Hospital Transfusion Committee

Laboratory Haematology Seminar Room
Queen Elizabeth Hospital
5th October 2005 at 12.30

Present:

Dr H Doughty	Consultant in Transfusion/Haematology
Dr J T Wilde	Consultant Haematologist
Mr John Whiting	Consultant General Surgery
Dr Hoth Tariq	Consultant Anaesthetist
Mr David Mayer	Consultant Liver Surgeon
Ms M Hitchinson	Hospital Transfusion Practitioner
Jane Tidman	Acting Blood Bank Chief, Haematology
Maggie Pailing	Hospital Liaison Manager, NBS
Bob Hibberd	Risk Management Advisor
Richard Daw	Pathology Quality Manager
Pam Goodall	Modern Matron, ROH
Bernie Craven	Risk Manager, ROH
Julie Tracey	Operational Project Nurse

Apologies: John George, Jacquie Roper, Dell Brothwood, Andrea Blest.

Chair: Dr John Isaac **Secretary:** Maureen Perks

1. **Apologies for absence**
As listed above. Future meetings – apologies to (*Maureen Perks – ext* GRO-C

Dr John Isaac introduced himself as the new chair for the Hospital Transfusion Committee.

2. **Minutes of meeting held 11th May 2005.**
Accepted as true.

3. **Matters Arising**
Update on cell salvage – (information collated by Davinia Bennett). Early data shows equipment being used in 15 out of 17 operations. 50% approx mean transfusion down from 6.2% to 3%. This presents a saving to the Trust of around £40,000. ODA's have been trained up to run unit. The cell salvage equipment can be utilized for all transplants and can be easily transferred to other areas of the Trust.

4. **E U Directive**
MH tabled document (attached).

Traceability - currently using blood register on all wards to collate evidence. This will be collected by the Blood Product Handlers. It was noted that this paper system would not be feasible long term. The PIC's system could possibly be the long term option but there were various issues still to be resolved and were currently under discussion.

RD/MH will be carrying out audit on blood fridges week after next.

MH raised the question of duplicate reporting through SHOT/SABRE.

5. **Update on the Emergency Blood Management Plan**
Trust has taken part in a national EBMA at NBS. MH/JT have seen whole national plan.

Dr Doughty has written response to contingency planning.

Further alterations had been made to the Plan and MH would be sending out the latest version with minutes of this meeting. (attached).

In the event of blood shortage a traffic lights system will come into play with a communications cascade down from NBS → Blood Bank → Consultant Haematologist who will then activate the hospitals Amber action plan.

It was agreed that it would be constructive to carry out an exercise to run through the processes. Discussion took place as to when the best time would be to do this.
Action: HTT would report back on the best way forward.

6. **Audits**
Cardiac Audit
Audit carried out by MH to measure the percentage of bloods ordered in relation to how many requested. It was established that 6 times more bloods were ordered than ultimately used. Only 30% overall required transfusion. Cardiac have been asked to re-visit their blood order schedule.

It was noted that the cost of platelets was around £1,000 per 4 bags and that it might prove useful to highlight this fact to the medics.

Harmonic scalpel
Audit conducted on the use of this new piece of equipment showed a reduction in blood use and a decrease in the operating time of 1½hrs. This could make a big difference to the quantity of bloods required. The cost of the scalpel was around £15,000 to £20,000.

7. **Reports**
Incidents and complaints
2 x transfusion recalls – NBS dealing with issue.

1 incident reported related to patient with 2 registration no's. It was discovered that patient had 4 different antibodies. There was a delay in getting blood at SOH and patient died.
Action: HD has written response to incident.

Usage and Wastage
MH tabled document. (see attached).

Lab Reports
BARS system – still not up and running due to unresolved problems. Company dealing with these issues and once resolved staff will be trained up in the use of the system.

Blood Stock Management – The blood stocks carried in labs were well below what NBS understood from their figures and will be updating their records accordingly.

O Neg usage showed a massive drop from 30% to 5% due to Product Handlers retrieving blood from ROH and SOH.

JT – There was an issue with cross-match requests arriving from ROH late (9pm) and being required for theatres (8am) next day.
Action: JT to contact ROH with details.

Protocol for Recombinant VIIa usage
Dr Wilde stated that he would be sending out a draft protocol to Consultants for comments before being put forward to the various bodies for clearance.
Action: JW to send draft protocol to Consultants

8. **Any other business**
Maggie Pailing stated that the NBS is now NHS BT(blood and Tissues) as of 1.10.05.

9. **Date of Next Meeting**

Wednesday 11th January 06 2005 at 12.30 - Haematology Seminar Room

Refreshments will be ordered only for those confirming attendance to Maureen Perks
A reminder will be sent out prior to next meeting.

West Midlands Inter Hospital Blood/Blood Product Transfer Form

THIS FORM IS TO BE COMPLETED WHEN PATIENTS ARE TRANSFERRED TO ANOTHER HOSPITAL WITH BLOOD AND PRODUCTS

To be completed by Issuing Hospital: Blood Bank Name---------- Date---------- Time--

CONTACT DETAILS:

Issuing Hospital Blood Bank Contact Name:	Issuing Hospital Blood Bank Tel No:
Request for transfer made by: ?Clinician or Blood Bank	Contact Details:
Receiving Hospital Blood Bank Contact Name:	Receiving Hospital Blood Bank Tel No:

Mount Sheet Adhesive **Mount Sheet Adhesive**

Please Note: A computer-generated list may be attached to this form instead of a written list.

Unit Number	Product	Group
Faxed computer generated sheet to follow not stuck on as this may cause difficulties when faxing.		

PACKAGING/DELIVERY DETAILS: Number of boxes in total.

PACKAGING	Name	Date	Time
Packed by:			
DELIVERY	**Name**	**Date**	**Time**
Collected by:			
Received by:			

Received by Blood Bank at:

Actions to be undertaken by the receiving Hospital:

1. Inform your local Blood Bank on arrival of the products

?appendices,attachments

2. Ensure form and products are taken to Blood Bank as soon as possible after receipt

3.

IF YOU HAVE ANY PROBLEMS OR CONCERNS REGARDING THE TRANSFUSION OF THESE UNITS CONTACT YOUR LOCAL BLOOD BANK FOR ADVICE

Extra Notes/Ideas

Stationery should probably be NCR so that it can be used during computer downtime

Or can be photocopied or faxed

List of blood bank fax and telephone numbers on back of this form yes

Would you like the format of the Unit number box to be as NBS credit slip i.e boxed for all 14 digits yes

Any other ideas Can we have tick boxes for This blood has been cross matched ☐
This blood is uncross matched ☐
Documentation to include details of a link to NBS website list of hospitals for details of delivery details/maps yes

Is there a need for a dispatch summary (Example below)??
yes
Dispatch Summary:

	O+	O-	A+	A-	B+	B-
Red Cells						
Platelets						
FFP						

One form for each box

Jonathan Wilde

From: Will Lester
Sent: 05 October 2005 09:00
To: Jonathan Wilde
Subject: beriplex

Dear Jonathan,

I've not had time to finish the beriplex draft but if you get chance to relay the new BCSH guidelines to the blood transfusion committee today I'd be grateful.

Recommendation

Reversal of anticoagulation in patients with major bleeding requires administration of a factor concentrate *in preference to* FFP, when this is available, (grade B level III)

Ideally we could hold a small stock in blood bank at QEH and SOH.
After you've made your own amendments, we could circulate it to interested parties perhaps?

Regards,

Will