review Group

- format and frequency of competency assessments should be revised
- Workshop September 18 TPs
- One off practical assessment with 3yearly update training with a transferable knowledge based testing (but MHRA need 2 yearly training)
- Electronic training with option for paper based format
- Four sub groups to develop core principles

- Update LearnBloodTransfusion Competency to reflect core requirements (?and become an acceptable method of assessment)
- 100% not achievable and allowance required for staff turnover
- NBTC should take ownership of the SPN
- NBTC asked to endorse the changes and investigate which NHS body has responsibility for NPSA recommendations

Reports from the Royal Colleges

- Anaesthetists
    - College has started an Anaesthesia Clinical Services Accreditation scheme for quality improvement through peer review.
- Intensive Care
    - Concerns regarding transfusion triggers and Hb targets in critical illness
    - Ongoing research in GI haemorrhage
    - ABLE study - age of blood and impact on clinical outcomes
    - Appropriate use of haemostatic products in ICU
- Emergency Medicine
    - Membership unhappy about guideline requiring two separate samples prior to transfusion - not practical. Guideline not a rule. 1 sample possible if secure identification of sample. Drive to electronic system. Need robust guidance from NICE.
    - Most EDs have a massive transfusion protocol
    - East of England is developing a Paediatric Massive Transfusion Protocol
    - Transfusion is in the curricula for Member and Fellow exams
- Obs and Gynae
    - Recurring errors in anti-D prophylaxis and administration of intrauterine transfusions for foetal anaemia
    - Ongoing concerns regarding correction of anaemia in pregnancy
    - Massive Haemorrhage drills are part of induction and annual training for staff as required by Clinical Negligence Scheme for Trusts (CNST)
    - Use of cell salvage increasing
- Paediatrics
    - Completion of paediatric guidelines for transfusion with ongoing concerns in maintaining safest practice for children
    - Production of platelets and single donor platelets for children
    - Variable uptake of two sample guidance
    - Patient id is an issue in an emergency setting
- Pathologists
    - Pathology modernisation and impact on service delivery
    - Concerns around lab training provision for haematology registrars and staff
    - Transfusion symposium planned for 2014
- Physicians
    - B.Soc.Gastroenterology sponsoring UK wide audit on blood component use in hepatic cirrhosis patients
- Surgeons
    - PREVENTT study on i.v. Iron to treat anaemia in major surgery nearly underway
    - Identification and Mx of pre-op anaemia
    - Consent on Transfusion in emergency setting
    - Concerns on non-trained staff using cell salvage

Update of Meeting

- Discussion about requirement for 2 separate blood samples - concern for A+E, paeds etc. Main issue is correct patient identification
- The group wish to promote patient information and consent - specific issues for paeds
- Query on who authorises training of cell salvage operators

- Concerns on impact of reorganisation of path services
- TPs - inconsistency as some are part of Biomedical sciences where jobs are at risk, and others part of nursing directorate
  SHOT update
- 97.7% NHS organisations submitting reports
- More than half relate to errors - correct patient id at all stages especially in communication and handover
- Recommends zero tolerance for incomplete and inaccurate labelling of path samples - must be carried out at bedside
- 9 transfusion associated deaths in 2012
- Errors in provision of components for transplant patients
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Harmonisation of Haemovigilance reporting

- PBM advised that SHOT had worked with MHRA towards a combined system. MHRA are consulting on a yellow card system
- Committee felt that SHOT have developed a unique identity and system. Analysis which SHOT provides has improved Transfusion practice
- No point disrupting a system that works
- Online Survey to be carried out

NBTC

- NICE - final scoping doc for Blood Transfusion guideline development progressing well. May 2015
- Medicines and Healthcare products Regulatory Agency
    - SABRE - 720 incidents : 482 Serious adverse events (mainly human error - storage, transport, labelling, collection), 238 Serious adverse reactions