Hospital Transfusion Committee

Laboratory Haematology Seminar Room
Queen Elizabeth Hospital
6th December 2006 at 12.30

Present:

Dr H Doughty	Consultant in Transfusion/Haematology
Dr Joanne Moysey	Consultant Critical Care
Jacquie Roper	Lead BMS Haematology/Transfusion
Mary Hitchinson	Hospital Transfusion Practitioner
Jane Tidman	Blood Bank Chief, Haematology
Richard Daw	Pathology Quality Manager
Bob Hibbard	Risk Management Advisor
Clare Wiley	Risk Associate Div 1 and 4
Pam Goodall	Modern Matron, ROH
Michelle Field	Senior Nurse, QEH

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

1. **Apologies**
Andrew McKirgan, Dr Jonathan Wilde, Dr Marcus Green, Dr Lynn Lambert, Dell Brothwood, Pat Sirrett, Andrea Blest, Debbie Palmer.
Future meetings – apologies to (*Maureen Perks – ext* GRO-C

2. **Minutes of meeting held 12th July 2006.**
The Minutes of the last meeting were agreed as an accurate account.

3. **Matters Arising** (majority covered on agenda)
   - Cold chain – JR/MH had submitted paper to COAG – funding had been agreed to replace fridges pending review.
   - JI had been in contact with Paula Gittoes to discuss requirements – this would now be discussed with clinicians and brought back to labs for discussion.

   Action: JI to take forward.

4. **Update on Blood Safety and Quality Regulations**
   - JR – paper had been submitted to Trust Board identifying all areas particularly non-conformances. To meet regulations additional staff had been incorporated within its content: Nurse (band 7), Cold Chain Manager, and 4 additional Product Handlers.
   - Laboratories would be undergoing their CPA visit in January and a visit from MRHA usually follow on from this. JI asked whether they would take into account planned improvements, it was agreed that clear evidence and action plans would need to be identified.
   JI stated that he would be willing to attend HTT meeting to identify weak spots. BH would also be willing to offer advice and support.

5. **Reports**
   - Tim Wong had trained new SHO's in the use of irradiated products and was in liaison with Mark Cook to add to PICS to eliminate the problem.
   - ROH - HD had been working with PG to resolve some of the issues regarding out-of-hours and transport.

Incidents & Complaints (Full summary attached)

- 24 units of plasma lost due to freezer failure in cardiac theatres.
- Delay in ROH transport – patient unharmed.
- ROH specimen lost by blood bank and repeat sample discarded.

Usage & Wastage (Full summary attached)

- MH stated that usage figures had been rising but this may be due to an increase in activity. It was noted that cardiac had been requesting 2 bags of platelets per patient.

Lab Report (Full summary attached).

- Expected rebate from NBS would be £127,992.
- NBS – possibility of strike over Christmas. Maggie Pailing had stated that an emergency plan would be put into action.
- Blood bank had received praise from Liver Team regarding their effort in supplying 100 units of Red Cells during surgery.

6. **Audit Report discussion**

Traceability

(Full audit of blood component traceability with UHBFT attached).

- JM enquired about the possibility of more robust blood registers as some paperwork had been found in patients notes. JI commented that scanners could be used for high use areas. MH stated that if we upgraded to the higher spec on the BARs system this would not be an issue. JR stated that bar codes could be used on forms to help the process. BH stated that Steve Chilten from IT was currently involved in work regarding barcoding patient bands. BH would look into this and report back to JI.

Action: BH to report back to JI on bar-coding.

Proposed audits

- JT reported that there was currently an audit by RCI on the closure of Regional Transfusion Laboratory.

Action: JT to report back to committee on outcome.

7. **Developments**

National Platelet Shortage Plan

This data had been released 2 years ago to identify actions in the event of a platelet shortage. MH would send out to HTC for reference.

- A traffic light system would be put into place to identify stock shortages. If system went red clinicians would be asked to prioritise their work load and non-urgent work would need to be deferred.
- HD asked the committee as to the best way of informing clinicians of the plan and the implications arising from it. It was agreed that this should be advertised through every available route and that all Consultants should be informed.

Action: MH to distribute plan to HTC.

National Patient Safety Agency (Full summary attached).

- This document detailed a programme offering a range of long and short term strategies to ensure blood transfusions are carried out safely. JR stated that a response specifying action plans (agreed) and actions (underway) was required by 22.11.06. A final deadline had been set for all actions complete by 1.5.07.

Transfusion Policy feedback

- It was agreed that anticoagulants should be kept separate.
- Transfusion training – it was discussed as to how often training should be undertaken. Web based training could be a possibility. From the medical point of view JI would liaise with Lynsey Webb.

8. Any other business

- None raised.

9. Date of Next Meeting

Schedule to follow shortly

Blood Transfusion Incident Summary; Apr 2006-June 2006

Total Number -26

Summary of transfusion incidents Nov 2006-Feb 2007

Date	Process /ID	Details	Action	Status	SHOT reportable?	SABRE reportable ?
29/01/07	**Prescription**	Inappropriate ordering by junior medical staff	Medic reminded of MSBOS and algorithms	closed	no	no
15/01/07 18/01/07	**Sampling** 49068/29736 49069	1. 2 patients with same name-patient details mixed due to notes being unavailable 2.2 patients with same name-patient details mixed when labelling sample-blood groups different	Medic realised error – preventative action taken Medic reminded of positive patient identification/ all patient information rechecked	Closed Closed	Near miss Near miss	No no
8/01/07 18/01/07 05/02/07	**Issue of component** 31390	1.Delay in issue of blood 2.CMV requirements not met-noticed by nursing staff 3. Blood Bank IT system down.	1.Clinical staff reminded to give adequate notice of transfusion requirements for patients with known antibodies 2.Error made by NBS compounded by error in Blood Bank. Root cause analysis performed 3 Staff reminded of contingency plan	Closed Pending NBS report Closed	no Near miss no	no yes no
	Storage and Transport					
20/02/07	**Administration**	Military patient given numerous group O blood in field to have group O red cells and AB FFP given 10 units of O FFP	Patient blood group determined by PCR-close monitoring of further blood components –all staff made aware	closed	yes	no

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12/02/02	**Transfusion reactions /events** 2007/002/021/HVI/001	1. Symptoms of fluid overload following 40 mls red cells transfused	1.All serological/ microbiological testing NAD (pt had 1000mls dextrose saline pre tx)	1.closed	1.yes	1.no
14/02/02		2. mild reaction to red cells	2. Anomolous antibodies detected	2. open awaiting follow up	2.yes	2.?
15/02/07		3. mild reaction to red cells	3. All serological/ microbiological testing NAD	3.closed	3.yes	3.no
20/07/07		4. mod/severe reaction to red cells	4.All serological/ microbiological testing NAD,pt closely monitored at subsequent transfusion	4.closed	4.yes	4.no
24/02/07		5. mod reaction to red cells	5.Anomolous antibodies detected	5 open awaiting follow up	5.yes	5.?
	Traceability	Many see audit				