University Hospital Birmingham
NHS TRUST

AE/ELPH/HBTC

29 October 1999

Dr J Wilde
Consultant Haematologist
University Hospital Birmingham
Queen Elizabeth Hospital
Edgbaston

Dear Jonathan

I enclose the Minutes of the Hospital Transfusion Committee Meeting on Tuesday 19 October. I would be grateful if you could read the enclosed and let me know your comments and whether there is anything else you would like me to include.

Kind regards.

Yours sincerely

GRO-C

Allen Edwards MCh FRCS
Chair - Hospital Transfusion Committee

Jonathan Wilde

AGENDA

HOSPITAL TRANSFUSION COMMITTEE MEETING

Tuesday 19 October 1999

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1. ✓ Introductions/composition of Hospital Transfusion Committee.

2. ✓ Minutes of previous meeting.

3. ✓ Terms of references.

4. ✓ Policy for administration of blood products (Rachel Rowe).

5. ✓ Octaplas. — List of preference gps & Heidi.

6. ✓ SHOT/serious incident reporting (Dominique Wright).

7. ✓ Maximum surgical blood ordering schedule.

8. Any other business.

UNIVERSITY HOSPITAL BIRMINGHAM NHS TRUST

MINUTES OF HOSPITAL TRANSFUSION COMMITTEE MEETING

Tuesday 19 October 1999

VENUE	Undergraduate Centre, Selly Oak Hospital
PRESENT	Allen Edwards - Chair Dr Heidi Doughty Dr Jonathan Wilde Dr Mav Manji Miss Rachel Rowe Miss Dominique Wright Haematology SPR
APOLOGIES	Mr Steve Potter

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1. Introductions and Composition of Hospital Transfusion Committee

All the members were introduced and the composition of the Committee agreed. It was also agreed that local experts would be co-opted on an ad hoc basis. Miss Dominique Wright informed us that she would be leaving at the end of the month, but her place would be taken by Miss Siobhan Heathfield, who has ITU nursing background.

2. Minutes of Previous Meeting

These were agreed.

3. Terms of Reference

Dr Heidi Doughty informed us that the terms of reference as set out in the RCP document were not, in fact, the Trust terms of reference. These are with Mr Andy Reid.
ACTION POINT: ATE to write to Andy Reid to obtain formal terms of reference and present at next meeting.

We were informed that the new terms of reference contain specific references for risk management and clinical governance.

4. Policy for Administration of Blood Products

Rachel Rowe presented a document for the administration of blood products within the Trust. We need to have this document in place by April 2000. The document has been circulated to all senior nurses within the Trust and their suggestions are being incorporated within the document. A number of issues were raised at the Transfusion Committee and Miss Rowe will include these in the final document.
ACTION POINT: Rachel Rowe to prepare final document by next meeting.

A number of specific points were raised during the discussion of the administration of blood products, namely the storage of blood in Theatre at Selly Oak. Currently, blood is stored in the Transfusion Room which is located between Theatres and Intensive Care. Dr Mav Manji informed us that although the unit is next to Theatres, it would improve the situation if a specific area was identified in Theatre.
ACTION POINT: ATE to write to David Rosser regarding problem.

The problem has been identified with cool boxes for transporting blood. As a general feeling, the number of cool boxes appear to have disappeared and a number of reasons were put forward for this. The haematology SPR who attended the committee meeting is going to identify how many boxes were bought and how many are still in existence.
ACTION POINT: SPR to present data at next meeting.

The issue of informed consent for transfusion was also raised and Dominique Wright suggested that although we do not have a formal consent form for blood transfusion, people should be encouraged to document in the notes that a patient has given verbal consent.
ACTION POINT: Committee to consider ways in which junior staff can be educated on this matter.

There was also an issue related to the use of microfilters for blood transfusion. Blood is currently filtered at the laboratory level and therefore filters may be unnecessary in clinical areas. This may represent a potential saving for the Trust.
ACTION POINT: Dr Mav Manji to review situation and formulate recommendations to the Committee by next meeting.

5. Octaplas

The document prepared by Dr Heidi Doughty was considered. This lays out current use of standard FFP within the Trust and outlines the cost pressure of £600,000 per year if we were to change over to solvent-treated FFP. The risk of transfusion infection appears to be extremely low, but all this needs to be weighed against the possible risk of litigation if such an infection were to occur. It was the general feeling of the committee that we should not recommend Octaplas for general use, but that we should offer it to specific patient groups.
ACTION POINT: Dr Doughty and Dr Wilde to prepare a list of high risk patient groups for discussion at next meeting.

6. SHOT Serious Incident Reporting

Dominique Wright highlighted the problems with identifying serious incidents related to the Transfusion Service. She is going to arrange for all transfusion related matters to be recorded under a suitable heading with suitable sub-headings to make data retrieval easier. It was agreed that the Serious Incident Report should be a permanent agenda item and Dominique Wright or her successor would identify recurring themes within these incidents. Dr Doughty outlined the SHOT reporting system and she will circulate committee members with all the SHOT incidents at the next meeting. Particular problems discussed were portering, Jehovah's Witnesses and incorrect labelling of transfusion request forms and bottles.

7. Maximum Surgical Blood Ordering Schedule

Dr Doughty highlighted the problem with inconsistent requesting of blood within the Trust. She informed us that other trusts have policies in place to guide junior staff in their ordering schedules. She also outlined some of the problems that we may encounter in getting clinicians to agree to such a schedule. *ACTION POINT: Dr Doughty and ATE to meet and agree maximum blood ordering requirements for commonly performed procedures and then circulate the relevant clinical specialities and ask for their comments, preferably within a two week timeframe. These schedules then to be available to clinical and laboratory staff to prevent wastage of blood products.*

8. Any Other Business

Dr Manji raised the problems associated with the laboratory service at Selly Oak out of hours. Unfortunately, there is only anecdotal evidence of deficiencies in the service and he has agreed to document all incidents and present this at the next meeting. If there is good documented evidence of failure of the service on the Selly Oak site, then the Committee can approach the laboratory service to try and improve the situation.

Date of Next Meeting

Tuesday 30 November 1999 at 5.00 pm in the Undergraduate Centre, Selly Oak Hospital.

CLINICAL LABORATORY SERVICES
Contact: Jacqueline Roper, Lead BMS Haematology Department,
Deputy Services Manager for Biochemistry/Haematology.
Queen Elizabeth Hospital
Tel: 0121 627 2475 Fax: 0121 414 1041

Re: blood availability out of hours on the Selly Oak site.

The service provision is as follows:

1. **Weekdays.**

- There is MLSO cover on site from 0900hrs to 2000hrs.

- 2000hrs to 2200hrs cover is provided from the QE site, however, one of the team there can be called across in the event of a trauma alert or circumstance that requires blood in less than 2 hours.

- 2200hrs to 0900hrs is covered on an on-call basis by an MLSO from home. Call outs should be for trauma alerts or circumstances that require blood in less than 2 hours.

2. **Weekends and bank holidays.**

- There is MLSO cover on site from 0900hrs to 2200hrs.

- 2200hrs to 0900hrs is covered on an on-call basis by an MLSO from home. Call outs should be for trauma alerts or circumstances that require blood in less than 2 hours.

If blood is not required within 2 hours then the request should be directed to the QE site where an MLSO is on site from 2000hrs to 0800hrs every night of the year.

Should blood be requested for SOH from QE, please inform the MLSO that the sample is on its way and the time frame within which you want the blood as this will help them to prioritise their workload.

Blood Issues April 1999 - September 1999

Form Number	Details
330	pt's blood sample delivered by porters to haematology but the unit denied having received any sample for this particular pt.
2001	blood transfusion record and microbiology report of pt in QEH itu sent to risk dept. Dr in itu said that the results would have been verbally reported.
4766	blood sample taken for urgent analysis at 22:00 but still at porter's lodge 2 hours later.
5008	Rang porters to ask for a unit of blood explained it would be labelled differently and that it had no paperwork with it. No blood appeared on the 2nd phone call. The blood bank then phoned and said the blood was still down there I explained the problem I was having with porters. They then came up with the blood 4hrs later after requesting.
5440	blood sample arranged to be collected at 15:00 hrs. At 19:30, nurse phoned blood bank to check if blood was ready, but discovered sample had not been collected from MIU.
5441	unit of FFP brought up to unit by sister in charge of hospital. The donor unit number on the red and white form was found to differ from the bar code number on the bag itself. Nurse phoned haematologist on call who advised not to give unit of FFP and to send back to blood bank at SOH in the morning. Unit was not given.
5448	Blood ordered via porters in emergency 2 further phone calls 15 - 20 minutes later for blood to arrive.
5476	soh awaiting urgent blood samples, but did not arrive until after 20:00 hrs, despite porters being informed of urgent delivery needed.
5559	confusion over correct procedure for collecting FFP.
5574	pt prescribed 2 units of blood which the porters collected from blood bank, blood arrived and has x - match on numbers still there has no corresponding no with the pt no record in the notes phoned registration and A & E no corresponded with unit no on the registration computer.
5577	pt required a unit of FFP the bags are labelled in the blood bank. Porters called to collect it porter refused to collect it reporting he had been told not to despite discussions portering staff negatiations to allow porters to collect. Night sister called out to collect.
6445	pts blood taken to porters to be transported - sample didn't arrive till 2hrs delaying pts treatment not satisfactory.
6867	3rd unit of blood was sent for to be commenced - 2 other units had been given by night staff. Hos reg no in notes casu no did not match the hos reg no either cross match form either for the 2 units given as the 3rd unit sent for but not given. Blood bank contacted she said give blood - not happy against hos policy. Sister contacted who came and agreed not to given blood.
6902	pt currently undergoing intermittant dialysis. Blood sample taken due to increasing potassium. Both porters + biochemistry contacted at 19.15 + informed of urgent nature of the specimen. At 20.15 a 2nd specimen was requested + on contacting Biochem I was informed that the 1st specimen had not arrived. Contacted porters 20.30 to request an urgent pick up. Specimen still on nccu 21.00 porters informed me no request record. On contacting biochem today 30/8 I was informed that the 2nd spec arrived at 22.02 and the 1st at 22.03 hrs I feel the pt could have been compromised by the late delivery of the 1st spec + late pick up of 2nd
8110	RIGOR following commencement of blood transfusion. Temperature up, shaking/shivering, followed by flushing. See attached SHOT form.
8781	x5 urgent blood samples awaiting collection - finally collected after 3 further calls - sr for hos informed.
8793	Checked 2 units of ffp needed urgently - checked pts name number and group against the blood form and the pt however we did not have the right form with the ffp unit numbers on and did not realise at the time until dr asked where the form was.
8885	possible blood transfusion reacted to stu unit of blood Haematology dept & medical staff conntacted + hospital procedure followed + liased Haematology drs.
9393	blood results received did not relate to pt numbers. Matter investigated and resolved.
10125	delay in transportation of blood sample. Sample delayed at porters desk from 14:00 until 18:00 hrs.

Form Number	Details
10126	delay in picking up blood specimen from ward.
10150	bag of blood delivered to ward by portering staff bag appeared intact on handling bag noted blood leaked onto hands after contact Leak appeared to be from sampling tube.
11372	pt given 2 different v numbers as registered on Ward and ITU for transplant. Confusion caused over blood results.
11533	Ward came to give a unit of blood and discovered it had a haematology lab no which could not be indentified with the pt. The date of birth although matching that in the pts notes was dispoted by the pt. Blood not given Dr and blood bank informed of the problem not used as it was not possible to establish how long it had been out of refrigeration.
11875	Doctor came to ward to change ratio of patients heparin pump- telephoned biochemistry for the blood results but was told no sample had been received. Sample box checked and the blood was still there - dr had taken the blood and tele the porters - the blood has to be taken to the labs as an emerg as the results were needed to plan the correct care for the patient.
14587	pt arrived in holding bay to be told that no blood available, because the blood match required was at QEH blood bank, and could not be ready until following morning. Pt had to be returned to ward, wasting theatre time and causing pt discomfort and distress.
14589	ward nurse removed blood bank copy of blood form from book. Therefore there was nothing to check against as per protocol when fetching blood, so had to check to see if any blood was crossmatched at all.
14590	pt for hemiarthroplasty group+ saved at QEH. Delay for available blood too great. Returned to ward from anaes room. Awaiting blood at SOH.
17151	11 pt samples left for collection at porters desk at 1700 did not arrive in bloodbank (for repeat testing to check results) until 0910am presume left at room temp all night- a delay of 16hrs to deliver samples in unacceptable - routine collection of late blood before 1800 these samples were missed.
21008	2 boxes of blood sent - 1 box containing 7 x matches & 20 units of blood left at room temp - only discovered when Roh phoned quering location - blood returned to QE for disposal.
21303	Transport driver reported that bloods from the HIV clinic had been carried to a specimen reception point within a metal carrier but then tipped them out into a plastic bag containing other lower risk specimens - investigate procedure for carrying high risk specimen and modify procedure necessary.
24455	specimens not collected from porter's desk - left overnight. Pt's to be recalled for repeat blood tests. Situation repeated following night as well.

SHOT SUBMISSIONS April 1998- Oct1999

Number	Component	Category	Clinical	Outcome
14486	FFP	Jehovahs Witness	-	Legal Review documentation
	Red cells	TRALI	ITU, Ventilation 24hrs	Donors withdrawn Staff education
14141	Cryoprecipitate	Wrong component	None	Education Laminated sheet in Day unit and laboratory
14168	FFP	?allergic, complement activated	Circulatory support	Premed before further FFP Exclude Anti-IgA
Near miss	Red cell	Wrong patient bled	Junior doctor	Lab staff compared with historical group HO advised
15229	Multiple	TRALI	ITU, ventilatory support	Greater awareness amongst anaesthetic staff
15431	Red cells	Blood to wrong patient, wrong blood collected and incorrect bedside procedure	None (Group O blood to group A patient)	Investigated by cardiac staff. Stop unecessary transfusions at night Education by R. Rowe
008110	Red cells	Catheter sepsis	Death	-
16659	FFP	TRALI	Dexamethasone	Identify donors