EAST OF ENGLAND REGIONAL TRANSFUSION TEAM

Minutes of the meeting held on Thursday 25th January 2018, 2 – 4 pm at Hallmark Hotel, Bar Hill, Cambridge

Attendance:

Name	Organisation	Name	Organisation
Hamish Lyall **HL** *Chair*	Norfolk & Norwich	Dora Foukaneli **DF**	Addenbrooke's & NHSBT
Michaela Lewin **ML**	Papworth	Kath Philpott **KP**	Addenbrooke's
Frances Sear **FS**	NHSBT	Carol Harvey **CH**	Colchester
Gilda Bass **GB**	West Suffolk	Jane O'Brien **JO'B** *Minutes*	NHSBT

Apologies: Kaye Bowen, Mohammed Rashid, Debbie Asher

1. **Welcome:** HL welcomed everyone to the meeting especially Kath Philpott as this is her first meeting.

2. Minutes of the last meeting: Agreed as accurate.

Matters arising:

- A single unit is defined by the pilot study as one unit transfused followed by an Hb check and assessment. 2 units transfused in a 24 hour period with an Hb check in between is regarded as 2 single unit transfusions whereas if there is no Hb check it is a 2 unit transfusion.
- There was discussion on the practicalities of auditing single unit transfusions. DF said the biggest problem is the definition of a denominator i.e. which patient groups are suitable. Major haemorrhage, dialysis, day unit and haematology patients are all excluded. However HL said that a trial for AML patients stated that Hb should be checked after a single unit. A simple measure would be from the lab perspective: is the single unit rate going up or down. DF said the TPs at Addenbrooke's are trying to determine the number of single unit transfusions using Haemonetics. HL said that 45% of requests at NNUH are for a single unit but other EPA hospitals use different criteria. DF said there is also the issue of whether the percentage of patients or the percentage of units transfused should be determined. FS said that the PBM team are attempting to find a definition and they have been asked to find out what is used in their regional hospitals, which will be discussed at their next meeting. GB suggested a business improvement report from LIMS.
- DF said a post transfusion increment should last at least one week and that it is detrimental to the patient to have a single unit every day with an Hb check each time.
- DF said that we should check with Mike Murphy who was the originator of the single unit recommendation.
- HL said there are 3 possible definitions: one unit in 24 hours; number of units per requests and number of units per valid sample.

3. RTC business:

- 2 sample rule: with regard to the informal survey, in which a variation of practice was observed, the TP Network and the TADG were asked if they thought that regional guidelines would be of use. The TP Network said no but the TADG thought they would be helpful. ML said she thought that TPs are more in tune with what occurs in clinical areas than lab staff.
- DF asked if there was an incompatible transfusion as the result of a labelling error who bears the responsibility. CH and KP said the Trust is responsible. However, in

some circumstances, if the sample was incorrectly labelled and this was not picked up by the lab then responsibility is joint.

- DF said that with the variation of speed with which different analysers provide blood groups, she thought manufacturers should be encouraged to develop faster testing. CH agreed to raise this at the next National Lab Managers group meeting. **Action 1.**
- Regional shared care form: with regard to the possibility of an audit of the use of the GB said we could look at specific groups. For example: shared care forms for patients treated with Bendamustine could be checked against hospital Pharmacy records and for neonates who have had intrauterine or exchange transfusions shared care forms could be checked against hospital records.
- FS suggested asking SHOT if they have an audit proforma which could be adapted.
- DF suggested an audit between two shared care procedures. Papworth have a procedure in place which informs shared care. It was noted that clinical areas often don't inform labs of special requirements, but they do sometimes inform clinical areas in shared care hospitals. Papworth are a tertiary centre and have a robust system in place for identifying special requirements, so it was suggested they carry out an internal audit. Shared care between Addenbrooke's and West Suffolk could also be audited.
- It was agreed that the presentation given by an FY2 doctor from West Suffolk at the RTC on a project improvement for paediatric blood prescribing was very useful.
- Clive Hyam has agreed to help EPA hospitals with stock management, dependant on his workload. It was noted that a workshop involving several hospitals at once would be the best way forward but this would require a room with several computers, which is not available at NHSBT. GB agreed to see if this facility at WSH could be used. **Action 2.**
- With regards to platelet wastage, HL said NNUH frequently get short dated platelets. FS agreed to raise this with MR. **Action 3.** It was agreed that where short dated platelets are issued, there should be the opportunity to get a refund if they are not used.

4. Education days:

BMS: suitable topics were discussed during the lunch break

Mums, Babies & Blood: it was agreed to try to get a patient speaker again as this is always very well received. KP agreed to ask Jenni Li (the patient speaker in 2016 who is herself a BMS) if she would be able to attend. **Action 4.** DF suggested circulating information about the event to bank midwives and NHS staffing agencies.

Main education event: FS said 3 RTCs had already had education days including major incidents and she has identified some topics which would be suitable and relevant. CH said that the cyber attack in 2017 caused failure of the IT system at Colchester, and other regional hospitals, for a week. Contingency plans and lessons learnt from this event would be useful. DF suggested audits of the use of the major haemorrhage protocol and it was agreed that a case study presented from clinical and lab perspectives would be interesting. DF also suggested regional use of blood components in air ambulances as a topic. It was agreed to set a date and book the venue. **Action 5.**

DF said that because some of the SpRs were not very happy with the lack of specific transfusion related topics at The Human Factor, they were being offered an additional session.

5. RTC working groups:

Pre-operative anaemia: HL said that a pre operative assessment clinician from NNUH had offered to join the group and he will send the contact details to FS. **Action 6.** HL said that we need to identify patients who need to have iron deficiency anaemia rectified before surgery.

Education: we are presently utilising and adapting existing presentations for the junior doctors' package.

6. Regional guidelines: our ATR guideline is due for its 2 yearly review. GB suggested that "and/or" should be added under *Mild* reactions between temperature rise and pruritis (as it is under *Moderate*). Also on the second page under *Investigate,* IgA and serial mast cell tryptase should have the proviso "if allergy suspected" added. JO'B said that she had considerable problems getting alterations made to regional guidelines as they are done by Media Studio, (the CUH graphic design studio). They were all done to our designs so we have ownership of them but we do not have editable versions and NHSBT does not have editing software. It was suggested that the pdf versions may be able to be converted to Word. **Actions 7.**

7. 2 sample practice: covered in item 3.

8. A.O.B:

- DF said that approximately 200 units are wasted because of people opening boxes to see what is inside.
- DF said that the problems of over stocking could be reduced by blood product sharing between hospitals in networks.
- FS said that some other RTCs have mechanisms for individual HTCs to report directly into the RTC. We have received some examples of the reporting tools from other regions which she will circulate to the group for feedback. **Action 8**

Next meeting: 17th May 2018, Hallmark Hotel, Bar Hill, Cambridge

Actions:

No.	Action	Responsibility	Due date/status
1	Raise subject of a recommendation of faster analysers at National TLM meeting	CH	
2	Find out if a room with multiple computers at WSH could be used for a stock management training course	GB	GB has ascertained that a room with 10 computers and a projector at WSH could be booked with no charge.
3	Discuss short dated platelets issued to NNUH with MR	FS	ASAP
4	Invite Jenni Li to Mums, Babies & Blood as the patient speaker	KP	ASAP
5	Set date and book venue for main education event	JO'B	
6	Send details of pre –operative assessment clinician to FS.	HL	
7	Make changes to ATR document	JO'B	A Word version of this document has been obtained & changes made. Amended version attached with minutes*
8	Send HTC reporting tools to RTT members for comment	FS	Circulated 7/02/18

* Although I have been able to make the text changes, the contact number boxes are not editable. Further work will be needed on this. JO'B