

# West Midland Region Hospital Transfusion Practitioners Focus Group



**NHS Blood and Transplant Donor Centre  
65 New Street, Birmingham  
Monday 10<sup>th</sup> December 2012  
Minutes**

## **Attendees**

Mary Hutchinson – Chair, University Hospital Birmingham (Queen Elizabeth)  
Andrea Harris – Secretary, NHS Blood and Transplant  
Jayne Evans – City and Sandwell University Hospital  
Michelle Reeves – City and Sandwell University Hospital  
Michelle Budd – University Hospital Birmingham (Queen Elizabeth)  
Jill Turner – Worcester Acute Hospitals NHS Trust  
Sarah Haley – South Warwickshire General Hospital NHS Trust  
Pam Irving – Mid Staffordshire NHS Foundation Trust  
Janine Beddow – University Hospitals Coventry & Warwickshire NHS Trust  
Karen Cooper – Shrewsbury & Telford Hospitals NHS Trust  
Sarah Robinson – Shrewsbury & Telford Hospitals NHS Trust  
Alex Radford – Robert Jones & Agnes Hunt Orthopaedic Hospital  
Maxine Boyd – The Royal Wolverhampton Hospitals NHS Trust  
Antoinette Turner – George Eliot Hospital NHS Trust  
Angela Sherwood – University Hospitals Coventry & Warwickshire NHS Trust  
Mandeep Dhanda – Walsall Healthcare NHS Foundation Trust  
Sara Strawford – SPIRE Little Aston Hospital  
Caroline Tuckwell – The Dudley Group Of Hospitals NHS Foundation Trust

## **Apologies**

Gill Godding – Worcester Acute Hospitals NHS Trust  
Tracy Clarke – Wye Valley NHS Foundation Trust  
Jayne Khorsandi – Heart of England NHS Foundation Trust  
James Taylor – Heart of England NHS Foundation Trust  
Angela Salmon – University Hospital of North Staffordshire  
Clare Pedley – Birmingham Children's Hospital NHS Foundation Trust  
Suzy Biggs – RTC Administrator, NHS Blood and Transplant

## **Minutes and actions arising from meeting 19<sup>th</sup> October 2012**

Minutes accepted as true record.

**Regional shared care document** – so far 6 hospitals have sent details of e-mail address to be used for this. Remainder of hospitals to be sent a reminder.

**Patient Blood Management** – no further information available as yet.

**BBTS Mollisons award** – no further information available as yet.

All other actions completed.

## **Plans for TP conference Monday 20<sup>th</sup> May 2013**

This conference, to be held at Walsall Hospital, will be called:  
**'Emergency Transfusion Medicine: Patient Blood Management'**

Themes for the day will include:

- Quiz to estimate blood loss
- Case study - getting it right
- Case study – getting it wrong
- SHOT and audit data – evidence of error
- Changes in clinical practice and BCSH guidelines
- Research (e.g. CRASH trials) and audit
- MOH / surgical / medicine
- Patients who say no – case study

All agreed with the plans for the conference, but stated that a flyer is needed ASAP.

**Action: AH to draft a flyer and circulate.**

There was a discussion whether the video from UHCW (showing trauma case study) would be appropriate.

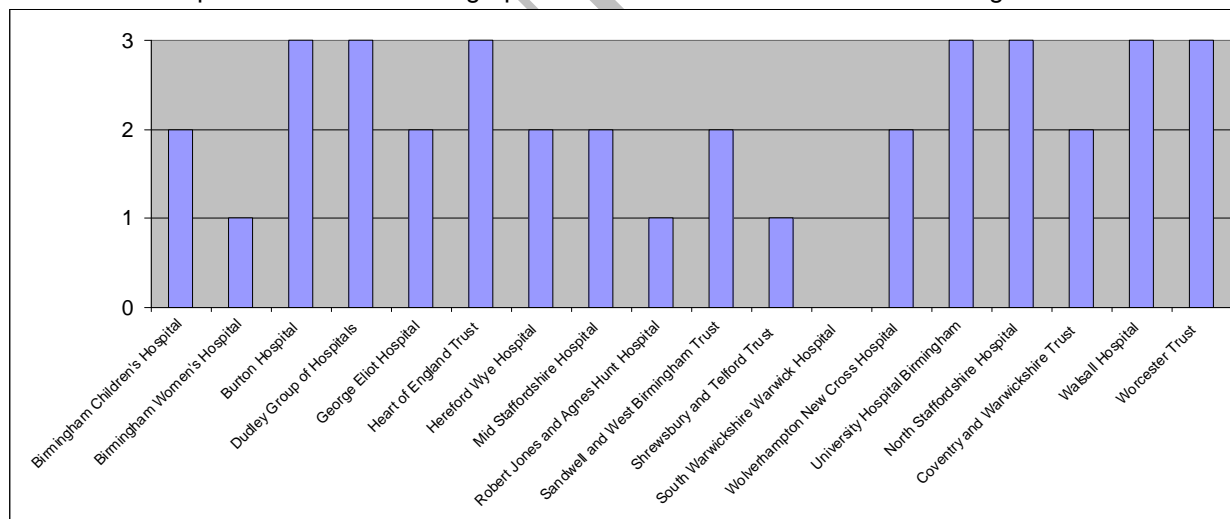
The group agreed that it would, as it raises a number of pertinent points including communication and appropriate use of blood including O neg.

**Action: JB to discuss with Keith Clayton and Nick Jackson and ask if one of them can present (Case study – getting it wrong)**

### **Regional and National Updates:**

#### **RTC:**

RTC membership was discussed. This graph shows attendance at the last 3 meetings:



TP's can attend if HTC chairs are unable to.

There are some plans to survey HTC chairs to assess their thoughts about the RTC.

A letter sent from Paul Turner expressing concern over pathology modernisation and the impact on blood transfusion services was taken to the NBTC and created some debate – other regions also have concerns. Adrian Newland (chair of NBTC) will raise this with Sir Bruce Keogh (Department of Health medical Director).

The group reviewing the NPSA SPN 14 – Competency Assessments for Blood Transfusion, continues with their review. It is planned that they will submit a paper to the NBTC next March.

### **Consent for transfusion**

– this has been discussed at NBTC – concerns over what consent for transfusion means to clinicians and impact on HTTs.

### **SHOT:**

40% of 'Wrong Blood in Tubes' (WBITs) are doctor related, which is a huge over representation. At the RTC there was discussion that currently there is variation across the region as to what actions are taken when a WBIT is identified, and there was a suggestion that there should be regional agreement on what should happen when an error occurs.

This created a lot of discussion within the TP meeting as to how this may be achieved regionally. AH has been asked to convene a regional group to look at this, and TPs will be invited to join.

JB stated that practice at UHCW has improved (blood sampling and patient observations during transfusion) since the creation of 'dash board' reports which are presented and clinical areas are 'named and shamed'.

### **The Regional Lab Managers group**

- had been discussing the 2 sample requirements of the new BCSH Compatibility guidelines. Wolverhampton New Cross Hospital has been doing this for some time – after some initial implementation problems, no problems since.

### **Regional cell salvage group**

– regional cell salvage data collection in progress.

### **RTC Audit Group update:**

Hopefully regional O neg survey report should be finalised soon. The next regional audit group meeting is next week.

### **Pre-op survey**

– questionnaire is being finalised – hopefully will be circulated to TPs early new year – TP's will then need to send appropriate pre-op assessment leads.

**The regional audit group** are also planning a regional platelet audit – but will need to fit in around NCA plans.

### **National Comparative Audit:**

3 outstanding audit reports (use of blood in cardiac surgery, medical use of blood and blood sampling) are due December 2012.

Plans for next year are:

Spring 2013: Audit of the management of patients in Neuro Critical Care Units

Spring 2013: Audit of the use of Anti-D

Autumn 2013: Audit of the management of patients with haemoglobinopathies

Autumn 2013: Audit of patient information and consent

### **SaBTO**

– CMV-ve requirements discussed at RTC meeting – all adult transplant centres in the region will be following SaBTO recommendations, but Birmingham Children's hospital is still to confirm.

### **BBTS / National TP Group**

– the next National BBTS TP conference will be held in Birmingham on Wednesday 15<sup>th</sup> May. The BBTS HoT SIG conference will be Tuesday 14<sup>th</sup> May at the same venue, with plans for an evening meal for those wishing to attend. Further information will be circulated when available.

### **Plans for joint regional TP / TLM meeting:**

Planned for Friday 15<sup>th</sup> March at NHSBT New Street. 2 meeting rooms have been booked to allow groups to meet individually, as well as having a joint meeting.

Suggested themes so far have included updates from projects such as AIM II and ABLE study, and looking at quality measures and regional component issues.

It was suggested that this would also be a good forum to discuss how to take forward issues such as BCSH 2 sample requirements, sampling intervals, shared care and consent for transfusion.

**Any Other Business:**

A query was raised about whether it was deemed OK if staff made changes to a sample label if they were still at the patient's bedside. This created a lot of discussion.

There was a lot of discussion about zero tolerance - and that zero tolerance should be what it says - any deviation is no longer zero tolerance.

In summary - currently, out of the 13 Trusts represented at the meeting, 8/13 would accept a minor change if it was initialled and paperwork signed to say that the change was made at the patient's bedside. Small change = e.g. minor name spelling.  
5/13 would not.

Following the round table discussions, when asked what their personal views are, only 2/16 TPs agreed that changes should be allowed, although some thoughts were still ongoing about phonetic changes (e.g. Jane instead of Jayne).

Another query was raised about sampling cord blood. Current practice is that the cord is taken away from the mother into the sluice to take the blood and label- is this practice safe?  
This again created a lot of discussion – with no conclusion or consensus achieved.

A hospital incident and root cause analysis was discussed.

**Future Meeting Dates:**

**Joint TP / TLM meeting:**

Friday 15<sup>th</sup> March 2013

**TP meeting dates:**

Friday 28<sup>th</sup> June 2013

Monday 9<sup>th</sup> September 2013

Friday 13<sup>th</sup> December 2013

**Pharmacosmos**

– lunch was kindly provided by Jon Kennedy at Pharmacosmos. Jon was unfortunately unable to attend the meeting.