NPSA SAFER PRACTICE NOTICE 14 REVIEW GROUP OF THE NBTC

Minutes of the meeting held on Friday, 7 September 2012
at NHSBT Offices, New Street, Birmingham.

Craig Taylor	(CJT)	Chair
Jayne Addison	(JA)	NHSBT Transfusion Liaison Nurse
Carol Blears	(CB)	The Mid-Yorkshire Hospitals NHS Trust
Paula Bolton-Maggs	(PBM)	Serious Hazards of Transfusion (SHOT)
Tony Davies	(TD)	NHSBT Transfusion Liaison Practitioner
Emily Okukenu	(EO)	Barts Health NHS Trust

14/12	**Apologies**
	Kairen Coffey, NHSBT BBT Education & Audit Lead.
15/12	**Minutes of the Last Meeting**
	The minutes of the teleconference held on 14 June 2012 were accepted as a correct record.
16/12	**Matters arising**
	Item 09/12:
	CJT stated that the role of Skills for Health with regard to the SPN 14 competencies remains unclear and that the NBTC and SHOT are proceeding with the review of the SPN. MHRA have advised that they are happy for the working group to proceed but would like to be kept informed of the outcomes. PBM had forwarded details of the NEQAS initiative relating to competencies for laboratory staff.
17/12	**Meeting of Transfusion Practitioners (26 June 2012)**
	CB provided feedback from the meeting of transfusion practitioners to her presentation on the work of the review group to date. The main comments from that meeting were: • The initial views on the proposal to move the strategy to knowledge based tests and not to re-assess were positive. • There is a need to consider transferability of competency assessments. • The requirement for relevant staff to be formally assessed against the competencies set out in the SPN should be adjusted to 90% as 100% is unrealistic.

	• Concerns were raised about the assessment of agency nurses and locum doctors. It was noted this is outside the remit of the review group. • Whether staff who have been competency assessed and make an error are negligent or incompetent. TD advised on a request from a neonatal practice educator to be involved in the wider virtual review group. **Action: TD to provide contact details to Kairen Coffey.**
18/12	**Review of current documents/resources**
	A total of 30 documents were circulated for review.
18.1/12	Paper 1: Y& H RTC. Venepuncture Training and Competency Assessment. Paper 15: The Mid Yorkshire Hospitals NHS Trust. Competency Assessment in obtaining venous blood samples. Paper 16: Y& H RTC. Guidance notes for assessors. Obtaining venous blood samples competency assessment document.
	• Transferability of competency assessments and recording on Electronic Staff Record (ESR). All documents need to be compatible with ESR. • Depth of assessment - proposed rating scale. • Labelling of the blood sample - needs to be expanded. • Need for more questions with minimum detailed response. • Laboratory staff need to understand basic ABO grouping.
18.2/12	Paper 7: Transfusion package competency assessment – produced by the Welsh education sub-group rev. Feb 2007
	Pages 10 and 11. • Assessor guidance notes on knowledge assessments and the need for candidate to demonstrate an understanding of the knowledge assessment. • Observational performance criteria.
18.3/12	Paper 12. South East Coast RTC – Obtaining a venous blood sample for blood transfusion.
	This work book covers the knowledge part. The candidate is required to complete the work book and achieve a pass rate of 90% or more.
18.4/12	Assessment
	• It was agreed that self assessment is not acceptable. • Collection and receiving of blood needs to be included. • Competencies produced based on NPSA and Welsh document - model answers in more depth and include things that must be answered.

	• Patient ID needs a separate sub module.
18.5/12	Decision to transfuse
	• Appropriateness of blood components. • Consider preparing 10 questions which should cross your mind before you transfuse. Guidance in 'ABC' format • The Learnbloodtransfusion module is being developed and can be dove-tailed. • Consider what is being highlighted under education – this should include the SaBTO recommendation on consent.
18.6/12	Request/Prescription
	• The request side is not covered by the NPSA only alluded to on sample and nowhere else. • Appropriate amount of blood prescribed – volume/units • Special requirements and groups. • Include nurse prescribing.
18.7/12	Collection/Safe Handling/Delivery and Receipt
	Paper 5: Collecting blood/blood products for transfusion assessment framework pro forma Paper 2: BHR page 13 onwards – question 4 onwards Welsh document – review questions on page 20. • There has to be absolute traceability – when the unit is dispensed/collected it has a traceability note attached to it. The issue tag on the unit needs to be completed and returned. • Ensure that the patient information on the blood collection slips matches the wristband. • Collection and safe handling demands some knowledge of what the components are and how they should be stored. This should be part of the practical assessment. Core knowledge about safety issues. • Include handing over of the blood components. A positive check that the blood components have been handed over to an appropriate member of staff. • Include emergency blood and the need for this to be clearly labelled. Specific increased risk about emergency units.
18.8/12	Administration/Paperwork
	NPSA document splits this up into two; receipt and preparation and administration. • Patient ID module. • Ensure the patient is ready. • Suitability of the blood component. • Expiry date/special requirements/reasonable requirements about special groups/ knowing when irradiated blood is needed.

	• Need for knowledge base on giving blood quickly in an emergency. • Know where to go for blood.
18.10/12	<u>Monitoring (A Sub Component of Administration) Separate Component Of Administration).</u>
	<u>Paper 11 – SEC RTC work book – receipt and administration</u> Paper 9 - Transfusing at night. Page 25 – Patients with a Fever • Need to include practicalities of monitoring and transfusion reactions – why and when. • Monitoring, recognition of reaction, management of reaction and reporting. • Observation/schedules. • Important patient information – make sure the patient knows what to do if they feel unwell.
18.11/12	<u>Documentation</u>
	• There are legal requirements for proof of traceability. • Clinical requirements and part of the basic transfusion to state start and stop times.
18.12/12	<u>Practical Assessment</u>
	Practical assessment has to be additional to the knowledge base. It is the responsibility of hospital trusts to make ensure staff are assessed. Practical/observational assessments should be the responsibility of the local clinical area as this would address issues in variation in practice in the various medical wards. These should be carried out by the department staff who are trained as assessors. Staff moving from one hospital or department may require to be risk assessed because of variation in local practice.
19/12	**Next steps**
	• CJT will provide a verbal update report to the NBTC meeting on 24 September 2012. • The review group to work on the basic framework. A minimum standard for the new competencies with supporting documentation (a toolkit). The documents will be circulated for comment by the wider group. • TD advised that SHOT are considering breaking down the transfusion process into key points with more tailored steps in the process. Not all the steps will be applicable to all staff. • Guidance is needed on action required if the member of staff fails the competency assessment with a recommendation on remedial action required. Establish a mechanism for staff who fail. Consult with hospital risk managers.

	• Whilst 100% competency may not be achieved, all hospitals units should have adequate numbers of staff trained to provide what is required in blood transfusion. The standards for transfusion are the same as for e.g. chemotherapy – staff should only administer if they have been assessed and trained. It is up to the department/hospital trust to determine the numbers of staff who are required to be assessed. • Aim of the review is to improve the knowledge base in the hope that it will influence practice more than previously has been. • Re-define the key principles of safe blood transfusion practice keeping it as simple as possible. • Draft set questions with clearly defined answers to fit the mandatory requirements. Provide answers which show an increasing depth of knowledge. • Provide statement on who can be an assessor. Not a formal qualification but the assessor should be competent in blood transfusion practice. • TD agreed to design a template form and circulate to members. • Agreed that the work would be reviewed as follows: Sample taking - JA Collection and handling - TD Administration and documentation – EO Monitoring – CB • Members to circulate completed forms within the review group for comment.
21/12	**Date of Next meeting**
	To be arranged.