EAST OF ENGLAND REGIONAL TRANSFUSION COMMITTEE

Minutes of the meeting held on Thursday 26th January 2023 via Microsoft Teams, 10:00am – 13:00pm

In Attendance:

Name	Role	Hospital
Lynda Menadue **LM**	RTC Chair / HTC Chair	North West Anglia – Hinchingbrooke and Peterborough
Dora Foukaneli **DF**	Consultant Haematologist	NHSBT / Addenbrooke's
Frances Sear **FS**	PBMP	NHSBT
Joanne Hoyle **JH**	TP / TP Group Chair	West Suffolk
Julie Jackson **JJ**	TP / TP Group Chair	James Paget
Suzanne Docherty **SD**	Consultant Haematologist	Norfolk and Norwich
Ruth Smith **RS**	TP	Addenbrooke's
Aline Seigneur **AS**	TP	Addenbrooke's
Isabel Lentell **IL**	Consultant Haematologist	West Suffolk
Emily Rich **ER**	TP	North West Anglia – Hinchingbrooke and Peterborough
Caroline Lowe **CL**	TP	Milton Keynes
Susan Turner **ST**	TP	Colchester
Claire Atterbury **CA**	TP	Queen Elizabeth KL
Swati Pradhan **SP**	HTC Chair	Bedford
Loraine Fitzgerald **LF**	TP	Bedford
Abdul Adamu **AA**	TP	Watford
Gilda Bass **GB**	TP	West Suffolk
Mireille Connolly **MC**		West Suffolk
Gregorie Pankhurst **GP**	TP	Norfolk & Norwich
Natalie Gravell **NG**	HTC Chair	Broomfield
Angela Giubileo **AG**	HTC Chair	Queen Elizabeth KL
Harriet Madiyiko **HM**	TLM	West Suffolk
Frank Baiden **FB**	TLM	Queen Elizabeth KL
Danielle Fisher **DF**	TP	Luton & Dunstable
Matthew Barter **MB**	TP	Queen Elizabeth KL
Martin Muir MM	TLM	Royal Papworth
Michaela Lewin **ML**	TP	Royal Papworth
Tracey O'Connor **TOC**		Circle Healthcare Group – West Suffolk
Alison Rudd **AR**	TP	Norfolk & Norwich
Te-Ahna Hans **TH**	Senior	West Suffolk
Stephen Wilson **SW**	HTC Chair	Norfolk & Norwich
Maria O'Connell **MOC**	TP	Basildon
Allan Morrison **AM**	Blood Transfusion Quality Manager	West Suffolk
Rebecca Smith **RSm**	TP	Ipswich
Donna Beckford Smith **DBS**	TP	Watford
Charlotte Alford **CAl**	TLM	Luton & Dunstable
Ellen Strakosch **ES**	TP	Luton & Dunstable
Jasmine Beharry **JBe**	TLM	Milton Keynes
Georgie Kamaras **GK**	HTC Chair	Luton & Dunstable
Kaye Bowen **KBo**	TP	North West Anglia – Hinchingbrooke and Peterborough
Claire Sidaway **CS**	TLM	Hinchingbrooke
Janet Shalini **JS**	TP	Princess Alexandra
Louise Meaney **LME**	TLM	Southend
Trisha McClure **TMcC**		Nuffield Health

Clare Neal **CN (Minutes)**	RTC Administrator	NHSBT

Apologies: Katherine Philpott **KP,** Mohammed Rashid, Florian Falter, Michelle Reece, Garcia Consuegra, Monica Bose, Ana Periera, Tanya Bancroft, Paul Cervi

1. **Welcome – Introductions, Apologies, Previous Minutes: LM** welcomed everyone to the meeting. Introductions were made. Meeting minutes have been changed to accommodate two members with the same initials. Lynda Meandue will be **LM** and Louise Meaney will be **LME.**

   Actions from Previous Meeting
   - Amber Alert Lessons Learned will be added to June RTC
   - One Unit Transfusion will be added to June RTC

2. **Regional Updates**
   - **FS** presentation attached. **ML** asked if the BMS education sessions are recorded. **FS** confirmed they are all recorded and uploaded to the PBM YouTube channel. We plan to upload all events like this as long as we have presenters' agreement.

   - **TP Group**
     - **Audits**: **JJ** we haven't had a lot of submissions for the bedside audit. We set the data collection date for after the NCA Sample Labelling but this was moved. We then had the Amber Alert. We have extended it to the end of January and we hope to feed back at the March TP Meeting. We plan to look at O Negative this year. Our audits are benchmarking audits, they are to provide information about what is happening in the region so we can discuss ideas and make changes. They are not for us to tell you what actions to take although we may suggest them when we look at the data. They are audits to give you facts to use in your Trust to support your will for change. The use of O Negative will look at who are we giving it to and why such as is it their own group, to avoid expiry, during emergencies. How many could have been given O Positive? That will be released in March for submission in June or July.
     - **Escalation to National Groups: JH** we have had some interesting presentations / talks on electronic prescribing and major haemorrhage drills. We had a couple of points that came from this that we have taken to the National TP Group, these are going to be taken to the National Blood Transfusion Committee Meeting. One of these is the understanding around non-medical authorisation of blood components and that some people who think they have done prescribing are able to authorise blood. We would like to see if nationally we can get a better message out. The other point was about major haemorrhage drills and the fact that it is difficult to get engagement from clinical staff to be involved in these drills despite the CAS Alert.
     - **WBIT: JH** We are still collecting WBIT data. **JJ** I was going to generate a report for this. We are encouraging everyone to input this data. We have only had 14 incidents reported from 6 hospitals. Hopefully this year, people can start inputting as they go. **LM** noted that **LME** was 300 group and saves down during the amber alert. Does that mean we would get less WBIT because everyone is taking less group and saves? **JJ** we don't know. I know from previous data, usually more than 6 hospitals would have had a WBIT. From those 14 incidents, the Trusts submitted 4 of them. The average across the region is 0.01%. It is a small percentage but a serious percentage. They are being discovered 50/50 is the lab area so I think the clinical area are showing an awareness for where they are going wrong. I was quite surprised as the majority happened during the week in normal working hours. The incidents happened where you would expect in ED, community wards, outpatient setting, maternity. Staff groups were mainly maternity and nurses. What is coming out as a trend is that the request form is not being generated before the blood is taken and the samples are being labelled from the request form with no positive identification. The reasons given are distraction, pressures and following the norm. I don't want more WBITS but the more we have we can build up

information in order to make improvements. **CA** ours was an agency nurse. We use a completely electronic theory but its old and a new one is on order. The agency nurses aren't doing the competencies so we have people slipping through the net. When we did the National Comparative Audit 69% of our errors were in A&E. **JJ** I think what is coming through is they are nor printing the form before the samples taken and they are using the form to label the sample and that has come through very strongly for all areas where mistakes have been made. **LM** that must mean they are taking the blood away from the patient. **JJ** they are using the paperwork at the desk. JJ since we have started using ICE labelling we have had a massive increase in blood science rejections for WBITs because they are using the form and they are sticking it on the sample without doing any PPI. They are doing it at the desk not by the patient. This has been happening for a long time and they see it as their normal practice and don't want to change. Using an electronic system will not stop an error. I had one 3 days ago where she had used the blood tracking system but had a wrist band in her hand, printed the wristband from the form and added the wrong form. **CA** we have that all the time. **AG** the other complication we have is that we have few PDA's working and the queues of ambulances outside brings pressure to take samples as early as possible. As soon as you step outside the door with your PDA it loses WIFI connection making it unusable at the back of the ambulance. It also forgets the barcode that has been using it so disconnects form the server. In Kings Lynn for 15 years we had a really good relationship with paramedics. They used to take the blood when putting in the cannula. You had two clinicians to one patient rather than one clinical to 10 patients. **JJ** we have only just got our new PDA's. Ours would work in the ambulance as they work independently of WIFI. The biggest problem is people are taking blood, they are not labelling them at the patient bedside with the patient identification, they are going to sit at a desk. **LM** we will take **AA** comment and then we can stop there. It is something we may need to discuss on a more clinical environment and then bring back to a later RTC. **JJ** I can put together a report. **AA** lack of concern about patient safety is what will bring the errors and it will never disappear if people are not putting patient safety into mind when they treat patients. You can put all the electronic systems in place but can still happen. It has change attitudes to stop making these errors. **LM** this subject brings up a lot of emotion. I think we need to bring it to the next meeting. If we can look at each Trust as we all have our own challenges and different Trusts take different things seriously. Maybe we can find ways to move forward whilst trying to consider whether this goes nationally. **FS** I would suggest that it is taken to the NBTC and the other group is SHOT as they have the years of data. The RTC can feed it up to nationally groups. **LM** if we can bring ideas to the next RTC.

  - **TP23: JJ** The National TP Symposium is on 17th / 18th May. The first day will be looking at Patient Blood Management. We've got 4 successfully introduced initiatives. We are launching QS138 audit tool. The second day will focus on Transfusion 24 which may be interesting for other staff groups. We are going to be looking at competency frameworks but also IT. Registration will be open during February.

- **TADG Update: LME** shared **KP** presentation. **CN** circulated an email asking what labs have in their Major Haemorrhage Packs. The information is being collated on a spreadsheet. Information has not been received by every hospital / Trust. **CN** will send a reminder email.

3. Presentation – Prothrombin Complex Concentrate

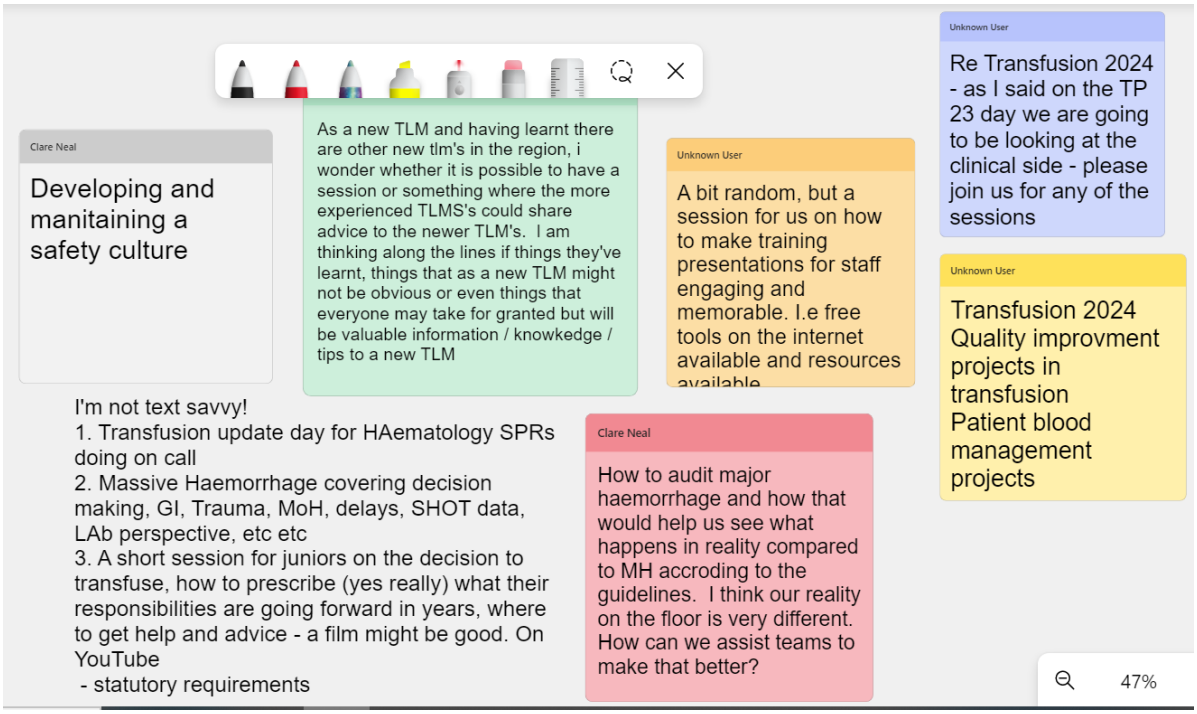
JH presentation attached. **JH** asked some questions via slido.com. **CA** does anyone else use the company to teach the staff how to mix it? **JH** we don't use the company. We teach it on their initial IV training as well. **CA** ours is also run completely by anticoagulation not us. **JH** that may be because yours comes out of pharmacy, ours comes out of transfusion. **JJ** I only ever did it once. We never did it since as we didn't get many attend. **JS** whenever we have a major haemorrhage simulation we ask a beriplex rep to come in. She will show us the reconstitution as well. **RSm** we used to be on the IV study day but we got taken off. We used to stand around with our beriplex kits and make it up. They have some good online stuff, we provided it to ED staff and go through it during their training. **JBe** for those who have a stock in A&E, we are looking to do the same. Do you get information on who the

stocks been given to, do you get good feedback? Are there any immediate problems? **LM** we are also looking at that, has anyone managed to do it? **ES** at Luton we have the traceability tags on them so we get those back so we know who it has been issued to. **JBe** that is our plan. **ES** we haven't had any that haven't come back. **JBe** with the A&E fridges is it hooked up to blood tracking? **ES** we haven't got the batch module. It is in their drug fridge not the blood fridge. It can be stored at room temperature anyway so it doesn't need to be in a fridge. **CA** we automatically issue the vitamin K with the beriplex. That works well. **JH** in our Trust the Vitamin K is everywhere. **JJ** unfortunately because we keep PCC in the lab we can't keep Vitamin K in the lab. **GP** within our lab, sometimes, there has been a reliance by the clinicians requesting the dose for the lab BMS to tell them what dose they need and the lab staff often are worried that there is no-one confirming the dose they are giving. The clinicians should be checking it. **ST** we have a standard dose of 1500. They review it later. The lab issue 1500. A clinician here decided the dose so the lab don't have to worry about it. **LM** do they decide at a later date on weight or do they decide if the INR has not been solved. **ST** I have no idea. I think they would discuss with the on-call Haematologist if needed. **LM** thank you **JH**, that has been really beneficial.

4. Sharing Ideas for Future Education, Presentations

CN shared a whiteboard to allow people to share ideas for future presentations, case studies and education events. **FS** please think as a wide as you like as we have more options with having virtual events.

- An idea for either education events or for the RTC was suggested by one of my BMS's: She showed me the attached image/post on facebook https://ccforum.biomedcentral.com/articles/10.1186/s13054-022-04279-4?fbclid=IwAR3qX2uJqcTD_I9ekR3t8m10rfQdkkT2ooragctxqkinOVAE4mAxkZB9gGo A presentation on this topic would be fab!
- Currently in the Mum's, babies and blood event and I have had an education request from some of our more experienced colleagues regarding CffDNA testing. Please see the email thread below (Erika Rutherford, presenter at Mums, Babies and Blood would be happy to present this topic).



5. Presentation – Code Red Awareness Week

MM / ML presentation attached. **ML** I really enjoyed the week. **MM** it was very positive. The reason I added the antibody bit in there was because we don't want the complacency that the emergency O Negatives are totally fine for everyone. We had the situation in October where they used the

emergency O Negatives but the lady ended up having an anti-c. It may not happen very often but it can happen. **JJ** I completely agree that it's really important to add that in. I would have a patient in simulation who they had just been transfused having a transfusion reaction. **LM** you have done an amazing job. I think we need to do something very similar for obstetrics. We work in a bigger area with much less haemorrhage and I think our lab team / transfusion have less visibility which we are tying to increase. **ML** one of the things for me was getting the whole team together rather than looking at an e-learning module. **LM** I don't think anyone has an idea what happens when you call that Major Haemorrhage number. **AA** have you included clinical support staff? **ML** we had a lot of Healthcare Support Workers, Porters, even secretaries could attend. No-one was excluded.

6. HTC Updates

- **LM** we are going to be focusing on major haemorrhage.
- **SW** we have got our next meeting in a couple of weeks. There have been some really good ideas coming out of RTC that we will be incorporating into this meeting. The biggest problem we have is getting peoples engagement. I can imagine that is a problem for most HTC's. **LM** we have had the same problem.
- **CA** after 27 years, I will be retiring. My job won't be the same so they will need support. They will continue to look at introducing the new blood track system. Ongoing massive haemorrhage will be a focus. **LM / DF** would like to take this opportunity to thank **CA** for all her contributions to the RTC.

7. AOB

- **ML** does anyone have a 'on the horizon risk spreadsheet'? We have been asked to start a database for anything that could happen but has not actually happened yet. **LM** who has asked you. **ML** Risk. We have the Risk Register. Maybe I should put WBIT as SI event for the region.
- **KBo** we are about to adopt a new Sarstedt Blood Tube, our Haematology Services Manager wanted to make sure we a re in step with the whole region. It is a 4.9ml tube. We are asking for surname, forename, ID, date/time of sample, DOB of patient, where they've had the sample taken and signature of who took the sample. Have we missed anything? **JH** have you got gender on there? **KBo** no. **ST** we do at Colchester. **JJ** it is on ours but we are not concerned if they don't fill it in. **KBo** thank you.
- **GB** will the region be issuing a revised Major Haemorrhage Guideline in response to the BSH guidelines. We are waiting to update ours. **LM** I think we should be making this one of our themes for this year. **FS** it is being considered and we were planning to discuss at the RTT. **SD** with the manor haemorrhage protocol, is everyone aware that Novo 7 is now licenced to be included in the Obstetric Major Haemorrhage protocol. **DF** Will Thomas and I wrote to the writing group of the massive haemorrhage guidelines because the licence of Novo 7 for massive haemorrhage has come only after the publication came out in June. Strictly speaking that hasn't been included and still in many people's minds utilisation of Novo 7 unless the patient almost dies is a contraindication. I don't know if there are funding issues. These issues will need to be addressed too. It is not clear. It is an area where we need many more discussions.
- **SD** I am in discussions with some of the pre-op team in obstetrics who are telling me that other hospitals in the region allow up to 14 days validity for group and screen samples and out cut off is 7 days. I know its 3 at some centres. Is anyone going up to 14 days? No-one agreed so **SD** will feed that back.
- **ST** has anyone had the same issues as Colchester where ladies have come in who are pregnant and if they need blood transfusion asking if the donor had a COVID vaccine. The other discussion has been around veganism. **LM** we have had the same but we advise them that we try to avoid giving blood but are they happy if they are dying. We have not had anyone refuse. **ST** it is the equipment and clotting factors they are questioning with veganism too. **LM** my response would be the same that we do our best to avoid it. **CA** I had the same thing a little while ago about veganism and went to NHSBT. **IL** am I missing something as a lot of the products are single use plastics etc. **CA** they don't want to take blood from a meat eater. **LM** I think there are questions raised about the reagents before too as I have definitely been asked

about pork products. It is immensely difficult to find out all the answers. **ML** we have had someone refuse due to where it was from. **TMcC** would we be concerned at this point that they don't actually understand even about the transfusion. **ML** he completely understood everything, there was no capacity issues. **LM** I do reassure patients they will only be given products if it is really necessary. **DF** we are hoping some guidance will come out this year because the demand from potential recipients to meet all these requirements is huge. These additional requirements need to be escalated as responses are being asked from NHSBT. **FS** there is a lot of work going on in the background as there will be new resources and information following the infected blood enquiry.

8. Date of Next Meeting and Close:

- 22 June 2023 – Face to Face
- 05 October 2023 – Face to Face

LM thank you for attending.

Actions:

No	Action	Responsibility	Status/due date
1	Amber Alert Lessons Learnt One Unit Transfusion Lab and Clinical Perspective	**Add to June RTC Agenda** **ALL – provide information to display around the room** **Discuss at RTT**	
2	WBIT	**Bring ideas** **JJ to present WBIT data**	June RTC
3	Major Haemorrhage Packs	**CN to re-circulate to ask for information**	Take to March TADG