EAST OF ENGLAND TRANSFUSION PRACTITIONERS NETWORK

Minutes of the meeting held on Tuesday 15th March 2022
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 Chair**	West Suffolk	Sharon Kaznica **SK**	Ipswich
Julie Jackson **JJ Chair**	James Paget	Loraine Fitzgerald **LF**	Bedford
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
Tracy Nevin **TN**	Princess Alexandra	Clare Neal **CN**	NHSBT
Benjamin Sheath **BSh**	Watford	Karen Baylis **KB**	Lister
Karyn McMurray **KMc**	Addenbrooke's	Michaela Lewin **ML**	Addenbrooke's
Julie Edmonds **JE**	Lister	Susan Turner **ST**	Colchester
Janet Shalini **JS**	Princess Alexandra	Sarah Clarke **SC**	Ipswich

Apologies: Gilda Bass **GB** Terrie Perry **TP**

1. **Welcome**: **JH / JJ** welcomed everyone to the meeting. Introductions were made. **TN** introduced Janet Shalini to the group. **TN** will be leaving next month and will be very sad to leave but hopes to work with everyone in future projects. **JJ** wished **TN** good luck in London and welcomed **JS**.

2. **Minutes of the previous meeting CN** to review previous minutes to ensure initials **KB / KBo** are correct. Otherwise, minutes were agreed as correct. Please inform **CN** of any changes.

   Actions from previous meeting

   - **JH** you completed a survey regarding how you would like to have future meetings. There was a real mix of feedback. Some would like virtual, some would like face-to-face. There is difficulty getting rooms and the cost of rooms is high. We were thinking that it would be good to have the joint TP / TADG meeting face-to-face. **FS** we are investigating rooms, there may be the option later in the year to meet at Cambridge Centre but this depends on capacity. We are just waiting for further updates. **JJ** for planning we thought it may be best to have the TP/TADG face to face but keep the TP meetings this year virtual so we know it is a definite that we can meet.

   There were no other outstanding actions. A new action plan will be started.

3. **TP Queries**
   - **BSh** Sample validity, there were no unusual comments from that. I didn't see any risk assessments. The LIMS part, it is down to version of enterprise. With regards to vein to vein, there is a split. Roughly half of us have vein to vein. Those that don't have it are in the process of getting it. I received a business continuity plan from **NO**. We had that alert from SHOT, so we raised that with our team so we were asked what others do.
   - **TP** one query was about our ODPs. We have had 3 hospitals merging to one Trust. When we tried to put the combined policy out for ratification, there was a selection of staff were upset. It was found that ODPs are not only checking blood but putting it up and one was doing it by himself. All your ODPs check blood and do the competency. Since then we are having to update the policy with that information to cover the ODPs. Perfusionists administer the cell saver blood so we have gone back to the policy on that. We just want to make sure we are covering the ODPs.

- **TP** we have a senior midwife who works within the community and the midwives who administer Anti-D in the home but the hospital want to bring it back to having it administered the community hospital. There doesn't seem to be anyone else that administers in the patients home. We can see why they are bringing it back but it is quite frustrating for the mums.
- **ES** our freezer went to landfill.
- **JH** quite a few people shared presentations. I did my teaching and then the Anti-D video came out from SHOT which is good.
- **KB** the problem is that there is going to be privatisation of pathology and we are out of scope. We have been told that they will address it of the privatisation continues. We have been in touch with Tracy, who says it will continue. It doesn't make sense that they want to make this change now. We have got a manager who is a nurse and all of sudden they want us to be managed by transfusion. **JJ** and **CA** were managed by the Lab pre-EPA but are now both managed clinical **KB** we felt it was done behind our back, nothing was said to us. **NO** be really careful and proactive. I thought everything would take care of itself. Lab information becomes business case sensitive. I was not included in meetings. They say it won't change anything but it does because the SLAs come down to the Trust. Please discuss with me anytime if you are going through that transition.
- **LF** we were asked to harmonise sickle cell policies. We have a policy but Luton didn't. **JH** shared her policy - thank you. **JJ** I have never written one so not sure that we have one.

4. GIRFT Report

JH presentation attached. The report can be found on www.rcpath.org It is about getting things right first time. It says Specialist Transfusion Nurses, it doesn't say Transfusion Practitioners. It is supporting the role but not named the role correctly. **JJ** I think we need to feed back to them that as a group we are Transfusion Practitioners. The National TP Group are onto this as we do need to educate people that the group is not just nurses, we have a wide variety of skills. **JH JJ** draft letter. **ML** we looked at this report a while ago, nothing ever changes, people write reports without the understanding. **JJ** they look at wastage numbers but don't look at the why. **JH** has anyone else got any thoughts? **CA** I thought it was unrealistic and out of date by the time it was published. **NO** I don't think people will do much with it. I thought that was interesting but know nothing will change. I may take it to my appraisal though.

5. CAS Alert

JJ I looked at this and felt it was stuff we have been doing for ages. We were compliant. We are considering how we evidence that we are compliant. We have policies in place. We have audits for a lot of things. Do the doctors know that the policy is there? Has everyone had a chance to look at this? It is about components released in major haemorrhage. **CA** we are pretty much compliant. One of our biggest problems is we don't have a policy on the site because our lead consultant thinks the regional algorithm is enough. Our staffing as it is, we will not be able to get staff to drills. We did have a situation where a consultant anaesthetist refused O Negative as he didn't think it was suitable for his patient. We could do better with upper GI bleeds. **JJ** we can't and haven't been able to have drills and simulations in the current climate. We have been doing Teams training. **ML** this has come at a really good time for the Trust. This is a good lever for training the doctors. We have a CAS Working Group set up. It has come up at a good time as we have two open SABRE reports so it's an opportunity to push this. **JH** we haven't done drills for several years but are trying to get them back on board. We are doing a video, we have been allowed an actor. This will be shown at the various governance meetings. It was discussed at the RTC, if you have any laid out drills or plans, please send to **CN** for sharing. We have completed an audit on the delay in administering PCC and will be happy to share that with this group or at the RTC. **JJ** I am due to reaudit this year. **NO** the closing date is 15th July, are people going to be competent by that date? It's reassuring to know that others are saying the training is an issue. We have a lot of work to do still. **TP** point 1b is taking a long time to gather the evidence. It is a lot more work than you think. **NO** we have been working on this a lot. **JJ** I have an audit plan, I am not going to rush and do an extra audit as have an action plan in place. It may not be completed by 15th July but the plan is in

place. **NO** they didn't really give us a lot of time as it only came out of January. **ER** it has enabled us to get some doctors training and e-learning. It is finding the right package to create our modules and link into ESR. We are working on it and have a CAS group. It will give us the ammunition to push things through but won't have it done by July. **KB** we have had the same problem with the doctors. We realised that they were missing them in training when we had some incidents. We had some Teams training but 24 didn't turn up, you can offer the training but it doesn't mean they will attend. **JJ** we are still recovering from COVID and still have a massive amount of sickness which impacts what we deliver. They will have to acknowledge this. When we get a handle on sharepoint, I would like to see people sharing policies etc.

6. NHSBT Update

FS presentation attached. **CA** you are right to mention logistics. We cannot reduce our holding of O Negative to less than 10 units due to logistics and travel. We can do other things but not for women delivering. We only need to waste one unit and we have wasted 10%. It seems very unbalanced on the rural areas because we don't have any choice. **FS** we are not criticising you regionally for not reducing below minimum levels. We mapped once, all the hospitals and the logistics to see if there was any relation. We are going to have a discussion with blood stocks to see if they can do this again. We will continue to look at this is more detail. Regionally we understand. There may be other areas we can improve. We are more than happy to support you regionally. **JJ** I love audit and looking at the stats. I will send my ideas to **CN** and if everyone can do the same. **FS** it can be a simple process. **JJ** if we can stick to two regional ones, I don't want to overburden people. **FS** we automatically check against national audits so they are not due at the same time. There is an ongoing tool for the NICE standards, they are doing the final tweaks. It is going to launched shortly but will be there to monitor NICE standards.

7. RTC / National TP Network Update

- **JJ** the competency has been submitted. I am trying to get a copy of the competency framework to share. The job descriptions were rejected. Has anyone got any experience with job profiling and job descriptions? **BSh** if you have a job profile that doesn't match, you create your own, you don't have to fit in with one that already exists. Jobs change over time. **CA BSh** is absolutely right. **JJ** before they accept new ones, you have to prove why you are not fitting into one that already exists. We need to people who have experience with job matching. **TN** I was doing job matching here, I have national template with a points system. **JJ** I think we can prove we don't fit in to current ones as we are cross discipline. Please contact me if you have any experience.
- National TP Meeting will be in 2023, hopefully it will be face-to-face. We need volunteers for the steering committee and ideas for topics. **JJ** personally I would like to hear from TPs in different countries. Please drop me an email and we can put these ideas forward. **TN** gender assignment was a big key discussion last time. Having an update of where do we go from here would be good. **JJ** I kind of volunteered our region. I volunteered myself for head of the steering group but hoped as a region we can be a shining light.
- **JH** the RTT are looking at junior doctors transfusion training and would like a list of what they need. Please feed back any suggestions to **CN** to feed back to the Education Working Group.

8. Case Study – TACO

CA presentation attached.

9. Case Study – TACO

SC presentation attached.

10. Q&A – TACO Case Studies

TN we had a patient who had a slow burning haemorrhage who died and ended in a court case. **TN** asked **CA** did they think about giving platelets and TXA early? **CA** he did have TXA had two lots of platelets. **TN** have they changed their policy going forward in endoscopy? CA no as it's a national guideline, they have written to the national group saying they have had a problem. **TN** do

your BMS ask the patient weight? **CA** we have just done an audit across all three hospitals of FFP use. I am so proud as there is a space on the telephone pad, every single patient had a weight documented by the BMS staff. **TN** but it more about out BMSs challenging it. **CA** it is a culture in our hospital, a consultant who has now retired worked closely with the lab and clinical staff so we were able to change a lot of things**.** The culture in our hospital is that our lab is in charge. **TN** there are still a lot of junior BMS staff who don't like to challenge. **CA** it is interesting when we get staff from other hospitals. They are really not keen when they first arrive, what they don't say is no you can't have it. We had a doctor who had transfused a patient who had clearly come in iron deficient, I asked to have a word. She was really scared but it's about learning not being told off. **JJ** something I picked up is that education since covid has gone backwards with doctors. There is no face-to-face, yes there are presentation but nobody is making sure that they are being done. We have got a lot of uneducated doctors out there. It is not that they are not following the policy, they don't know the policy. **CA** I agree, they are so scared of everything. **JE** it would be good to share how we can get weight. **JJ** yes it would be good, some of the ones we don't have you can understand as we don't have weighing beds. **CA** we ask even in the middle of a major haemorrhage we ask them to guess so we can dose FFP. **JJ** I agree it should be standard across the board.

11. Hospital Updates

- **BSh** we have only recently implemented electronic patient prescribing at Watford. It doesn't really work in the way we want it to. I would like to ask for shared learning experience, what has been your learning experience? What have been the subjects you would of liked to of known more about at the beginning. We are grappling with a system that we don't really understand. We are told different things. It would be helpful to understand the learning journey from others to enable us to use the system properly. The system is run by Cerner, I don't know the version. **JH** we use Cerner and will be going to electronic prescribing, I probably need to learn from you. **ST** critical care have electronic prescribing and that seems to work ok but not sure what the system is. **JH** does anyone from Addenbrooke's Hospital or Royal Papworth use it? **ML** we use electronic prescribing for everything including blood transfusion. The blood transfusion side causes us lots of problems. There is a known issue between Epic and Blood track. Alerts are generated when the prescription is absolutely fine, the blood that has been issued is absolutely fine and the blood that has been collected is fine but all the electronic systems try and speak to each other and provide fixed text alerts that mean nothing to the user. We had issues last week. None of this would happen with a paper system. Our system is very complex, it will let a ward area order a paediatric unit in ml but then prescribe in adult units. There is no alert for the prescriber that it's been ordered in mls so you are now prescribing in adult units. The prescription then doesn't match the blood order. Usually we have time to resolve this but I know recently it came up in ITU that they were desperate to get a bleeding child red cells and it was all going wrong as the epic system was saying no you can't transfuse. It was all because the difference on the prescription and order placed with the lab. Electronic systems are good but can be a hindrance when they all need to align. **JJ** I am thinking this may be a future topic. **JJ** I refused to allow component authorisation to be put on EBMA (electronic prescribing) as it couldn't meet the SHOT requirements, backed by HTC. **DF** if we could explore this more. We have gone live on the paediatric ward. Learning from everyone would be useful. **BSh** the limitations are really interesting. One of the things we are trying to explore is business continuity and when we are expecting the clinical team to override the system as it is not working and how do you say if it's not working for a length of time, can you revert to your paper system. Finding evidence of how long to wait for this is quite difficult. We are on the verge of implementing porters collecting blood at Watford and ask how do you monitor that process? If anyone doesn't do it, why not? We would like to learn a bit before we start. It would be helpful to understand. **ML** that is exactly what our clinical areas would do when they get alerts is go to their manual bedside procedures but they get so reliant on electronic process they are scared to revert back as they have a system saying something is wrong. **JH** we use porters. **ST** I have been doing this job for 12 years and the porters have always collected blood, I do the training and give the barcodes. We have had 2 incidents in all that time where I have had to take barcodes away. One of the porters was outside with a bag of blood having a cigarette on a break. The second one was about checking the name properly and he had been told this before. They have their

moments but they are all very good. You usually have co-ordinators of your porters, if you do those first, then they feed that back to everyone else. I would recommend it. **BSh** do you set any KPIs or targets. **ST** they come up scan their barcode, take the unit out all on an Ipod system that they carry. They have to do that one job, they know it has to be with the patient within half an hour and if the nurses don't sign for it they will take it back to the blood bank. **JH** it may be worth sending that round as a query to ask for others experiences. **NO** porters are brilliant at Southend. **LF** I do the training and if there is a problem I have a good working relationship them. Porters are trained yearly. **SC** we have started doing it because Colchester have done it previously. It is slightly more complicated as ours are OSC employed and not Trust employed. We are rolling out blood track at the moment, We have kept high usage areas as collecting themselves. One of the wards are really keen to continue collecting the blood themselves even though they are not included as a high usage area. They have all completed their e-learning and want to be trained as they don't feel the porters will come. **JH** we had that when we moved to porters and kept high usage areas as collecting. We have now removed everyone else from collection. The porters have an electronic device, a notification comes up and the porters have a quick response time. The TNSs have started to offer to collect blood to fit around other work due to the increased workload within the trust. **SC** it is difficult to take something away from a clinical area when they want to continue using their skills. **BSh** I will send out a query to the region and we can feedback at the next meeting. **TN** we will be rolling out the same as you, we are doing it as a phased rollout. It would be interesting to do a comparison between Princess Alexandra / Watford. Has anyone had any WiFi issues with the handheld devices that porters hold? **JH** we did initially but they seem to have been resolved.

- **ST** I just wanted to say about the implementation of cell-free DNA testing. We have been trying to implement this for a long time but COVID hit. We implemented in November last year. We are fully live, they have access to SPICE. It is a really good thing for us. Ipswich were already doing it.
- **ML** we are losing a couple of TP's, Monzeer Ibrahim is going UCLH and Megan is emigrating to South Africa. Both leave end of March. **JJ** asked **ML** to congratulate the 2 and wish them luck in their new areas

12. Items to escalate to RTC / National TP Network

- GIRFT Report re: the use of Transfusion Specialist Nurse
- If there is anything else that needs to be passed to RTC or National TP group or any ideas for future discussion / presentation please advise **JH / JJ.**

13. Sharepoint

CN showed the sharepoint page. All TP's have been emailed to ask they are happy to be added. This is work in progress but is a place where presentations, minutes and documents can be shared by the whole group.

14. AOB

- If anyone would like to be Vice Chair please advise **CN**.
- Terms of reference have been circulated, if there are no queries then these will be ratified for the next year.
- **TN** I have presented the WBIT tool to the London region. My first project is to get a regional WBIT audit using the electronic system. **JJ** asked **FS** to have a meeting with Brian so we can feedback data at meetings. **FS** we will organise that.

15. Meeting Close and Next Meeting

JH thanked everyone for attending.

Next Meeting: **16th June 2022, 7th December 2022**
Joint TP / TADG Meeting 20th September 2022

Actions:

No	Action	Responsibility	Status/due date
1	Draft Letter regarding GIRFT Report	**JH / JJ**	**ASAP**
2	Present PCC Audit	**JH**	**RTC / TP**
3	Send ideas for Audit to CN	**ALL**	**Ongoing**
4	List of Junior Doctors Transfusion Training Ideas	**ALL to CN**	**Ongoing**
5	Future Topic: Electronic Patient Prescribing		
6	Future Topic: Electronic Prescribing Rollout	**Watford / Princess Alexandra**	

DRAFT