University Hospital Birmingham NHS
NHS Foundation Trust

Hospital Transfusion Committee

Haematology Seminar Room, Haematology Laboratory, QEH

15th Dec 2010
12.30

1. Apologies

2. Minutes of the meeting of 29th Sept 2010

3. Matters arising;
NPSA -Massive Transfusion Protocol to sign off (enclosure 1) **HD**
NPSA – Right Patient Right Blood **ST/MH** to update
Browser –**MH**

4. Internal Reports
Laboratory Update –**JT**
Incidents and complaints – (enclosure 2) **MH**
Usage/ wastage- (enclosure 3) **MH**

5. Audits
Wastage of Fresh Frozen Plasma **JT**
Traceability **MH**
MSBOS in Urology **MH**

6. External Reports/discussions
NHSBT report re blood stocks over holiday period –**MH for AH** (apologies)

7. AOB

8. Dates for 2011.

Hospital Transfusion Committee

Please note that these minutes may be made available to the public and persons outside the Trust as part of the Trust's compliance with the Freedom of Information Act

Admin Seminar Room, Admin Corridor, QEH
Wednesday 29th September 2010 at 12.30

Present:

John Isaac (JI)	Consultant Anaesthetist –Liver Surgery
Heidi Doughty	Consultant Haematologist –Military Liaison
Dr Jonathan Wilde (JTW)	Consultant Haematologist
Mary Hitchinson (MH)	Hospital Transfusion Practitioner
Oliver Beavan (OB)	Hospital Transfusion Practitioner
Jane Tidman (JT)	Blood Bank Chief, Haematology
Sheena Taylor (ST)	Risk Management Advisor
Karen Morris (KM)	Group Quality Manager
Dan Banton (DB)	Clinical Educator
Deborah Turfrey (DT)	Consultant Anaesthetist-Cardiac surgery
David Innes (DI)	Military BMS2 Blood Bank
David Leonard (DL)	BMS2 Blood Bank, BARS Manager
Helen Peat (HP)	BMS3 Point of Care
Michelle Field (MF)	Nurse Education Co-ordinator
Chandra Bhimarasetty (CB)	Consultant Anaesthetist- ROH

Chair: John Isaacs - Consultant Anaesthetist **Secretary:** Mary Hitchinson

1. Apologies

Maureen Perks, Jacquie Roper, Andrea Harris, Davinia Bennett.
Future meetings – apologies to Maureen Perks – *(ext* GRO-C

2. Minutes of meeting held 23rd June 2010 at 12.30

It was agreed that the minutes were accurate.

3. Matters Arising

MSBOS

Although MH and John Whiting had collected more data re blood usage in Urology and GI surgery it had been agreed at the HTT to wait until after the 2nd phase move of the new hospital to change the MSBOS

Action: MH to produce new MSBOS after 2nd phase move to new hospital

Provision of Beriplex

Will Lester (WL) had written to JI re his concerns that no agreement had been made over the provision of Beriplex. MH stated that at present it is not a requirement of BSQR to trace Beriplex .HD stated that it was a pharmacy issue.

Action: JW and WL to work towards a conclusion and determine the Trust's obligation in this matter.

Use of Tranexamic Acid in Trauma Patients

Following the CRASH 2 trials HD been involved in a national debate with Professor Murphy and proposed the use of Tranexamic acid in trauma patients. JI was unconvinced that Crash 2 trials had conclusively shown the benefits of Tranexamic Acid although agreed that it was of benefit in military trauma cases. JI proposed the continuance of use of thromboelastography to determine the need for antifibrinolytic therapy in civilian cases. CB stated that Tranexamic acid was being used routinely for

elective surgery at ROH.

4. Education

NPSA – Right Patient Right Blood (document sent out with agenda)

JI had presented the NPSA action plan at the Clinical Quality Management Group and since written to Tim Jones and Dave Rosser asking them to confirm acceptance of our potential non compliance in November.

MF has recently interviewed for 2 transfusion trainers. The post was for 12months. 14 individuals applied with only 8 suitable for interview. Of these 5 DNA'd and others not appointable. Although a lot of work has been done to meet NPSA requirements if unable to recruit to these posts we will be unable to fulfil the plan. ST to report to NPSA and has asked for gap analysis to identify deficiencies.

Discussion around future of NPSA which may be incorporated into Clinical Quality Commission. There is a move to make transfusion serious untoward incidents a 'Never Event'

Action: MH, MF & ST to meet to identify deficiencies

5. New Hospital

Blood bank issues

JT stated that wireless problems in Blood Bank have improved since IT had provided a central router. Blood Bank had blood stored for the papal visit.

Massive Transfusion Policy (MTP)

JT presented poster showing MTP. Much improvement in usage and wastage of blood since 2 bags of emergency blood had been incorporated into system. HD stated that protocol needs updating. Poster stimulated much interest and won award in the biggest section at the recent British Blood Transfusion Society conference. Lively discussion around MTP.

Action: JT to update protocol

6. Reports

Browser

MH stated that IT had been working on Blood Bank report for Browser. Unfortunately report could only show what had been issued by Blood Bank and could not be updated if blood had been used. JI stated that report should be on PICS or Clinical Portal and before it is in use should be shown to clinicians to gain their opinions. DL stated that BARS could provide a ward search to show whether blood was in the issue fridge. MH stated that this information would be incomplete as it cannot determine whether blood is in a satellite fridge,

Action: MH to provide JI with details of Browser before next meeting and before it goes live.

7. Other reports (see enclosures previously distributed).

8. AOB

JW – following an incident were patient bled and died, report queried whether BMS should have activated the MTP. JW stressed that it is not the duty of the BMS to activate the protocol.

DL- asked committee whether they had any objections to putting a BARS box in cardiac theatres. JI was not keen to move this forward at present as theatre staff are still getting used to the move to the new hospital.

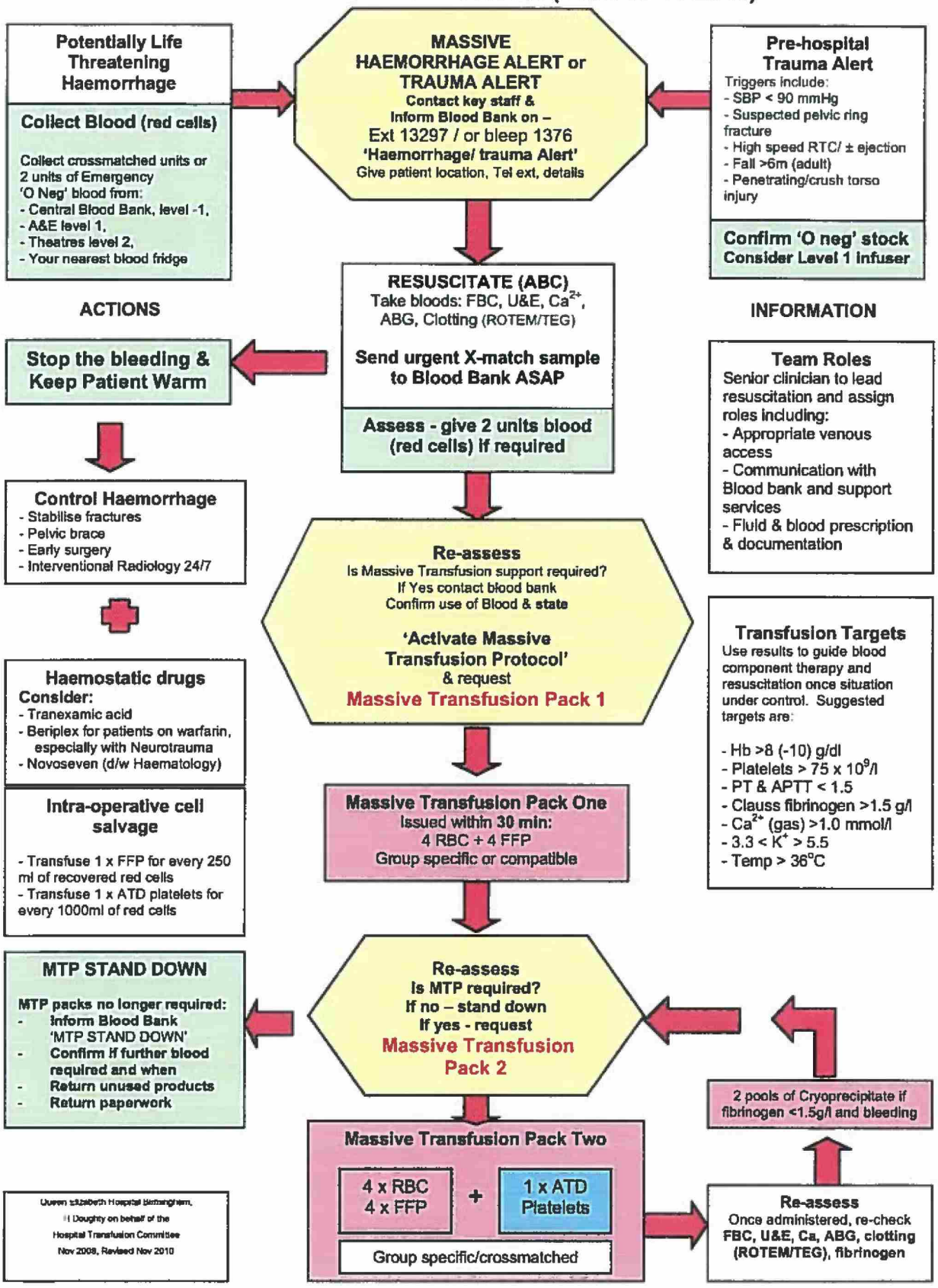
ST,MF,JI-following success at BBTS it was suggested that JT/HD be nominated for Best in Care Awards

Action: JI to follow up on this.

Date of Next Meeting

15th Dec at 12.30 in Haematology Seminar room

MASSIVE HAEMORRHAGE PROTOCOL incorporating the Massive Transfusion Protocol (Draft 18 11 2010)



Hospital Transfusion Committee

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Haematology Seminar Room – Queen Elizabeth Hospital
Queen Elizabeth Hospital
16th March 2011 at 12.30

Present:

Dr John Isaacs	Consultant Anaesthetist
Dr Heidi Doughty (HD)	Consultant in Transfusion/Haematology
Dr Jonathan Wilde (JTW)	Consultant Haematologist
Mary Hitchinson (MH)	Hospital Transfusion Practitioner
Jane Tidman (JT)	Blood Bank Chief, Haematology
Sheena Taylor (ST)	Risk Management Advisor
Karen Morris (KM)	Group Quality Manager
Michelle Field (MF)	Senior Nurse for Education
David Leonard (DL)	BMS2 Blood Bank, BARS Manager
Chandra Bhiramasetty (CB)	Consultant Anaesthetist (ROH)

Chair: Dr Jonathan Wilde Secretary: Maureen Perks

1. Apologies

Deborah Turfrey, Jacquie Roper, Lisa Pim, Dell Brothwood, Joanne Moysey, Louise Denner

Future meetings – apologies to Maureen Perks – (ext GRO-C

2. Minutes of meeting held 15th December 2010

The minutes of the last meeting were agreed as an accurate account.

3. Matters Arising

NPSA – Rapid Response Report

- MH has updated policy and will forward to Keith Porter and HTT. One specific communicator required for every clinical team and that person should continue the process. HD ~ responsibilities and processes are specified in the Massive Transfusion Protocol.
- MH carrying out teaching in satellite areas. JI asked to keep an eye on it and to feedback on any issues.
- HD ~ should be incorporated in Trauma Team Training.
- HD ~ Flow chart text needs updating but should be compliant by action date.

NPSA – Right Patient Right Blood

- MF reported that will be compliant by 1.4.11. Nurses who have not undergone training will not be able to transfuse. Should be enough trained nurses in the system to accommodate. The main focus is on administration but with sampling possibly around 80% compliant.
- JTW/JI had met with Dave Rosser to discuss medics compliance. Medics putting paper together to take to CEOG.
- ST stated that although originally compliant NPSA had re-issued compliance document. Now working towards compliance by 31.3.11.
- ST ~ ABO never event relating to severe transfusion reaction or death to come into force by 1.4.11. Coroner is required to disclose any event. Financial penalties are incurred i.e. non payment of care.

Browser
- JT awaiting action from I.T. JT will send out date once confirmed.

Action: JT to distribute date.

- JI stated that majority of anaesthetists do not use the Clinical Portal and as a result would require training.

Action: JT to inform JI before sending out Trust communication.
Action: JT to organise communications in Loop.

4. Internal Reports

Laboratory Update
- JT reported CPA inspection carried out on 31.1.11. No non-conformances raised with many examples of good practice noted.

Massive Haemorrhage Protocol activations
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- Liver transplant patient received over 100 units on 16.2.11. Lab thanked for their help.
- One bag of blood untraced.
- HD/JTW to visit ED to highlight to clinicians use of blood stocks.
- JI stated that this was a laboratory view and not clinical and more specific details of the case were required. Clinicians were working in unpredictable situations which made it difficult to call accurately.

Incidents and complaints (full report previously distributed)
- Acute Transfusion Reaction – reactions discussed.

Usage / Wastage (full report attached with minutes)
- Improvement since closure of SOH.
- JT reported that out of temperature control should also improve.
- Platelet wastage raised. JT stated that lab only order platelets for named patients.
- O Neg has been critical in winter months. SOH had high percent of O Neg use due to RCDM. Since move to New Hospital this has improved.

Action: JT to supply audit to JI and HD.

5. Audits

Wastage of Fresh Frozen Plasma
- Retrospective audit carried out on wastage of FFP. Data was extracted from laboratory computer system. Cardiac and Liver biggest offenders. JI asked for details on areas within Liver to see where wastage was.

Action: JT to provide information to JI.

Traceability
- 98% reported for February. One area did not trace any units.

6. AOB
- HD – Cell salvage meeting to take place 1.4.11.
- West Midlands Regional Transfusion Committee Workshop to be held on 27.6.11 includes Conflict Management, Communications and Self Control.
- National TP Educational Event to be held on 23rd/24th June.
- Training Day – BBTS National Society 29.4.11 response required.
- Annual SHOT Symposium 2011 to be held on 6th July at the Royal Society of Medicine, London.

- CB ~ ROH produced transfusion protocol ~ based on UHB's protocol but less relevant data removed. Awaiting approval. Should be reviewed together with UHB to be kept up to date.

7. HTC Dates for 2011 ~ Venue: Haematology Labs Seminar Room

Wednesday 15th June at 12.30
Wednesday 14th September at 12.30
Wednesday 14th December at 12.30