NHS Lothian

NHS Lothian Transfusion Committee
Meeting held on Wednesday 23rd February 2022 at 14:30
Online (Microsoft Teams)

Present:

(HR) Huw Roddie (Chair) Consultant Haematologist WGH, (Chair WGH HTT)
(BB) Bella Brownhill, Transfusion Practitioner RIE & RHCYP
(JO) Jane Oldham, Transfusion Practitioner WGH & SJH
(JF) Jonathan Falconer, Transfusion Laboratory Manager WGH & SJH
(CBe) Craig Beattie, Consultant Transplant Anaesthetist, RIE (Chair RIE HTG)
(DM) Donna Medine, Advanced Healthcare Scientist, Transfusion Laboratory, RIE
(AT) Andrew Tambyraja, Consultant Vascular Surgeon, RIE
(CP) Claire Palmer, Clinical Nurse Manager, Cancer Services, WGH
(JE) Jenny Easterbrook, Transfusion Medicine Consultant, RIE
(CBl) Carol Blair, Consultant GI & Liver Physician, RIE
(GR) Gemma Ruck, Quality Manager SNBTS (South East)
(FS) Fiona Smith, Senior Charge Nurse, Haematology Day Treatment, WGH
(JM) John McLenachan, Consultant Cardiothoracic Anaesthetist, RIE
(JC) Jen Clarke, Specialist Trainee, Haematology

1. Apologies for absence:

(MRow) Megan Rowley, Consultant Haematologist, SNBTS
(SM) Scott McNeil, Consultant in Anaesthesia and Intensive Care Medicine, RIE

2. Minutes of Lothian Transfusion Committee meeting held on 6th October, 2021

CBl noted that the initials 'CB' had been used which did not distinguish between CBe and CBl. JO will correct.

Action JO

3. Actions and matters arising

CBe has enquired about outcome from SAE associated with major haemorrhage at RIE but has not been informed of any action plan. JO will find out if outcome has been added to Datix report.

Action JO

No feedback received to date from SB who was planning to take new refusal of blood guidance to anaesthetic consultants' meeting to identify whether any changes required for paediatric setting.

JO confirmed that charge nurse at SJH early pregnancy unit was taking forward educational and awareness raising activity with the relevant nursing team following repeated anti D near miss events. JO will contact SK regarding outcome of investigation into prescription aspect of these events.

Action JO

BB had followed up TACO event in ward 202, RIE: the most recent version of the transfusion document (which contains the TACO risk assessment) had been used but the risk assessment had not been performed.

BB had followed up WBIT in the surgical day unit, RIE.

Duplicate sample numbers at RIE are being collated and DM shared associated rates of rejection. These data have yet to be incorporated into the Lothian rejected sample report.

A prompt for clinicians to request a paediatric emergency team if triggering a major haemorrhage protocol for a child at SJH has been added to that site's protocol.

The Blood Assist app has been promoted on the NHS Lothian intranet banner.

The TRAK team are progressing the planned red cell antibody alert.

Date of Meeting	Agenda Item No.	Action By	Subject	Brought Forward	Complete
	2	JO	Amend 06/10/22 meeting minute ('CB')		**Complete**
	3	JO	Review Datix report from MHP event associated with SAE		
	3	JO	Ask SK about anti D incident follow up		
	4	HR	Set up meeting to address actions required following SHOT safety alert (transfusion delays)		
	5	JO	Collate WBIT trend data		
	6	DM/BB/JO	Incorporate RIE duplicate sample data into rejected sample report		
	7	BB/JO	Liaise with DCN regarding MHP additional alert proposal		
	9	HR/JO/BB	Draft transfusion policy		
	9	JO/BB	Satellite blood fridge policy revision		
	10	JO/BB	Transfusion document rollout		
	11	JO/BB	Blood group check poster rollout		
	15	HR	Arrange next meeting		
Actions carried over from 06/10/2021					
06/10/2021	3	CBe	Chase SAE outcome (RIE MHP called for incorrect patient)		**Complete**
06/10/2021	3	RB	Email SB re refusal of blood guidance for paediatric setting	**Ongoing**	
06/10/2021	4	SK/JO	Investigate anti-D near miss events gynaecology ward SJH	**Ongoing**	
06/10/2021	4	BB	Follow up TACO ward 202RIE re documentation used		**Complete**
06/10/2021	4	BB	Follow upWBITSurgical Day Unit RIE		**Complete**
06/10/2021	4	JO/BB	Arrange withdrawal old transfusion document versions when new is introduced	**Ongoing**	
06/10/2021	5	DM/BB/JO	Rejected sample (duplicate) data RIE incorporate into rejected sample report	**Ongoing**	
06/10/2021	6	JO	Add paediatric emergency team		**Complete**

			prompt to SJH MHP		
06/10/2021	8	HR/JO/BB/CBe/AA/SB	Progress transfusion policy	**Ongoing**	
06/10/2021	8	JO/BB	Satellite Blood Fridge Policy revision	**Ongoing**	
06/10/2021	8	ALL	Decide which transfusion document to adopt		**Complete**
06/10/2021	11	JO/BB	Blood Assist App on intranet banner		**Complete**
06/10/2021	11	HR	Email Committee re wording for TRAK antibody alert		**Complete**
06/10/2021	13	HR	Add Marion Mathie to Committee membership		**Complete**
Actions carried over from 02/06/2021					
02/06/2021	3	SB	Feedback following review of refusal of blood documentation for paediatric settings	06/10/21	Ongoing
02/06/2021	4	JO/CB/BB	Follow up SAE review outcome following major haemorrhage trigger for wrong patient at RIE	06/10/21	Ongoing
02/06/2021	5	JO/BB	Meeting with ED leads re clinical wastage associated with MHP		Ongoing
02/06/2021	8	HR/JO/BB/CBe/AA/SB	Review the Lothian and National Transfusion Policies and Transfusion Documents	06/10/21	Ongoing
02/06/2021	9	ALL	Committee to review wording on poster for blood group check sample policy.		**Complete**
Actions carried over from 02/12/2020					
02/12/2020	3	MRow	Update from Transfusion Team on investigation into electronic blood management system options	06/10/21	Ongoing
02/12/2020	9	HR / JO	Policy working group to report on decision regarding national transfusion document at next meeting	06/10/21	**Complete**
Actions carried over from 05/08/20					
05/08/2020	6	JF	SJH laboratory team to have a look into APEX options regarding Kleihauer test prompts		
05/08/2020	11	MRow/RB/CI	Review postpartum document		
05/08/2020	13	MRow/RM	Look into Traceline > SCIStore data transfer issue	06/10/21	Ongoing
Actions carried over from 13/05/20					
13/05/20	3	MR	Communicate suggestion for electronic transfusion system development at national level		
13/05/20	3	CI / JO	Share LBT matrix with education leads		
13/05/20	9	CI / JO	Review transfusion policy		
13/05/20	11	JO / CI / JF / SL /AN	Revise blood group check poster		**Complete**
Actions carried over from 19/02/20					

19/02/20	5	CI, JF, JO	Discuss plans for electronic system project with MR & CB		
19/02/20	8	RB	Inform Theatre User Group of MHP feedback sheet		
19/02/20	14	SL	Share proposed TRAK sample result layout / wording with Committee prior to finalising		
Actions carried over from 03/07/2019					
03/07/19	8	RM	Communicate request of LTC to see revised Traceline > SCIStore blood result format/wording before this goes live	Ongoing	
03/07/19	8	RM	Feedback progress on Traceline/APEX interface development at next LTC	Ongoing	
03/07/19	12	RL & CBl	Discuss extension of availability of freeze dried fibrinogen	Ongoing	
Actions carried over from 06/03/2019					
06/03/19	4	MRow, CBe, JO, CI, JF	Initiate investigation into current electronic blood management system options. JO, CI, JF to get an update and help take this forward.	Ongoing	
Actions carried over from 25/09/18					
25/09/18	8	SL	Request removal of initial antibody status line from Traceline > SCIStore report	Ongoing	
25/09/18	8	SL	Share proposed comment regarding suitability for EI that will be used in SCIstore with group	Ongoing	
Actions carried over from 09/08/17					
09/08/17	7	MRo & SL	Investigate how Blood Bank can access TRAK	Ongoing	

4. New Matters: Safety alert – preventing transfusion delays in bleeding and critically anaemic patients

The safety alert issued by SHOT (SHOT/2022/001) in January had been shared prior to the meeting. Responsibility for coordinating the associated actions on behalf of NHS Lothian has been delegated to this Committee.

The required actions were discussed in brief.

It was agreed that a subgroup of the Committee will meet separately to complete the required gap analysis and identify required action. HR will set up meeting. The deadline for actions is 15th July 2022.

Action HR

5. Incident Reports

JO and BB provided overview of all SHOT and MHRA reportable incidents and near miss events at SJH, WGH and RIE. Questions were invited and actions discussed where required. Full details available in the LTC Microsoft Teams channel.

Three reports from RIE were presented: two wrong blood in tube (WBIT) near miss sampling errors and one allergic reaction associated with FFP and/or platelets.

Five reports from WGH were presented: three WBIT near miss sampling errors, one possible febrile non-haemolytic reaction (associated with RCC) and one probable transfusion associated circulatory overload (TACO) reaction.

Three reports from SJH were presented: one further anti D request near miss event (recognising that this represented a repeat occurrence in the same setting), one probable TACO reaction and a delayed administration of prothrombin complex concentrate in a critically ill neurosurgical patient.

JO thought that the rate of WBIT events had increased recently and will collate data to allow trend to be reviewed.

Action JO

6. SNBTS Transfusion Team (TT)

Pre-transfusion samples rejected

Overview provided. Report available in the LTC Microsoft Teams channel.

Work to incorporate RIE duplicate sample data into Lothian report remains an action.

Action DM/BB/JO

Blood use and conservation

Overview provided. Report available in the LTC Microsoft Teams channel.

Traceability

Overview provided. Report available in the LTC Microsoft Teams channel.

Traceability compliance across all sites remains very good with rates often reaching 100%. These continue to be monitored monthly.

Clinical discards (SNBTS Blood Bank Dashboard)

SNBTS TT key performance indicators for the East region were presented, including O negative booked in rates, RCC, platelet and FFP clinical discards/non-use. Work with RIE ED team to influence RCC wastage rates continues.

Training and competency assessment

The Committee remains aware of the impact of COVID restrictions on training and competency assessment. RIE audit data continues to demonstrate significant numbers of staff collecting blood who were not trained or assessed as competent to do so.

SNBTS blood collection quarterly audit

Discussed under previous item.

Other activity

Progress on national transfusion team project work available in LTC Microsoft Teams channel.

JO highlighted that the new UK BTS patient information leaflets were now available for staff to order via PECOS. A communication will be issued to alert teams to the change in ordering process.

7. Major Haemorrhage Protocol

A request had been received from Jeremy Morton, Consultant Anaesthetist, regarding the addition of an alert for major haemorrhage protocol calls triggered from DCN. It was suggested that a modification of the group bleep membership might be more reliable than adding an expectation for callers to instigate a further request. BB/JO to liaise.

Action BB/JO

8. Guidelines

No new guidelines discussed.

9. Transfusion policies review

Transfusion Policy / National Transfusion Policy

The planned amalgamation of the current NHS Lothian Transfusion Policy and Procedures with the new National Transfusion Policy was discussed. HR, JO and BB will meet to compile draft.

Action HR/JO/BB

Emergency Blood Management Plan (EBMP)

Revised national guidance is anticipated. In the meantime, the current version remains in date.

Satellite Blood Fridge Policy

Review is still outstanding following changes at RHCYP.

Action JO/BB

10. Transfusion documents

Lothian transfusion document / proposed new national transfusion document

Committee members had been asked whether they would prefer to continue to use a Lothian transfusion document or to adopt the national transfusion document. The responses were equally balanced. AT and others had suggested that, if the majority of other Boards in Scotland were adopting the national document, it would be sensible for NHS Lothian to do likewise to enable continuity and reduce risk. It had been ascertained that, to date, 12 out of 16 NHSScotland health boards have adopted the national document: introduction is also now imminent in NHS Greater Glasgow and Clyde.

The Committee decided that the national transfusion document will be adopted for NHS Lothian. JO/BB to coordinate introduction.

Action JO/BB

11. Blood group check sample policy education

Educational poster has been finalised and is now ready for printing (once funding source agreed) and dissemination.

Action JO/BB

12. IT issues

Electronic issue (EI) of blood components at WGH and SJH

In place. No problems identified.

Links between RIE (SNBTS) and WGH/SJH (NHS Lothian) Blood Bank IT systems

No update available.

SNBTS transfusion sample results on TRAK / SCIStore

No update available.

Recording of RCC antibodies on TRAK

TRAK team have been informed of agreed wording. Introduction by TRAK team awaited.

13. Audit projects & research studies

Convalescent plasma Remap-Cap clinical trial for immunocompromised individuals recommences end February 2022.

14. Any other business

Nil.

15. Date of next meeting

To be arranged. **Action HR**