



# South East Coast Regional Transfusion Committee

## Education

## 2018 Activity Summary Report

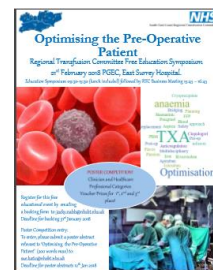
CELEBRATING SUCCESS

### Regional Transfusion Committee (RTC) Education and Business Meeting –

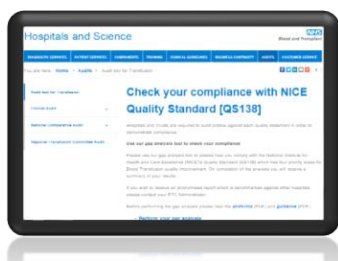
An 'Optimising the Pre-Operative Patient' event was held at East Surrey Hospital on February 21<sup>st</sup>, attended by over 90 delegates with excellent feedback. Topics included Managing Pre-Operative Anaemia and Avoidance and Alternatives to Transfusion in Surgery. 12 posters were presented as part of a poster competition to share good practice. 100% of delegates fed back that their objectives had been met; 82% said that they were likely to change practice as a result of attending.

**RTC Autumn Education Event** - A successful 'Human Factors – Risks in Transfusion' day was held at the University of Brighton on October 17<sup>th</sup>, 61 delegates attended with talks presented on Dotting the i's - Meticulous Practice, Wrong Blood in Tube, SHOT incidents and Capacity Planning. 100% reported they would recommend a similar event to colleagues; 68% said they were likely to change an aspect of their practice as a result of attending the event.

**Joint London and South East Coast (SEC) BMS Education Day** – A 'Paediatric' day was held for BMS staff at Tooting on November 30<sup>th</sup>, attended by 35 BMS staff, 10 from SEC. The day was rated as 'excellent' by 96% of attendees and included talks on BSH Guidelines, Antenatal Antibodies and an Empowerment Workshop. Posters and presentations from events (where permission has been granted) are available [here](#)



## Regional Audit



**NICE Quality Standard QS138** – An online audit [tool](#) has been developed by the Transfusion Practitioner (TP) group with NHSBT to facilitate hospitals to measure compliance. This audit tool has been endorsed by NICE and is now available as a national resource and provides benchmarking against regional data. 343 cases across 7 hospitals have been audited to date using this tool in the SEC, audits will be continued bi-annually and reviewed at regional meetings.

**PBM Scorecard** – A regional scorecard to monitor the regional uptake of PBM initiatives was developed and shared. The aim of this resource is to identify any opportunities for development.

**A D Negative Platelet Stock Audit** – Following on from the NBTC Components workshop, where RTC's were requested to restrict, within reason, use of this component, an exercise was carried out in Summer 2018 to review regional stock holding practice to establish whether if/how these units are held. The results will be shared and reviewed at the next RTC meeting.

**2017 National Comparative Audit of Transfusion-Associated Circulatory Overload** – Regional results were shared and reviewed. 15 hospitals took part with 224 inpatients and 191 outpatients audited.

## Shared Learning

Now available on the [resource](#) section of the SEC JPAC website:

-Managing Iatrogenic Anaemia in an Intensive Care Unit or High Dependency Setting, Sample Discard Guidance, London/SEC Iatrogenic Anaemia Working Group

-Investigation Interview for a Wrong Blood in Tube (WBIT) incident template, Western Sussex (WSHT)  
Coming soon: The 'Consent for Blood Transfusion' sticker pad, originally developed by SEC RTC has now been adapted and developed into a national resource; a collaboration between NHSBT and Surrey and Sussex Healthcare NHS Trust (SASH).

**2018 BBTS Annual Conference SEC poster submissions viewable [here](#):**

- Provision of O RhD Positive Red Cells for use as Emergency Blood across 5 sites, Berkshire Surrey Pathology Service (BSPS)
- Implementation of the NBTC 2016 requirements for 'Training & Assessment in BT, BSPS
- Implementation of non-invasive prenatal testing for Fetal RhD genotype (5 sites), BSPS
- Consent for blood transfusion -The experience of a large District General Hospital, SASH
- Development of a Tool for the NICE Blood Transfusion [QS138] Quality Standard, SEC RTC

**A 'Component Checklist'** has been developed by WSHT which is given out with every blood component unit issued to help staff reduce the risk of human error during checks.

### Dates for your Diary

8<sup>th</sup> March SEC RTC  
Education Business  
Meeting

22<sup>nd</sup> March SEC TP  
Meeting

28<sup>th</sup> March TADG  
Meeting

For further information on RTC Activity or to forward any ideas for future regional work or education events, please visit our [website](#) Or contact the Regional Transfusion Team via our RTC Administrator: [Frances.moll@nhsbt.nhs.uk](mailto:Frances.moll@nhsbt.nhs.uk)