EAST OF ENGLAND TRANSFUSION PRACTITIONERS NETWORK

Minutes of the meeting held on Friday 29th November 2019 at Cambridge Donor Centre at 10am.

Attendees:

Name	Hospital	Name	Hospital
Tracy Nevin **TN Chair**	Princess Alexandra	Joanne Hoyle **JH**	West Suffolk
Frances Sear **FS**	NHSBT	Sarah Clarke **SC**	Ipswich
Donella Arnett **DA**	Watford	Tina Parker **TP**	Broomfield
Sheila Needham **SN**	Lister	Sue Turner **ST**	Colchester
Gilda Bass **GB**	West Suffolk	Monzeer Ibrahim **MI**	Addenbrooke's
Julie Jackson **JJ**	James Paget	Kay Bowen **KB**	Peterborough
Janet Pring **JP**	Norfolk & Norwich	Andy King-Venables **AKV**	Hinchingbrooke
Natalie Outten **NO**	Southend	Clare Neal **CN**	NHSBT
Becky Smith **BS**	Ipswich		

Apologies: Maria O'Connell, Loraine Fitzgerald, Karen Baylis, Julie Edmonds, Ellen Strakosch, Danielle Fisher, Ali Rudd, Kathy Ford, Cathy Flatters, Ben Sheath

1. **Welcome**: **TN** welcomed everyone to the meeting. Thank you to **KB** and **GB** for the last few years as Chair / Vice Chair of the meeting. **TN** has taken on the role of Chair along with **JJ** and **BS** as Vice Chairs.

2. **Minutes of the previous meeting**: Previous minutes were agreed.

   Actions from previous meeting*:*
   1) *Will be discussed later.*
   2) *CF to share Consent Form at next TP meeting – outstanding item*
   3) *Item closed*
   4) *A few hospitals have already put their names forward for this.*
   5) *All patient information leaflets are currently on hold and will be updated. There is a suggestion that a link will be given to access the most up to date information for risks on the website.* ***NO*** *noted that Mohammed Rashid advised that there is a code on leaflets to be able to check if they are the most up to date.* ***TP*** *asked when the Infected Blood Enquiry is likely to be publicised.* ***FS*** *does not know.* ***BS*** *advised they were involved quite early on.* ***TP*** *has had one enquiry.* ***ST*** *noted they had to go through a lot of paperwork.*
   6) *Michaela Lewin discussed this at the RTT and enjoyed the course.* ***KB / GB / JH*** *also enjoyed this and found it very informative.* ***KB*** *found it was really useful being held at the hospital where they are based. The level taught was what they will see. The simulation was very effective.* ***JH*** *said it made it more real having to find drugs, oxygen etc.*
   7) ***KB*** *has this with her if anyone would like to view it. It is split into different areas.* ***TN*** *noted that the level of competency was discussed at the RTC. There should be different levels according to where staffs are in their training / how much experience they have.* ***KB*** *said there would be 4 levels which have similarity but staff would progress between them all. The National Forum is looking at them.* ***TN*** *this is an ongoing process with a lot of background work taking place.* ***SN*** *asked where that will leave staff as their skills may suit their Trust but not the competencies outlined.* ***TN*** *there will be a generic competency with additions to suit staff / Trusts.* ***DA*** *suggested looking at the job descriptions that all TP's have.* ***KB*** *asked if anyone has been through UKAS and been asked about competencies.* ***SN*** *was observed whilst training phlebotomists.* ***NO*** *said they were surprised there was only one TP so a recommendation has been put in place.*

3. **Group exercise – Ideal MDT Working Partnership:-**
   How can we help laboratory staff?
   How can they help us?
   What barriers are in place preventing us from having this ideal working partnership?

   Attached as a powerpoint.

4. **Feedback – group exercise**
   Attached as a powerpoint.

5. Presentation – Blood Transfusion Pathway

TN showed the group the Adult Blood Transfusion Pathway and a lanyard for junior doctors. There would be 3 pathways – Adult, Paediatric and Day Case. The pathways will contain consent (including retrospective consent), TACO risk assessment, RTC Transfusion Reaction Algorithm, MBL Care Bundle (see attached draft copy still under review). **GB** asked if this would be externally printed and how this would work if there are changes. **TN** said that old charts would be removed and used for training. **SN** was concerned that if there were larger documents to complete, would areas be missed? **TN** will send round for comments. **GB** felt that printing internally would be really beneficial as there is scope to change the document if needed. **KB** felt that it may be a really useful document to have on wards as a resource. **TP** noted that lanyards are not allowed. **TN** thought an app would be useful.

6. Presentation – HSIB WBIT Report Overview

HSIB deal with 'every baby counts'. **JH** said there was a discussion at the HTC, numbers are randomly generated. **JJ** noted they can't have random numbers. **BS** advised they have a lot of unknown males on the system. Some stay this way as they have moved to Addenbrooke's or elsewhere. **TN** asked if anyone caters in policies for emergencies. **GB** can only label if seen it taken and is checked. **SN** there are times that samples are being taken from patients without wrist bands but there is no choice. **KB** was unhappy with the SHOT video as it states that you do not need two samples. **JP** is seeing more and more phlebotomy errors. There is a pile of forms on trolley, they are remembering details, going to the patient and then back to the trolley using the top form. It could be that other staff are moving forms or are putting forms on top of the ones there. **NO** was asked to re-train phlebotomists. **JP** felt the phlebotomists are under more pressure. Midwives errors happen because the labels are mixed up for cord / mum blood. **JJ** discussed how WBIT only happen when things consistently go wrong and records all errors. **DA** holds monthly inductions on blood sampling. They train staff and then assess. **AKV** felt it is important to catch staff not trained and look into why practice slips. **JH** it is important to look at why processes are not being followed. **JP** noted that there is not always a place at the bedside to label samples.

Dicing with Death

This was finished yesterday. **TN** suggested trialling at the next TP meeting by having 3 scenarios as World Café experience. **FS** felt that this would be good for mums, babies and blood. **JJ** will re-send out with an acknowledgement**. JP** thought that adding in unlikely events like fire alarms going off or vans breaking down would be good too. **JJ** feels the interaction is really important as it is taken in more and remembered.

7. Presentation – TACO Assessment

JH presentation attached. **NO** said it is important to educate nursing staff to question prescriptions and look at patients. **JH/GB** confirmed that IT has to respond to their requests. There was discussion around systems used and electronic records. **AKV** asked whether there is a time frame for blood results being pulled across. **JH** confirmed it would be the latest result available. It would include the date on the system.

8. RTT/RTC, PBM and NHSBT Updates

FS presentation attached. **JJ** will also look at regional toolkits.

9. Feedback from National TP Network

TN discussed the National TP Action Log, **TN, Kate Maynard (NHSBT) and Brian Hockley** to develop O D negative audit specifically for clinical side. **TN** requested input from **All** to review questions to ensure we are capturing the relevant data. **TN** also updated that she was also working on an audit with **Kate and Brian Hockley** regarding roles and responsibilities of the new nursing groups (Nursing Assistants, Student Nurses, Nursing Assistants and Associate Physicians) and requested input from All to review audit questions and to ensure we are capturing the relevant data. It was also agreed that we should adopt the Action Log to include our Committees so we can keep track of outstanding actions as well as have a log of implemented work. **KB** noted that there was a NMC document published. **TN** said there was nothing for Associate Nurses. There is a lot of confusion and would like a policy to reflect practice. **ST** asked what will be said to students. **JH** said that they will be working under supervision. They will have to attend training and be competency assessed. **DA** offers refresher training for staff. **AKV** noted that you can't have hospitals 4 miles apart doing different things. **JH** felt the region needs to think more about presenting / providing feedback to BBTS. **FS** suggested writing articles for blood lines. **FS** will look at entry / publish dates.

10. TP queries

1) Ipswich has had a problem with Paediatric Haematology samples since this was circulated.
2) No responses to Electronic Request Form for cffDNA
3) SHOT recommended to save documents as a PDF before sending to anyone so that it cannot be changed.
4) **ST / TP** have a lay person at their HTC.
5) MHRA is now looking at whether switchboard staff should have GMP training.
6) **JJ** shared certificates with the MHRA
7) All agree we send unit back following re-call process. **JJ** said that there is a code on re-call paperwork. The code informs you if it is a precaution or serious.

11. Next meeting: TP Meeting, Wednesday 4th March 2020, 10:00am – 15:00pm, Cambridge Centre

Suggested Agenda Items:-

1) *Dicing with Death*
2) *QUIST Pre Op Assessment*
3) *JH – Single Unit Transfusion Audit*
4) *GB – Anti D Audit*
5) *KB – Competencies*

12. A.O.B

ST informed the group that she was made aware that patients on Ecluzumab should not have FFP.

JJ asked how many people monitor transfusion times and report all transfusion over 5 hours to SHOT. On benchmarking James Paget's number of adverse events report is much higher than all the others – this is because 21 out of 31 of these reports were HSE > 5 hours (various reasons mostly staffing, skill mix and workload). Most present do not monitor but report if identified.

13. Meeting closed

Actions:

No.	Action	Responsibility	Status / due date
1.	Ideas for Education Day	ALL	ASAP
2.	Review Toolkits	ALL	ASAP
3.	Blood Transfusion Pathway and Lanyard for junior Doctors – draft copy for comments and review	TN	
4.	Dicing with Death to develop some scenarios for trial next meeting for World café'	JJ	Next Meeting
5.	O Neg Audit – suggestions of questions you would like to see	All	ASAP
6.	– Snapshot Audit questions for AN, AP and student nurses roles (see attached template so far)	All	ASAP
7.	TP list send up to date names and email addresses of all TP's to CN	All	ASAP
8.	WBIT audit - data review if there are any more questions to add.	All	ASAP