Volume 1, Issue 4 February 2011

SERIOUS HAZARDS OF TRANSFUSION SHOT

NEWSLETTER

SHOT Team Update

SHOT Team Update

SHOT's Medical Director Dr. Clare Taylor left the scheme at the end of November for a career break, after 3 ½ years in the post. A locum Medical Director has been appointed, Dr. Sue Knowles, who may be familiar to many people as she has during her career worked for NHSBT and has been on the SHOT Steering Group. More recently she has been a Consultant at Epsom and St. Helier's University Hospitals NHS Trust. Dr. Knowles will take on the role as an interim measure until a new substantive appointment for SHOT Medical Director is made. It is hoped that the new appointment will be made to commence in Summer 2011 after the SHOT Symposium.
The SHOT Operations Manager Mr. David Mold also left in November 2010. He has opted to return back to working as Hospital Transfusion Practitioner at University College Hospital.

Alison Watt has been appointed to this post with effect from January 2011. Alison was previously the Service Development Manager for NHSBT Specialist Services after a long career as a BMS managing both hospital and Blood Service laboratories.
Hilary Jones, who has been working with SHOT almost since the beginning in 1996, will be retiring at the end of March 2011. The post of Research Analyst will therefore be advertised in the near future. This appointment will then complete the team once again, joining Hema Mistry, Julie Ball, Tony Davies, Kathryn Gradwell and Vicky Peake.
The SHOT Steering Group is very grateful to them all for their hard work over the years, which has contributed to the scheme's status as a world leader in haemovigilance.

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SHOT Annual Symposium 2011
Wednesday 6th July 2011.
Royal Society Of Medicine, London.
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Donor Adverse Events

Work is currently in progress towards adding donor adverse events data to the SHOT database. At the present time the 4 UK Blood Services collect data on donor adverse events independently which is collated within the services. The data sets are being standardised UK wide, and in line with European data as far as possible, and it is planned that the data will be submitted to SHOT from January 2011. In the first instance this would be to a stand alone database but after 1 year, if all goes well, this will be added to the online Dendrite pages. Donor adverse events will be sent via nominated individuals working in Donor Services from the four UK Blood Services and will be sent at intervals as collated data rather than as individual cases.

This is an important development for SHOT as this means that the haemovigilance chain is complete in terms of reporting adverse events from vein to vein, donor to patient.

Inside this issue:

Pulmonary complications of Transfusion

In line with the recommendation in the 2009 SHOT Report (published July 2010) SHOT wishes to remind reporters that it is essential to report all respiratory complications of transfusion whether or not they fit the existing categories of TRALI and TACO. Cases which do not meet the criteria for TRALI and TACO can still be reported in the TAD category (Transfusion Associated Dyspnoea). Cases which are investigated for possible TRALI but found ultimately not to be TRALI (including those occurring after the 6 hour time cut off) should also still be reported. SHOT is aware that there has been a tendency for some cases with respiratory complications, which are not going to be investigated for TRALI by the Blood Services, to end up not being reported at all. We need to correct this if we are to avoid losing important trending data in relation to pulmonary complications. If reporters are in any doubt about how to report a case or the status of their report, they should contact Julie Ball in the SHOT office.

Hospital stocks and usage of platelets

Clarification of statements made in the SHOT reports

In the 2007 and 2008 reports, a learning point from the Haemolytic Transfusion Reaction chapter included the following statement:

"Group O platelets can cause acute haemolytic reactions even when tested and labelled negative for high-titre haemolysins. They should only be used for non-group O patients (particularly paediatric patients) as a last resort, and should not be kept by hospitals as stock" This statement has been one factor leading to a disproportionate demand from the UK Blood Services for group A platelets for stock, which is not sustainable. Furthermore, in endeavouring to meet this demand, the Blood Services need to obtain platelets from both buffy coat pools and apheresis and to use donors of either sex; both of which are contrary to the current safety strategy for reducing the risks of transfusion-transmitted vCJD and transfusion-related acute lung injury (TRALI).

Consequently it is necessary to revise this statement in the interest of the overall safety of the blood supply and to emphasise that the risk of giving group O platelets to a non-group O adult patient in the context of trauma or massive haemorrhage is negligible.

SHOT Recommendations

- Hospitals who need to stock platelets should keep a mix of group O and group A
- Hospitals should transfuse ABO identical platelets whenever possible

Further information and references about the risks of transfusing group O platelets to non-group O patients can be found on the SHOT website. www.shotorg.uk

Arms Length Body Reviews

The ALB review was published by the Minister of Health, Andrew Lansley on 26th July 2010. The MHRA has been maintained in its current format but has to operate in a more cost effective and efficient way. The functions of two Arms Length Bodies are to be transferred to other organisations: these are the Human Fertilisation and Embryology Authority and the Human Tissue Authority. Two Arms Length Bodies are to be abolished as statutory organisations and their functions transferred to the Secretary of State as part of the new Public Health Service: these are the Health Protection Agency and the National Treatment Agency. Four Arms Length Bodies are to be abolished completely from the sector: the Alcohol Education Research Council, the Appointments Commission, the NPSA and the NHS Institute for Innovation and Improvement. These various changes are not all for immediate implementation but are to take place over a period of time. In addition the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) as a body no longer exists and will be reconstituted in the Department of Health as an advisory committee.

SHOT Symposium Report

The 2010 meeting took place at the Lowry Arts Centre, Manchester, which proved to be an exciting venue and very popular with the delegates. The meeting was well attended and the feedback was excellent with very high ratings from most delegates on overall atmosphere, programme, presentations, posters, exhibition, and venue and catering. Exhibitors from the industry were also very positive. Highlights of the meeting included an introductory talk on the state of the art of haemovigilance from Prof Rene de Vries, President of the IHN, and a comprehensive overview of TRALI and TACO by Dr. Mark Popovsky which was felt by delegates to be a very valuable contribution.

NPSA & Under / Over Transfusion

In October 2010 the NPSA issued a rapid response report (RRR) on the subject of access to blood: "Transfusion of blood and blood components in an emergency". Link http://www.nrls.npsa.nhs.uk/alerts/?entryid45=83659

This document was developed in close collaboration with members of the NBTC and with SHOT. It is based on a number of reports which have been received by the NPSA in which patients did not receive blood components in a timely fashion owing to logistical and communication problems.

SHOT remains very keen to receive reports of cases in which there has been patient harm from delayed transfusion or either under or over transfusion. Please do make all the members of your Hospital Transfusion Committee aware of the desirability of collecting this important data, since not all cases come to the notice of the immediate Transfusion Team and this is an area of growing concern especially following the issue of the RRR from the NPSA .

Report on SHOT Steering Group Meeting October 2010

This meeting saw the attendance of two new members:

Dr. Sue Knowles, who has since commenced as locum Medical Director of SHOT and Dr. Heidi Doughty representing the Defence Medical Services. Details of all members of the SHOT Steering Group are available on the SHOT website (www.shotuk.org). Updates were received on the status of the Dendrite database and it was gratifying to learn that the speed of access to Dendrite has been much improved since moving the database to the N3 server. The new SHOT website has proved popular with an average of 129 hits per day and has been generally acknowledged to be a big improvement on the previous version. SHOT has continued to raise the profile of adverse events reporting by attending meetings nationally including BGS Durham, ScotBlood and BBTS as well as giving presentations at international meetings such as EHA, IHN, SIMTI, and AABB. SHOT has a slight under spend on this year's budget.

The main recommendations in the 2009 report were discussed:

- A project is to be undertaken by NEQAS in collaboration with SHOT to evaluate haemoglobin estimations performed on blood gas analysers. Currently these are not included as part of any external quality assessment scheme and NEQAS is going to pilot a scheme for this.
- The main IT recommendation from the report to liaise closely with manufacturers to develop standard, detailed specifications for electronic systems in the laboratory, at the bedside and at the clinical-laboratory interface, has been discussed at the NBTC and referred to the IT subgroup of NBTC and the Transfusion Laboratory Managers group for progression.
- The recommendation regarding pulmonary complications of transfusion will be taken forward through SHOT (see reporting section) and a prospective study is under discussion to investigate fully a greater number of cases of potential TRALI and to obtain some denominator data.
- A patient empowering initiative may be developed following SHOT's recommendation that patients should ask 'do you know who I am?' before allowing clinical staff to carry out any investigations or interventions such as blood transfusion. This too was discussed at the NBTC and may be taken forward by the Patient Awareness Group. However it is acknowledged that this problem of patient identification is not only related to blood transfusion but is also crucial in drug administration, investigations, operations, diets etc. Therefore a much wider inclusion across all hospital specialities would be necessary for this to be an effective initiative. If this were initiated by the Department of Health nationally it could be a very important step forward in reducing patient identification errors.

Below are photographs of Dr Hannah Cohen (Chair of SHOT Steering Group) presenting leaving / long service awards to Dr Clare Taylor, Mrs Hilary Jones and Mr David Mold on behalf of the Steering Group.

Diary Dates

- IHN . 9th—11th February 2011. Amsterdam. International Haemovigilance Society (www.ihn-org.net)
- EHA 9th-11th February 2011. TelAviv, Israel. European Hematology Association (www.ehaweb.org)
- BSH 4th—6th April 2011. The Brighton Centre British Society for Haematology (*www.b-s-h.org.uk)*
- ISBT 18th—21st June. Lisbon Portugal. ISBT-WEB.ORG *(www.isbt-web.org)*
- **SHOT Annual Symposium. Wednesday 6th July 2011. The Royal Society of Medicine** www.shotuk.org

SHOT Annual Symposium 2011

Wednesday 6th July 2011.
Royal Society Of Medicine, London.
Keynote Speaker: Prof. Sunny Dzik.
Details to follow on our website

Call for Posters

Share your experience and knowledge with the transfusion community.
£100 book token for the poster judged best on the day by Prof. Mike Murphy.
Deadline for submission: Fri 29th April 2011.
Instruction for submission

Call for Sponsors and Exhibitors

Join us and promote your company to the transfusion community.
Help us to keep the costs down for delegates attending this important educational meeting.

Further details www.shotuk.org or 0161 423 4208