Transfusion Practitioners Group
British Blood Transfusion Society

Highlight Report – TP Special Interest Group (SIG): Sept 24

- The BBTS Annual Conference was held in Glasgow on 17th-19th September and was a huge success. We hope those who attended enjoyed the programme content and social events – we welcome any feedback you may have (details at the bottom of this page). For those who were unable to attend – we requested summaries from the presenters of key sessions that may be of interest to TPs (enclosed).

- The TP SIG are aiming to submit a TP-related article each quarter for publication in the BBTS magazine Bloodlines. This article could relate to a staff or patient experience, meeting report, audit feedback or anything else that would be of interest to the wider TP and transfusion community. If you would like to work with our SIG to develop an article, please get in touch with your regional representative(s) (details at the bottom of this page).

- Please continue to use the BBTS TP forum for general discussion and sharing of challenges, ideas, resources and experiences. All TPs or those working in associated roles are welcome to join (its free and you don't need to be a BBTS member): British Blood Transfusion Society - Please Login (bbts.org.uk)

- T2024 TP Framework developments continue. Slides presented at our last meeting:

BBTS UPDATEProfessional

- The TP SIG Terms of Reference have been updated to give preference to new member requests from established BBTS members.

- Please contact your regional representative(s) if you have anything you would like escalated to the TP SIG for discussion and feedback. Contact details and further information relating to the TP SIG can be found on our dedicated webpages: BBTS | Transfusion Practitioners |

SS2: SHOT session summary (written by the SHOT Team)

Speaker 1 – Learning from laboratory errors, Victoria Tuckley, SHOT

Victoria outlined the common trends and themes from laboratory errors detailed in the 2023 Annual SHOT Report, including transfusion delays, gaps in communication, incomplete or errors during testing, and the influence of staffing numbers, knowledge, and competency on transfusion safety.

15.-Laboratory-Errors-2023.pdf (shotuk.org)

Speaker 2 – Safer transfusions for patients with shared care, Nicola Swarbrick, SHOT

Nicola discussed shared care errors, which disproportionally impact cancer, transplant and haemoglobinopathy patients. Errors included gaps in communication and information sharing, lack of knowledge, lack of IT interoperability, and single points of failure. Solutions included improving patient education, interoperability, improved discharge records, accurate patient history, involvement of haematology teams and use of available patient databases.

East of England shared care document (currently under review)
https://www.nationalbloodtransfusion.co.uk/sites/default/files/documents/2024-03/Shared%20care%20form%20V7.1%20EoE%20FINAL.pdf

26.-Transfusion-Errors-in-Transplant-Cases-2023.pdf (shotuk.org)

25.-Haemoglobin-Disorders-2023.pdf (shotuk.org)

NHR – Home (mdsas.com)

Safe-Transfusions-in-Haemopoietic-Stem-Cell-Transplant-recipients.-updated-August-2021.pdf (shotuk.org)

Safety-Notice-SRNM-June-2022.pdf (shotuk.org)

Speaker 3 – Transfusion associated circulatory overload, Simon Carter-Graham, SHOT

Simon gave details about pulmonary complications of transfusion, and that it remains a leading cause of transfusion-related mortality and morbidity, contributing to more than 50% of transfusion-related deaths reported to SHOT from 2013 to 2023.

Transfusion-Associated Circulatory Overload (TACO) Cumulative Data - Serious Hazards of Transfusion (shotuk.org)

TACO-Alert-final-published-April-2024.pdf (shotuk.org)

TACO-Safety-Alert-FAQ-document-April-2024-1.pdf (shotuk.org)

Speaker 4 – SNBTS Transfusion Team TACO campaign, April Molloy, SNBTS

April outlined SNBTS transfusion team's approach to their successful TACO -Think About Choosing One campaign. This included a detailed strategy to promote the use of the TACO risk assessment policy, developing merchandise, email signatures, educational presentations, screensavers, improving communication links, and utilising social media to promote their key messages.

Transfusion Associated Circulatory Overload (TACO) resources | National Services Scotland (nhs.scot)

Speaker 5 – Patient powered transfusion safety, Dr Shruthi Narayan, SHOT Medical Director

Dr Narayan gave some illustrative cases outlining the importance of working closely with patients and their families to improve transfusion safety. Patient engagement may range from low level information sharing to high level partnership, collaboration, and shared decision-making, allowing patients access to inform policy and organisational aspects of transfusion safety. Dr Narayan outlined potential opportunities for patient engagement in the transfusion pathway, and the soon to be released MyTransfusion App to support shared decision making, co-created with patients to maximise engagement and improve patient care.

Patient Information - Serious Hazards of Transfusion (shotuk.org)
4.-Key-Messages-and-Recommendations-2021.pdf (shotuk.org)

Speaker 6 – Patient experience – My personal experience over the last 6 weeks, Dipika Shah, UK NEQAS BTLP Senior BMS and regular transfusion recipient

We heard from one of SHOT's patient representatives, Dipika, about her recent transfusion experiences, and the importance of including the patient in their own transfusion journey, engaging them to maximise safety and promote an inclusive attitude towards their own care.

Speaker 7 – Engaging with the patient – the hospital experience, Stuart Lord, Lead Transfusion Practitioner, Gloucestershire Hospitals NHS Foundation Trust

Stuart discussed a case study relating to transfusion patient engagement, and the importance of clear communication, and involvement of the patient and family/carers in this communication. Stuart discussed the NHS frameworks for involving patients in patient safety, and the fantastic patient representative they have on their local HTC who give patients a voice at high level clinical meetings, and how this improves transfusion safety and patient care.

NHS England » Engaging and involving patients, families and staff following a patient safety incident

SS2: SHOT – Engaging with patients – the hospital experience (written by Stuart Lord – Lead Transfusion Practitioner, Gloucestershire Hospitals NHS Foundation Trust)

The Serious Hazards of Transfusion (SHOT) team held a session at the BBTS Symposium titled 'Improving Transfusion Safety' with the last part focussed on 'Engaging with patient's' and how and why this is an important tool in Haemovigilance. During this session, I presented the hospital experience from a Transfusion Practitioner's perspective.

Firstly, outlining an incident I was principal investigator for, where deviations occurred resulting in an incorrect blood component transfusion where patient engagement and their voice was a key factor in both how this incident was found out, but also demonstrating engagement with this patient's and empowerment they received to speak up regarding their care was a powerful tool in the learning identified. The NHS England Framework was briefly outlined which outlines the 'how' and 'why' hospitals should implement this framework by involving patients in patient safety.

Finally, the last part of the talk focussed on how the organisation I work for utilise the patients voice at our Hospital Transfusion Committee through a Patient Safety Representative, and how they influence and contribute to transfusion safety discussions at a high level, multidisciplinary team transfusion meeting.

SS4: IT - Making the most of your IT – Electronic Blood Management Systems (written by James Davies – Senior Transfusion Practitioner, Kings College Hospital NHS Foundation Trust)

Electronic Blood Management Systems (EBMS) have evolved considerably in the last 20 years. Despite the wealth of evidence that show they improve patient safety and numerous recommendations for their use from haemovigilance bodies and health boards they have still not been fully adopted by hospitals throughout the United Kingdom. Furthermore, in settings that do have an EBMS often only part of the transfusion process (sample collection, blood fridge control/clod chain, bedside administration, remote issue) is electronically controlled with other processes still relying on paper or a mixture of other electronic health record systems. The presentation explored how to maximise the benefits of EBMS by focusing on the end user experience and the role of human factors in usability, hardware and system architecture, training and adoption of such systems. Consideration was given to how data from EBMS can be used to assist transfusion teams in guiding best clinical and laboratory practice, audit, training and incident investigation. Finally we examined contingency planning for EBMS downtime and how EBMS can be used to maintain business continuity when other systems fail.

SS6: IT – Equality, Diversity and Inclusion: Transgender and gender diverse patients in hospital: Barriers preventing safe and inclusive care (written by Samantha Bonney – Lead Transfusion Practitioner, Mersey and West Lancashire Teaching Hospitals NHS Trust)

I was delighted to be invited to present at the EDI session of the BBTS conference. The focus of the session was transfusing the transgender patient. National data suggests that at least 1 in 200 people have a gender identity that is different to their sex assigned at birth. The barriers preventing hospitals from providing care that is inclusive and safe for such patients, was the focus of the presentation.

Hospital IT systems present the biggest safety challenge with regard to transgender and non-binary patients. Gender identity and birth sex are often used synonymously, with the gender field in one system, such as the Electronic Patient Record, populating the sex field in another, such as the laboratory information system. This means that childbearing potential can be overlooked.

A patient may request, via their GP, to change gender on their patient record at any time and they do not need to have undergone any form of gender reassignment treatment to do so. They are then given a new NHS number and are registered as a new patient. This is problematic for transfusion laboratories as previous heath records cannot be interrogated for red cell antibodies or special blood requirements, unless clinicians alert the laboratory to the patients previous NHS number.

Finally, conflicting legislation often causes confusion for clinicians who may be unsure of how to act in the 'best interest' of the patient. It is unlawful to share a patient's transgender status, even for medical purposes, without consent. However, Caldicott Principle 7 states that '*The duty to share information for individual care is as important as the duty to protect confidentiality'.*

Attendees were encouraged to be vocal about this important topic in their own Trust. Any barriers preventing safe and inclusive care should be escalated appropriately and incidents must be reported.

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SS9: Transfusion Practitioner – TP Professional Development Framework – how will it benefit TPs today and in the future?
(written by Jennifer Rock – T2024 Transfusion Education Specialist, NHSBT)

Presented by Wendy McSporran - Advanced Transfusion Practitioner (RN), The Royal Marsden NHS Trust and Jennifer Rock – T2024 Transfusion Education Specialist, NHSBT

The role of the Transfusion Practitioner (TP) has evolved significantly since it was first signposted in the 1998 Health Service Circular's recommendations. As the demands on the NHS continue to rise, the responsibilities of TPs have expanded, underscoring their vital role in ensuring patient safety during the transfusion process.

Despite the increasing importance of TPs, there appears to be a concerning lack of investment in their training and development. Many TPs have reported facing more barriers to accessing professional development opportunities, which could hinder their ability to perform their crucial functions effectively.

The call for a professional development framework for TPs that includes appropriate governance and reflects their roles and responsibilities is crucial. Such a framework would not only help in recognising the significance of the TP role but also ensure that practitioners are equipped with the knowledge and skills necessary to maintain high standards in transfusion practices.

Moreover, the collaboration through the National Transfusion Practitioner Network (NTPN) must play a pivotal role in elevating the TP profession. By involving key stakeholders—including patients, professional bodies, pathology networks, and nursing representatives plus many more TPs can collectively advocate for the recognition of their work and commitment to patient safety on a national level.

This collaborative approach can enhance the visibility and appreciation of the TP role, ultimately leading to better support, investment, and development opportunities for practitioners, which will benefit healthcare facilities and patients alike.

In conclusion, it is essential that TPs support the NTPN to create and promote a culture of collaborative working not only with TPs but with key stakeholders to gain an accurate account of the TP role. This account is required to structure the framework. The framework and a collaborative culture will support TPs today and in the future.

https://nationalbloodtransfusion.co.uk/sites/default/files/news/2024-09/McSporran-Rock-BBTS-Presentation.pdf

SS9: Transfusion Practitioner – Educational Resources: What's new and coming soon! (written by Anne Davidson – Education Lead, PBM Team, NHSBT)

Summary of key points from BBTS presentation:

In response to feedback, and recognition of the need to expand the reach of the educational resources, the Patient Blood Management team have changed to a more collaborative development approach for education and patient information resources. The range of collaborators and stakeholders we are engaging with is very extensive including those you would expect, e.g. SHOT, Transfusion 2024, and some you may not, e.g. blood donation and charities.

Our key focuses for these resources remain:

1) Patient Blood Management

2) Safe transfusion practice

3) Patient and public information

In the background we are also prioritising improving the accessibility of all our resources. This includes providing a range of formats for the patient information leaflets. We recognise that the provision of hard copy versions of high-volume leaflets and print friendly on-line versions for low-volume leaflets, are part of this provision; however, we are encouraging on-line access to the leaflets. This is good for the environment, ensures version control and allows the reinvestment of the printing costs into more accessible formats e.g. translations.