EAST OF ENGLAND TRANSFUSION PRACTITIONERS NETWORK

Minutes of the meeting held on Thursday 18th November 2021
Microsoft Teams Meetings
10:00am – 13:00pm.

Attendees:

Name	Hospital	Name	Hospital
Frances Sear **FS**	NHSBT	Ellen Strakosch **ES**	Luton & Dunstable
Donna Beckford Smith **DBS**	Watford	Danielle Fisher **DF**	Luton & Dunstable
Joanne Hoyle **JH**	West Suffolk	Maria O'Connell **MOC**	Basildon
Julie Jackson **JJ Chair**	James Paget	Kaye Bowen **KBo**	North West Anglia
Claire Atterbury **CA**	Queen Elizabeth KL	Natalie Outten **NO**	Southend
Tina Parker **TP**	Broomfield	Ruth Smith **RS**	Addenbrooke's
Monzeer Ibrahim **MI**	Addenbrooke's	Emily Rich **ER**	North West Anglia
Gilda Bass **GB**	West Suffolk	Clare Neal **CN**	NHSBT
Helen Dakers-Black **HDB**	Addenbrooke's	Karen Baylis **KB**	Lister
Sheila Needham **SN**	Lister	Rebecca Smith **RSm**	Ipswich

Apologies: Tracy Nevin **TN,** Benjamin Sheath **BSh**, Kathy Ford **KF**, Sue Turner **ST**, Julie Edmunds **JE**, Sandie Jardine **SJ**

1. **Welcome**: **JJ** welcomed everyone to the meeting and for anyone who wasn't at the joint TP/TADG meeting explained that TN had announced standing down as chair of this group with immediate effect and **JJ** had stepped in as interim chair.

2. **Minutes of the previous meeting** Minutes were agreed as correct. Please inform **CN** of any changes.

   Action Plan was reviewed by the group, the updated action plan will be circulated.

3. **Updates**
   - **CA** we are having a few issues as our version of BloodTrack comes to the end of its life, this is across Norfolk. We had a proper TACO last week and it was really interesting. One of the things I looked at was that the patient went to three places really quickly and had an emergency transfusion and the TACO came the following day, nobody weighed him anywhere. It would have been really helpful if someone had weighed him at his routine appointment. The outcome was good for the patient. **JJ** what we are going to do at the next meeting is present some TACO case studies so we can look at similarities / differences. If someone else has a case study to present that would be great. **CA** and Sarah Clarke (East Suffolk and North Essex) to present case studies followed by discussion.
   - **GB** we are going through an exercise to reset and monitor competency. We are the only speciality in the hospital that monitor competency. We are not going to lose it, but it is so much work. **CA** we do it as we got down to 16%. I can put you in touch with our Transfusion Administrator who helps with this as we do it via ESR. **GB** we have been told CQC don't monitor but would probably care if we stopped doing it. **CA** CQC are coming to us within the month and been told they are coming to transfusion.
   - **DBS** we have had an MHRA inspection. We were fortunate that we only had 2 majors. We need to look at traceability, rejected figures and avoiding wastage. We are doing the work but some of what we do is not visible to everyone. It needs to be on Q-Pulse. **BSh** had sent out a query regarding students.
   - **DF** we are doing training via ESR, we have rolled it out with A&E, neonatal and anaesthetics. We have gone through each area and applied the right competencies. The first assessment

will be face to face and then they can revalidate on ESR. We are merging with Bedford starting with Blood360 but that is delayed until next year.

- **JH** I don't think I have anything else to add. I will be interested to hear your presentation later.
- **KB** there has been **SN** and I for the last 7 months. Julie has returned on a phased return. We have had a lot of face-to-face training. We have been struggling because there has been a national comparative audit out. There has been a struggle with the emergency department having sample errors and problems trying to get down there for training. I have got an initial meeting on Monday with them, and we will be trying to bring the two departments together to improve communication. We are looking at updating the major haemorrhage policy. We have an issue with competencies and staff moving around due to COVID. All our anaesthetists are out of date so there is an awful lot going on at the moment. **JJ** it sounds like training is an issue for a lot of us.
- **SN** not a lot to add. The Emergency Department has been going through a lot of building / configuration so that has contributed to some issues. We are hoping to become a vascular hub so we are already having people come through ED on rapid admission straight up to theatres.
- **NO MOC/ TP** have kept me sane in the past few months. We are really focusing on merging policy. We were looking at focusing on training first but due to COVID this was difficult and now the policy is more urgent. Training at Southend is quite intense as it is face to face. They say dates are not available so you put dates on and then they can't attend so we are trying to make it e-learning as much as possible so they can access is easier. Traceability was particularly bad during COVID. We got the tags back and we had to pull a lot of notes, but we are up to date now. The lab wasn't on top of processing due to staff leaving. The national comparative audit has been a struggle whilst we have been catching up on training.
- **MOC** we have had a lot of software changes. We went from youlearn to Ilearn and data migration didn't go across. Incident reporting has changed to DATIX so has been challenging changing over systems and learning the new systems. We had a MHRA inspection in August. We had no critical, one major and five others. Mainly around incidents and reporting. With our traceability at Basildon, they had been reporting figures incorrectly, they weren't fating them that they had received them back. **NO** sample traceability, rejection and waste seem to be a theme with MHRA. **MOC** our sample rejection was quite high at the time, we always used to write a hospital number on the sample and the request form but where we have merged, they have asked that we put a prefix on. The lab started rejecting the samples without the prefix. We should see a decrease with the rates now. **NO** we might be forced to go over to NHS numbers.
- **TP** the wastage we have got on top of now. We did a huge project on empowering staff a while ago. Rejection rate is higher but doesn't seem to be any quick fixes for that until we have an electronic requesting system. **NO** it needs to be more robust and it's like they think we should know everyone in the trust that is involved in transfusion. **JH** I just wanted to ask about MHRA inspections and about sample rejection. Were they are asking about rejection rate and what you are doing about it? **TP** they wanted to know the rate and what you are doing about it. **NO** it seems to be falling on the TP's now and its admin support we are short on. **RSm** we added the prefix as it was part of the hospital wide system. My rejection rates before 2014 was around 4% but now they never go below 5%. I can't get them down to where they were before the prefix, it was about 7-8% for a while. Sometimes there are peaks. **CA** I just wondered if everyone codes so they know what sort of unsuitable sample it is. We don't get that many as we insist on them using BloodTrack. DBS when the MHRA talked to us about rejection figures. We do know what ours are as we send reports to managers and the chief nurse but what the MHRA ask is what you are doing about the figures. Our response is training but they felt that training isn't working. If a department gets over a certain threshold then we will need to DATIX them so we can see how they are going to reduce figures. That is what MHRA want to see is the evidence. **SN** we code all our sample rejections. We photocopy our rejected samples. Once a month we sort them and we look at repeat offenders so we can show where they went wrong and re-train. It is time

consuming. **CA** Emergency Department is our biggest problem. What we do now is because we use BloodTrack we disabled their barcode until they have completed a reflection. I can't remember any issues with HCA or support worker. Even the doctors are now doing reflections, they are really quick questions. **JJ** the GMC have cottoned on to reflections and they now have to do them the same as nurses.

- **RSm** I am trying to put Haemonetics in at the moment. We can't work out if there is anyway to limit someone collecting a unit of FFP after its expiry after thaw. **JJ** can we look at as part of the 10 years.
- **MI** Addenbrooke's is dealing with some BloodTrack issues at the moment so **RS** and **HDB** may not be able to speak at the moment.
- **JJ** with sample labelling our rejection rate is 4%. We monitor every month. We were down to 1.5% for mislabelled samples. The reason it went up was due to COVID. Every mislabelled sample has an incident form completed. I group them by area so if I have 5 from one area it goes onto one incident. We start off with blanket training and run refresher updates. If we are dealing with repeat offenders, they have a discussion of concern, bespoke training and told if they continue to make the errors it will be taken further. We have had success using this system. The steps are Raise awareness, Target Area, Target Individual. We ended up going through a disciplinary with a member of staff. **JH** how many rejected samples to you get? **JJ** at the moment we look at them weekly, we had 45 in October. Last week we had 17. I am seeing a reduction in some areas.
- **KBo** and **ER** we have had had some issues with access control to the blood bank.

4. TP Queries

- Nursing Associates doing transfusion – **JJ** our Trust has decided that NA's can't do IV's and to be involved in transfusion they have to do IV's. My personal view is we are being devalued as a profession. **CA** we are insulting the Band 4s. **JJ** it's a way of making nursing cheaper which is an insult to us and patients. **DF** the general response was that Band 4s are not being used for blood transfusion so we will watch this space. There are discussions about IV'S, they are looking at a trial of s small cohort. **JJ** if these Band 4s are doing the same as a registered nurse, why are they not getting paid the same.
- Student Nurses being involved in transfusion – **JJ** student nurses are doing their IV training in their 3rd year. At James Paget they can do the theory but cannot do the practical until they have finished their registration. **DBS** the Deputy Chief Nurse set up a task and finish group. We changed the two person check to a single person check. All aspects of transfusion are being looked at. Staff are saying e-learning is too long. One of the issues was around students, they want us to get them competency assessed. I have read their student documentation and it doesn't state about taking a sample, it says they need to manage a transfusion. They are insisting they need to take a sample. The document isn't clear. **CA** this is a matter with registration. Our policy covers those who are contracted by us. Students are not contracted to us and not employed by us as nurses. If they are employed as a HCSW they can do that role but they cannot go beyond that. **JJ** we approach sample collection slightly differently, if they have had training, can evidence this and been competency assessed then we don't have issues with any students taking blood. **DBS** the argument is if a HCA can take a blood sample why can't the students. **CA** we use learnpro, once we see their certificate we start on BloodTrack training. If there is an error then we address it. **GB** we allow student nurses from year 2 as its part of the curriculum as long as they are trained and competency assessed.
- Collection slip - **JJ** we use them but they are not mandatory. **JH** we are not there with our system. Currently we have a company that are going to give us the same as BloodTrack. Currently the porters go to a clinical area to collect prescription before going to the laboratory to collect blood. There doesn't seem to be an easy way of having an electronic system for porters. I did get some answers.
- DOAC Dipsticks - JJ does anyone have DOAC dipsticks yet? We have reviewed them but didn't think they were good enough but it has been suggested about contacting the company about a research project to collect more data.

5. NHSBT Update

FS presentation attached.

- There is a PBMP role being advertised. This position is for someone with a nursing background. Information will be circulated.
- I've had an email this morning that the devolved countries are going to start working on consent and a consent platform. The idea is to gather all the information and provide this on one platform. I will let you know how this develops.
- Blood Stocks - we are well below where we should be at this time of year. We would normally stock building. This is due to the impact of COVID, we are having last minute cancellations but there is work going on in the background. A lot of what happens will depend on demand. It is probably going to go on for a couple of months. **SN** I did feedback to our acute day treatment centre, they embraced this and were trying to recruit donors as they get a lot of relatives who want to donate but donors were struggling to get appointments until December / January. It is so hard putting out a message when they can't get appointments. **FS** part of that issue is down to COVID and that why they are looking at how some of the sessions are running. I do appreciate the frustrations. Staffing levels has also been an issue. They are working on this as much as they can. **KBo** on a similar note, my husband has had the same issue. One of the restrictions is that you cannot donate if you have had a cold 28 days, he had to cancel his session. The next appointment available is February. You will lose a lot of donors if you have to have 28 days free of a cold over the winter. **FS** I will feed this back.

6. Presentation – 10 Years of BloodTrack

JJ presentation attached.

- **JJ CA** do you want to add anything? **CA** we do fating on begin and end transfusion. We installed it in stages. We trialled it with phlebotomy. Their errors are mainly putting someone a form on top of another they are using so they have a sample that doesn't match their form. It seemed to work for both of us even though we implemented differently. We us it for everything. The laboratory decided they didn't want two different systems. In the last month we have started using it for histology. We need updated software but the company no longer support the PDA's we use. As they die it becomes a problem. It does cause issues but our traceability has been so easy to prove what has happened and see where errors are. It makes life easier. **GB** can I ask, you have said that you use a paper form, do you have any electronic check that you are using the correct form? **JJ** we don't have the facility to. **CA** we are trialling transfusion request forms on our cancer unit as they use 60% of our blood but this is stalled due to COVID. **GB** is there a barcode on your request form that they could use to print labels away from bedsides? **JJ** the ICE request form, you can have patient ID labels printed. We have opted not to do that but Norfolk & Norwich use it. **GB** we don't want it. **JJ** the ideal would be use of ICE with BloodTrack. **JH** I was going to ask how long you spend compiling all your reports to see if it has been transfused within 5 hours. Do you look at that weekly, monthly? **CA** we stopped looking at it as there wasn't enough that were over for it to be a problem. Most reports take a matter of minutes. Last week we had a WBIT, I wanted to look at how many times someone had taken blood and it took me less than 30 seconds to find out. **JJ** my support worker looks at it every day and it doesn't even take 30 minutes. It's imported into excel and we have automatic calculations. The monthly one I do takes 4 hours but I am looking at patient history and the whole thing. **ES** we are looking at MSoft Sample 360 but we are going away from request forms as they will be electronically on the PDA. **JJ** people will always find a way of getting around it. **CA** I would be interested to find out how you get on with it. **JJ** once you go live, we can put on the agenda for a future meeting. **NO** when you did introduce the system did it show you they were going over 4 hours. **JJ** when we introduced the system we did see a lot of bad practice but we have ironed this out. However, of the 17 SHOT reports last year, 10 were more than 5 hour transfusions because I can find them. **NO** it is something we are looking at. **ES** with blood track, do you find the ones run over 4 hours. Is it because they forgot to end it? **CA** a good

example of that is the TACO from last week. **JJ** our training is if you cannot use the PDA in real time, don't use it. The only mandatory transaction is the beginning of transfusion. If they can't finish it at the time, they send the tag back but if not we check the notes to make sure there is an end time there. The majority we get back are done in real time. **ES** we are probably going to change it so it's not got a mandatory end time. **RSm** if people have been able to control the expiry of thawed FFP, do they know if it was via the lab system or haemonetics system. **JJ** most labs have an issue default date. They have to manually change the default date for whatever the time is. If they do that and someone comes to the kiosk to collect after that time, it will flag that up. It can be done but it very much relies on you BMS staff changing the date. **RSm** they are not going to help me with date in labs. **JJ** if they are refusing to do it then there is nothing you can do. The lab staff still write the expiry date and time and I ensure staff that do check this. You need the co-operation from the lab staff.

7. Discussion – Fating Units transferred to other hospitals

JJ came up at RTC raised by **JH**. **JH** not very often but we do have air ambulances drop into the hospital because they need to stabilise a patient prior to moving onto another hospital, they take our blood, transfuse on route and we don't know what happens with it. We then struggle with traceability. It's not a huge problem but definitely is one for our hospital. It can take hours of work to try and find out what happened to the blood. **CA** we have a similar issue, we are not a trauma centre but are a trauma unit. It's less of a problem with air ambulances but if they are going by road, it goes in a sealed box but it can take months to get the answers. Unless it is a child, they all go to Addenbrooke's so we tend to find out. We don't allow our blood to be transfused on route as they haven't been competency assessed although it may never have been an issue. **GB** asked **CA** why do you send it if it can't be used? **CA** it doesn't go on air ambulances at all, if they come to us it's because they are unstable and don't go anywhere. On land ambulances it goes but one of our nurses goes with it. **DF / ES** if we have a patient going to be transferred with red cells, the nurse that goes with them checks them, puts them up, keep them clamped. If a doctor goes, they can't check them, then we set up, connected to the venflon clamped, they then transfuse if needed. **GB** I understand but not sure we will adopt that policy. **JJ** expressed concern that this exposed the patient who might not need a transfusion to a donor unit. **DF / ES** we need to look at it as it is a policy that has been in place for about 3 years. It would be better to check blood, box it up and then it can be attached if necessary. **JJ** we don't send blood if the member of staff is not competent. **SN** just a question for **JH**. When they come to collect the blood, I am assuming it's signed out and that it's been passed to them. Do they give you contact details for example, the name who signed it out so you can call to find out whether it was given? **JH** it is more that they have requested products in Emergency Department and then whizzed off. **JJ** from RTC this is going to go to the national committee to ask the air ambulance crews to notify the issuing hospital where the blood has been left so they can chase up with the TP of that hospital. With road transport, I think it is best to talk to colleagues in the receiving hospital. **JJ** if it is given on route, let the issuing hospital know it was given on route. **JH** the blood was given in the ambulance but by the doctor. **GB** we need direction as we agreed from the RTC nationally, they need to understand what we need and implement it into their training and knowledge of their staff. The bare minimum needs to be documented into their records. **JJ** it is going to the National Committee but it was brought back to this group in case anyone had any other issues that needed to be raised.

8. AOB

- **FS** raised the question should we nominate a new chair or JJ to act as interim chair if TN wanted to come back. JJ TN stood down with immediate effect and didn't express any intention to return to the chair position. Whilst she is willing to continue acting as interim chair she feels that we should vote for a new chair **JJ / RSm** can decide to nominate themselves as chair or can stand another two years as deputy.
- **JH** when is the next meeting? **CN** I would like to get a chair in post and will then agree the next meeting but will be around March. **FS** capacity has been reduced in the Cambridge Centre so we do need to look at other venues if you are moving back to face-to-face meetings. We can put money towards it but we may not be able to fund all meetings. If

anyone has any options for venues, that will help us facilitate meetings, please let us know. **GB** look at the farmers club in Bury St Edmunds. **DBS** Watford Football Club. **JJ** can we ask what TP's would like to do with regards to having face-to-face meetings or virtual. **KBo** asked if we hold a face-to-face meeting, whether TP's can still access via Teams. **CN** suggested it may depend on the venue. **FS** we have had some issues in some meetings. I'm not closing it off but it may depend on the venue. **KBo** I think it would be good to ask the venues.

JJ thank you to **TN** for being a great Chair and we sincerely thank her for all she has done and we know that she will continue to give some great input to the group. **JJ** advised that **TN** has suggested that she does a presentation on MHRA that we can look at and after hearing several others have had inspections suggests that those who've had inspections give us overviews of the non compliances and solutions. For consideration when next chair elected

Thank you all for attending.

9. Meeting Close – Dates to be Confirmed

Actions:

No	Action	Responsibility	Status/due date
1	Ask for TP Chair Nominations	CN	ASAP
2	Ask TP Group their preference for meetings	CN	ASAP