NHS Lothian

NHS Lothian Transfusion Committee
Meeting held on Wednesday 8th June 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
(SM) Scott McNeil, Consultant in Anaesthesia and Intensive Care Medicine, RIE
(JF) Jonathan Falconer, Transfusion Laboratory Manager WGH & SJH
(DM) Donna Medine, Advanced Healthcare Scientist, Transfusion Laboratory, RIE
(CP) Claire Palmer, Clinical Nurse Manager, Cancer Services, WGH
(JE) Jenny Easterbrook, Transfusion Medicine Consultant, RIE
(RV) Rahul Velineni, Consultant Vascular Surgeon, RIE
(BBe) Bryan Beattie, Transfusion Support Assistant, SNBTS Transfusion Team (East and West 1 Regions)

1. Apologies for absence:

(AA) Anne Armstrong, Consultant Obstetrician & Gynaecologist, SJH & RIE (Chair SJH HTT)
(RB) Rosamunde Burns, Consultant Anaesthetist, RIE
(CBe) Craig Beattie, Consultant Transplant Anaesthetist, RIE (Chair RIE HTG)
(CBl) Carol Blair, Consultant GI & Liver Physician, RIE
(ME) Marion Mathie, SNBTS Regional Head of Service, Edinburgh & Glasgow

2. Minutes of Lothian Transfusion Committee meeting held on 23rd February 2022

- *Italics = previous action statement*
- **Bold = Action Update**
- Closed Actions will be removed from the minutes of the next meeting

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

Action Closed

No further amendments to the minutes were requested.

Date of Meeting	Agenda Item No.	Action By	Subject	Brought Forward	Complete
08/06/22	3	BB	Contact SB re refusal of blood guidance (paediatric considerations)		
08/06/22	3	JO	Contact SK re anti D near miss events – prescribing aspect		
08/06/22	3	BB	Review WBIT surgical day unit RIE		

08/06/22	3	BB	Raise difficulties with SNBTS in use of new rejected sample data		
08/06/22	3	JO	Follow up antibody alert progress with TRAK team		
08/06/22	3	DM	Find out if any progress regarding Traceline / TRAK interface		
08/06/22	3	SM/JO/BB/JF	Review MHP feedback form and liaise re awareness raising		
08/06/22	5	JO	Continue to collate WBIT data		
08/06/22	6	BB	Progress implementation of new component labels for ED		
08/06/22	7	BB/JM	DCN MHP bleep update conclusion		
08/06/22	9	HR/JO/BB/ALL	Transfusion policy revision		
08/06/22	9	JO/BB	Satellite blood fridge policy revision		
08/06/22	10	JO/BB	National transfusion document rollout		
08/06/22	14	JO	Investigate RCC issues to REH		
08/06/22	15	HR	Arrange next meeting		
Actions carried over from 23/02/2022					
23/02/2022	2	JO	Amend 06/10/21 meeting minute ('CB')		Complete
23/02/2022	3	JO	Review Datix report from MHP event associated with SAE		Complete
23/02/2022	3	JO	Ask SK about anti D incident follow up		Complete
23/02/2022	4	HR	Set up meeting to address actions required following SHOT safety alert (transfusion delays)		Complete
23/02/2022	5	JO	Collate WBIT trend data	Ongoing	
23/02/2022	6	DM/BB/JO	Incorporate RIE duplicate sample data into rejected sample report	Ongoing	
23/02/2022	7	BB/JO	Liaise with DCN regarding MHP additional alert proposal	Ongoing	
23/02/2022	8	HR/JO/BB	Draft transfusion policy	Ongoing	
23/02/2022	9	JO/BB	Satellite blood fridge policy revision	Ongoing	
23/02/2022	10	JO/BB	Transfusion document rollout	Ongoing	
23/02/2022	11	JO/BB	Blood group check poster rollout		Complete
Actions carried over from 06/10/2021					
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	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	8	HR/JO/BB/CBe/AA/SB	Progress transfusion policy	Ongoing	
06/10/2021	8	JO/BB	Satellite Blood Fridge Policy revision	Ongoing	
Actions carried over from 02/06/2021					
02/06/2021	3	SB	Feedback following review of refusal of blood documentation for paediatric settings		Ongoing
Actions carried over from 02/12/2020					
02/12/2020	3	MRow	Update from Transfusion Team on investigation into electronic blood management system options		Ongoing
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		Ongoing
05/08/2020	11	MRow/RB/CI	Review postpartum document		Ongoing
05/08/2020	13	MRow/RM	Look into Traceline > SCIStore data transfer issue		Ongoing
Actions carried over from 13/05/20					
13/05/20	3	MR	Communicate suggestion for electronic transfusion system development at national level		Ongoing
13/05/20	3	CI / JO	Share LBT matrix with education leads		Ongoing
13/05/20	9	CI / JO	Review transfusion policy		Ongoing
Actions carried over from 19/02/20					
19/02/20	5	CI, JF, JO	Discuss plans for electronic system project with MR & CB		Ongoing
19/02/20	8	RB	Inform Theatre User Group of MHP feedback sheet		Ongoing
19/02/20	14	SL	Share proposed TRAK sample result layout / wording with Committee prior to finalising		Ongoing
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

3. Actions and matters arising

- *Italics = previous action statement*
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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. **CBe spoke to the team and reviewed the Datix, it was felt the initial incorrect detail provision didn't contribute to the delays in providing blood. Action is now closed.**

Action Closed

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

Action BB

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. JO to follow up with the charge nurse. **JO has not heard back from SK but advised that AA had spoken with the charge nurse of the early pregnancy unit who confirmed that the nurses working in the unit have undertaken anti D eLearning. Waiting for more information regarding the three related near miss events and whether these had reached the prescription stage. JO will feedback to meeting once received. Session has been offered to speak with the team.**

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 has spoken to the team to remind them to use the risk assessment.**

Action Closed

BB had followed up WBIT in the surgical day unit, RIE: **BB to review this and will feedback at next meeting.**

Action BB

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. **DM advised there was a new way of capturing this information but had to ensure it was visible to all who needed access. BB confirmed that she has access and can add this to the rejection data but, due to the new way of reporting, it's made it a longer process to extrapolate the relevant data. BB has discussed this with Furat *(Alattili, SNBTS Compliance Officer)* but the new arrangement has been decided at national SNBTS level so BB will feed this back.** **Action BB**

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. **JO confirmed that this is now on the protocol.**

Action Closed

The Blood Assist app has been promoted on the NHS Lothian intranet banner. **HR confirmed that this is now being advertised.**

Action Closed

The TRAK team are progressing the planned red cell antibody alert. **JO has tried to obtain update on progress from TRAK team but no response to date. This development was agreed and was in progress.**

Action JO

Historical outstanding actions relating to IT communications between the two laboratory LIMS and TRAK were discussed. DM offered to find out if there had been any progress regarding interface between Traceline and TRAK.

Action DM

Action Plan for preventing transfusion delays in bleeding and critically anaemic patients

A subgroup of the Committee had met separately to complete the required gap analysis and identify required action relating to the safety alert issued by SHOT (SHOT/2022/001). The deadline for actions is 15th July 2022.

The subgroup has generated responses to all of the questions and these are available to the Committee to look at.

The Committee discussed the available Major Haemorrhage Protocol feedback form of which most have not been returned, and if completion of this should be made mandatory. SM advised that he hadn't seen the form before and would question if the form reaches the appropriate people to fill in: he thought the form looked very useful. It was also stated that it may be missed due to being issued at the start of a major haemorrhage, thus it might be better to send out or request this during the stand down period after the event. The possibility of the form being added to the major haemorrhage section of the blood transfusion intranet page was discussed.

It was agreed that the feedback form and scribe sheet be separated so that the scribe sheet could be available to clinical teams for use during an event but the feedback form available at a more appropriate time after the event. It was also agreed that this would form part of a relaunch of the resource.

SM suggested initially targeting areas such as Theatre, ICU and A&E and said he would be happy to contact relevant people in these areas to remind them that the form is available to be completed after a Major Haemorrhage Protocol activation.

Action SM/JO/BB/JF

4. New Matters: UK Infected Blood Inquiry - Rule 9 Request re Hospital Transfusion Committee

HR advised that the UK Infected Blood Inquiry were interested in looking at the activities of transfusion committees and had issued a rule 9 request to NHS Lothian. HR had responded to

questions relating to transfusion activities dating back to the 1970s, with the assistance of previous Chairs Alastair Nimmo and Charles Wallis. HR wanted to make the Committee aware that this would be published on the Inquiry website.

No Action

5. Incident Reports

JO and BB provided an 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.

7 reports from WGH and 1 report from SJH were presented:

- 1 wrong blood in tube (WBIT) sampling near miss event
- 3 handling errors (involving 1 incorrect giving set used and 2 incorrect flow rates)
- 1 incorrect blood component transfused (special requirements not met)
- 3 reactions (1 probable TACO reaction; 1 probable febrile non-haemolytic reaction and 1 probable hypotensive reaction (this had occurred at the Edinburgh Cancer Centre @ East Lothian Community Hospital)

6 reports from RIE were presented:

- 3 WBIT near miss events
- 1 moderate non-haemolytic febrile reaction
- 2 near miss events (one involving laboratory testing, the other involving delay in the commencement of transfusion due to multiple sample rejections and an associated increase in rate of transfusion for a non-urgent transfusion)

JO shared raw data on WBIT which showed there had been a recent spike rather than an increasing trend for WBIT but would continue to monitor.

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 is still ongoing at this time due to the new format in which the data is reported being less user friendly.

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.

A slight increase was recorded in April for tags not returned, but this will continue to be monitored.

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. BB pointed out that component wastage data for the RIE was higher due the number of Major Haemorrhage Protocols and Code Reds during the month under review. JE stated that the FFP non-use increase is due to pre-thawing though JO mentioned that the number is coming down overall which is an improvement.

Training and competency assessment

The Learnbloodtransfusion modules: Consent for Transfusion, Acute Transfusion Reactions and the Safe Blood Sampling for Transfusion video are being added to the mandatory transfusion education requirement for FY1s, starting this year (July 2022 intake).

Communication around the new patient information leaflets and the new ordering system that is coming with it has gone out to the relevant clinical areas. Other information leaflets about irradiated blood, red cell antibodies, fetal neonatal alloimmune thrombocytopenia and sickle cell disease have been updated. The latter two aren't available in print form, but the links can be sent to the appropriate individuals.

JO advised that code for the new National Transfusion Record wouldn't be active on PECOS until the stock of the older Lothian Transfusion Document had been run to zero. The Committee discussed how to move forward with this. It was suggested that it may be better to find a way to order out the remaining stock and set a start date with the new document.

SNBTS blood collection quarterly audit

Not discussed.

Other activity

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

Due to high clinical discards in RIE ED, JO and BB had designed new labels to go down with the components. These have been agreed by laboratory and ED staff so the plan is now to implement these.

Action BB

7. Major Haemorrhage Protocol

Following the request received from Jeremy Morton (JM) regarding an addition to the DCN group bleep, BB had enquired to confirm if the team are now carrying the extra pager and is still awaiting confirmation from JM that this has gone ahead.

Action BB/JM

8. Guidelines

No new guidelines discussed.

9. Transfusion policies review

Transfusion Policy / National Transfusion Policy

HR asked that, if anyone was wanting to get involved with the process of the planned amalgamation of the current NHS Lothian Transfusion Policy and Procedures with the new National Transfusion Policy, they were welcomed to contact him.

Action HR/JO/BB/ALL

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

This was discussed under *Training and competency assessment*. Rollout planned and imminent.

Action JO/BB

11. Blood group check sample policy education

The Committee was shown the finalized educational poster which went out two weeks ago, awaiting the new figures, but JF suggested that this has already had an impact and this will continue to be monitored.

JE advised the Committee that there had been a change in process at the RIE regarding the 10-minute gap between the two samples. This limit has now been removed, but samples cannot be taken at the exact same time by the same individual and any sample that is would be discarded.

12. IT issues

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

In place.

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

Discussed under agenda item 3. Not expected to be resolved in the short term.

SNBTS transfusion sample results on TRAK / SCIStore

Discussed under agenda item 3. Not expected to be resolved in the short term.

Recording of RCC antibodies on TRAK

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

New Laboratory Information System (LIMS)

JF advised the Committee that a company has been selected. Arrangements for order of Board implementation are yet to be confirmed. It was stated that this could potentially take place within 12 months.

13. Audit projects & research studies

A National Comparative Audit of acute upper GI bleeding has been implemented, primarily at RIE, but will involve WGH and SJH. JO advised that recruitment has started.

14. Any other business

JO mentioned the Major Haemorrhage Protocol that was triggered at the Royal Edinburgh Hospital, which was extremely rare. Clinicians had contacted the laboratory who organised for the blood to be issued quickly. However, the patient was in the process of being transferred, as was the normal and correct action to take, so the blood wasn't transfused until the patient arrived at the RIE. JO wanted to make the Committee aware that nursing staff on that site do not undertake mandatory transfusion education, but it has been noted that rare blood component issue is made to the site. JE questioned why the odd individual units are going out to the non-blood giving sites and JO advised that she would investigate.

Action JO

15. Date of next meeting

To be arranged. **Action HR**