MINUTES OF THE MEDICAL STAFF COMMITTEE MEETING HELD AT THE REGIONAL TRANSFUSION CENTRE ON 25 APRIL 1991

Present: Dr Lloyd, Dr Condie, Dr Waddell, Dr Dunstan
Dr Walker, Dr Walls.

1 **Apologies:** Dr Rusby, Dr Jaiswal, Dr Collins.

2 **Minutes of the last meeting:** these were accepted as correct.

3 **Matters Arising:**

a) re Illness sheets (Item 3b)

The new illness sheets are now in use. Donor details are recorded on these, so replacing the BDR.

b) re SOP's (Item 3c)

An SOP entitled "Procedure for the pre-donation medical assessment of plasma donors" was circulated from Dr Rusby with a view to discussing the document at the next staff meeting.

c) re Gulf War (Item 3d)

Dr Lloyd said that no market had been found for the extra blood collected for the war.

d) re NBTS 110 (Item 3e)

The proposed content of the NBTS 110 should be discussed by all the medical staff at a separate meeting: this meeting should also include representatives of Donor Panel and the Laboratory Office. Dr Lloyd suggested a possible trial of both documents - the new and the old to see which gleaned the most useful information from donors. It was noted that there may be a problem with Human Growth Hormone, perhaps needing a separate question, but this could be discussed at the proposed meeting. The format should be designed by professionals.

e) re Donors with lipaemic plasma (Item 3i)

Someone from the Community Health Council will be coming to talk to the plasma staff about the use of the diet sheets on 3 June.

f) re Director's Update (Item 4)

i) the date of the next inspection by the Medicines Inspectorate is not known but will probably not take place until after the components laboratory has been upgraded.

ii) the Optipres system is being taken in two stages:-

Stage I platelet production
Stage II plasma production

Stage II depends on BPL accepting full wedge packs.

iii) the Team Leaders would take a more active role in determining rest periods.

iv) a memo on Yersinia enterocolitica has been circulated.

g) re PCS-plus evaluation (Item 5)

Haemonetics were implementing a new programme and any further evaluation would need to wait until this was in place.

h) re Library (Item 7)

Dr Lloyd noted that the problem of the library needed to be tackled though a plan had not yet been formulated.

i) re medical fees for private patients (Item 8)

This is being attended to.

4 **Director's Update**: (HL)

a) Product suitability chart:- no problems had been found with the new format.

b) Network:- there were a few teething problems but these were settling down. Training sessions for everyone will be arranged by Mr M Brittain.

c) Computer Audit:- The RHA were conducting a computer audit on the Network to validate the system. The Network was now handling all issues. Dr condie enquired about contingency plans for power cuts: these would be allowed for by an uninterruptable power supply.

d) Hepatitis C testing began on April 24 testing for anti-HCV. This would be using the second generation test which had a low rate of false posivity. The timing of this introduction of testing may well cause some problems with the National Directorate.

5 GP's as donors (FW)

This was discussed at length, Dr Waddell describing one particular GP who, while not having a positive history of previous infection with chickenpox, had been in contact with so many cases without succumbing that he felt he must be immune and so eligible to donate. Dr Lloyd felt reluctant to have alternative rules for health workers and decided that the normal exclusion clauses should apply ie:-

Childhood infectious diseases:

Same rules as the general public.

Contact with HIV positive patient:

accept provided no undue exposure to body fluids ie needlestick injury or cuts and no personal risk factors.

Contact with Hepatitis B patient:

accept if they have a proven level of immunity prior to exposure. If no proven immunity they should wait 6 months. If they have in addition received immunoglobulin they should be deferred 9 months.

6 Donors on Medication

An agreement had been reached with the Wolfson Unit to have data for a new edition ready by June. It was hoped that this second edition could be published commercially. Any new drugs that should be included in this edition should be given to Dr Dunstan within the next two weeks.

7 Matters arising from Health and Safety Committee (PC)

a) Virology testing on all donors

Dr Condie expressed concern that donors giving samples for low Hb/bone marrow etc only were not tested for anti HIV/hepatitis. This raised difficulties for staff protection after exposure eg needlestick injury etc. This was discussed at length and Dr Lloyd concluded that HIV testing could not be done if it was not directly in the interests of the donor or the recipient of the blood transfusion ie testing could not be done merely for staff interests. The same considerations applied to half-full bags. These would not be transfused and virology was not necessary. Dr Lloyd enqured about the procedure in hospitals for anti-HIV testing of a patient following a needlestick injury. In that situation the chances of tracing the patient concerned would be remote. Specific permission would need to be sought for anti HIV testing and in practice would probably not be done.

Where needlestick injuries have been received from an unknown source immunisation with Hepatitis B should be arranged.

b) Protective overalls at sessions

Dr Lloyd ruled that the medical staff committe meeting was not the appropriate forum for discussion on this item and that it should be referred back to the Health Safety Committee.

8 Prison Staff and Bone Marrow Register (FW)

Dr Waddell enquired whether prison staff were eligible to donate both blood and bone marrow. Dr Lloyd replied that this was in order provided that they complied with all the normal condition and exclusions.

9 Contacts of Vaccinees (PC)

Dr Condie gave details, obtained from the manufacturers of the incidence of clinical infection in the recipients of polio vaccine (oral) and their contacts. Of those vaccinated 1 per 2 million doses per annum develop poliomyelitis. In addition every year one person develops poliomyelitis following contact with a recipient of the vaccine. It was not clear in the second case whether the recpient of the vaccine developed clinical infection or remained asymptomatic.

The manufacturers recommended that as the virus was excreted for up to 6 weeks following vaccination the recipients of polio vaccine and their contacts should be deferred from donating blood for 6 weeks. It was not clear whether either the recipients or contacts developed a viraemia at any stage. Dr Condie would make enquires for the next meeting. Dr Lloyd felt that the risk was so low that further precautions were not warranted. However this would be discussed in the light of further information.

10 Any other business

a) Hereditary haemochromotosis (HL)

Dr Lloyd referred to a recent letter in the BMJ (volume 302, March 9 1991, p 593) from the Welsh Regional Transfusion Centre suggesting frequent donations (4 times per annum) for donors found to have hereditary haemochromotosis. This would provide extra blood donations and help prevent the complications for haemochromotosis.

The proposals made in the BMJ were discussed but it was felt that it was not the function of the Transfusion Service to be treating patients.

11 Date of the next meeting

The date of the next meeting was set for Thursday 16 May at 10.30 am.