London Regional Transfusion Committee

London & South East Trauma & Haematology Group

Monday 11th March 2019
West End Donor Centre

Topic

Welcome (James Uprichard)

Attending

Name	Hospital	Name	Hospital
James Uprichard (Chair)	SGH	Richard Whitmore	Customer Services NHSBT
Steve Wiltshire	SGH	Gemma Fawke	PBMP, NHSBT
Emily Carpenter (minutes)	KCH	Laura Green	NHSBT/ RLH
Sue Hemmatpour	OUH	Fatts Chowdhury	NHSBT/SMH
Ursula Wood	GSTT	Ben Clarke	EHAAT

Apologies

Name	Hospital	Name	Hospital
Shubha Allard	NHSBT/RLH	Alastair Hunter	Frozen Components, NHSBT
Dora Foukaneli	NHSBT	Matthew Free	SGH

Previous Minutes and actions:
LG updated regarding the new 'Red Cells and Plasma' trial discussed at the last meeting. Harriet Tucker has joined the team as the new clinical fellow. Wastage has been a problem but only as far as predicted. The team has started looking into mitigations. The shelf life is 14 days, and they are normally received from NHSBT on day 3, they then stay on the Air Ambulance until day 10. As of February, after day 10, they are now going to ED remote fridges. As a result, wastage has gone down, and they are now aiming to get below 30%. To further reduce wastage, they are also considering other remote fridges (e.g. theatres) but there are concerns it will go to non-trauma patients. The group queried if it might be appropriate to allow it to go to non-trauma patients, but LG explained that as it is trial component, it cannot be given to non-trauma patients without officially revaluating, although this may be discussed with MHRA in future. It was noted that it had been used in the past, and that the UK regularly gave non-LD whole blood to cardiac patients in the 1970s. Cardiac surgery is located at Barts site, so it would be useful if it could be given to any bleeding patients there. Stock is rotated to reduce waste. The possibility of sending it back to NHSBT to remanufacture red cells was also discussed, but they expected that it will not be possible to due to shelf life and logistics.

Following on from capacity planning, SGH went from 3 to 4 Barkey thawers, and updated prethawed plasma from 2 to 4.

In response to the previously discussed trauma audit, LG said we should be able to use the NCA trauma data to avoid asking hospitals re audit data and adding to audit fatigue. It may be possible for the NCA team to benchmark this group against the rest of the country. Current NCA data appears to be indicating that only 20% of hospitals are using TxA, which LG thinks is incorrect, but caused because trauma prescriptions are often made using different systems or different paperwork compared to the rest of the hospital so maybe tricky for non-ED staff to locate. LG is trying to get the data via TARN for trauma patients. It is probable that this group would not need to do independent analysis, and NCA team can compare London to National.

Action JU: Contact KBrohi with LG with results of TU:MTC data ratio results to confirm sufficient

Education Day – So far 149 delegates confirmed, to meet with previous year we are aiming for 200. If required the auditorium can hold up to 300. The agenda has now been filled. Education days are very important particularly for our trauma units, as some TUs like William Harvey (Ashford, Kent) are getting similar number of trauma cases as some of the MTCs.

Updates – Major Trauma Centers

OUH- Sue Haemattapour
Have starting sending out an additional blood on board box; now sending out blood with 1 helicopter and 2 cars, staff have noticed that preparing a 3rd box is noticeable harder. Recording FFP wastage data, but it has not been long enough for meaningful results yet. Oxford uses group A FFP.

SGH- Steven Wiltshire
Noticeable busy during Dec and Jan, but not as much trauma. SGH has commenced new TEG training, having deployed TEG 6S. Anthony Hudson is looking into protocol development. MHRA are aware of the new changes. The TEGs in ITU and Cardiac are linked to the lab.

SMH- Fatts Chowdhury
Noted last month as being particularly busy. They have received requests for the pre thawed plasma to be stored in the ED fridge and are trying to make it happen. They are looking to get new fridges and a new TEG in theatres. With the new fridges, they want to be able to store plasma in theatres also, giving a total of 4 in ED and 4 in theatres. Portering continues to be a problem after moving to Mint Wing there is now a bigger distance between BTL and ED. Trauma team has noted a 3-4 min delay, especially out of hours

RLH- Laura Green
MHRA currently inspecting Whipps Cross, expected to inspect RLH and Barts soon.

KCH – Emily Carpenter
Helipad to become 247 for KSS following agreement from Lambeth Council. Unable accept landings from other HEMS as restricted by number of night landings by Lambeth.

Following SW's capacity info, KCH have done a table top exercise for FFP thawing. Findings showed significant delays if >4 code reds start at the same time. KCH has 4 thawers. Considering if we would reduce lag time by keeping all trauma packs 4:4 rather than 6:6.

No longer have single sample exception

EC also queried if during an MI can NHSBT thaw plasma for hospitals but RW said it would not be possible as most NHSBT sites do not have thawers.

5 Day Rules for Post-thaw FFP/Octaplas

EC fedback that RTT have requested that we issue some additional information to reinforce the recent guidelines regarding FFP post thaw extension.

It would also be useful to include the groups' opinion regarding Octaplas which NHSBT could not comment on.

LG commented that the current guidance available for FFP was comprehensive and that staff

should use this exclusively. The group agreed that current guidance is comprehensive but as there has been a request for help, it was suggested that we could write a signposting statement and include information regarding Octaplas.

Action EC – Draft plasma signposting statement and send to JU and LG

Pre Hospital Sampling
Discussion with representation from London Air Ambulance, Essex and Herts Air Ambulance and Kent Surry and Sussex Air Ambulance.

Ben Clarke (BC) attended this meeting representing EHATT HEMS. He fedback that they have been giving BOB and lyoplas as of 20/03/18 based on the KSS and LAS protocol

BC presented the new request form for pre-transfusion group and screen samples which was well received by the group. The group felt it would make it clear that the sample was taken pre-hospitally, and the extra information included would be useful.

FC requested a contact number for the signature to be able to provide instant feedback. Although it was decided HEMS would unlikely still be on site when BTL might want to contact them regarding the sample or form, it was agreed that the contact details for the Duty Manager would be useful. This would allow for timely feedback (within 24 hours) should there be any issues with the form or sample.

Action BC: Arrange for duty manager contact details to be included on the form.

SW raised that it is likely that each hospital would need to raise an SLA for the samples. It was not clear whether one was already in existence for the patients arriving, and if this could be updated to include samples.

Action All: Review own MTC's SLA provision.

Noted so far KSS samples are being discarded in some cases (either in ED or BTL), thought to be due to miscommunication over labelling requirements and acceptance requirement.

Group raised disposal method for samples and spare wristband labels as this is a BTL requirement.

Action BC: Arrange for disposal for any unwanted samples, wristbands and labels to be added to the SOP

BMSs will have to check red sample sticker with red form sticker, as well as PID on form and sample.

Handover from HEMS to ED must include samples, as 2nd sample only would be needed if it was possible to take a pre transfusion sample.

Although GW had to send apologies, he forwarded some feedback regarding the EHAAT form. He explained that it might be possible for KSS to share EHAAT's form if they were happy with this, but it might be that it will be tricky to fully complete the form in all cases due to time pressures (hospital turn around time is one of their performance metrics). As has been discussed before, GW also reminded us that the patients receiving BOB are their most seriously injured patient group equating to approximately 8% of the total patients, and a sample cannot always be obtained for numerous reasons.

SW suggested that we should pilot this process for a 6 month period. He also suggested that

during this process we should not use the pre hospital sample as the primary sample. This is unlikely to have a clinically impact as staff are already used to taking 2 samples, we would expect to continue to receive 2 in-hospital samples until a change in practice was encouraged. The group felt it was unlikely that not using the pre hospital sample as the primary sample was unlikely to cause a delay in receiving ABO identical blood.

We are awaiting a paper to be published to give us a clearer picture as to how many units is normally administered before a patients group shows contamination and can cause confusion regarding the patient's true group. This will give us more evidence as to how much value there is to be gained from taking and processing this system.

It was noted that LAS are also particularly trying to get other pathology samples. These are hoped to create a useful baseline. We await feedback from LAS as to whether this has been effective.

Audit style pilot to start on 1st May

Any other business including date for next meeting

Query Intraosseous (IO) sample can be used for grouping only. Group were unsure if samples could be run on the analyser, as they are known to cause damage to other analysers. It was however clarified that it is possible to transfuse into IO access.
Post meeting link (https://www.ncbi.nlm.nih.gov/pubmed/29492974)

Ursula (GSTT) raised the recent Safety Alert for Safer temporary identification criteria for unknown or unidentified patients which has a deadline for 5/6/19.
https://improvement.nhs.uk/documents/3535/Patient_Safety_Alert_-_unknown_or_unidentified_patients_FINAL.pdf
The group responded that individual MTCs had working groups working on this which transfusion was feeding into. SMH have changed their MI to be the same as trauma, and will not be implemented the estimated DOB.

Action EC: Send round previous naming proforma

Date of Next meeting: ?24th June (post meeting update: scheduled for 1st July 2019).