NPSA SAFER PRACTICE NOTICE 14 REVIEW GROUP OF THE NBTC

Minutes of a meeting held on Friday, 15 March 2013
at NHSBT offices, New Street, Birmingham.

Present:

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)
Kairen Coffey	(KC)	NHSBT BBT Education & Audit Lead
Alister Jones	(AJ)	NHSBT Transfusion Liaison Nurse

Apologies:

Emily Okukenu	(EO)	Barts Health NHS Trust

1.0	**Introduction**
	CJT stated that arising from a review of Safer Practice Notice 14, the introduction of the competencies has not been effective in reducing ABO incompatible transfusions and they have proved difficult and time consuming to implement. The focus now is on developing competency documents which contain an increased depth of knowledge and the primary purpose of the meeting is to produce a competency document for pre-transfusion sampling. PBM advised that NEQAS are developing better learning exercises for laboratory staff.
2.0	**Process of training and competency assessment**
	A draft algorithm (Appendix A) on how the process of training and competency assessment would work was produced. There was discussion on the frequency of re-training and it was noted that MHRA requires competencies for blood collection to be revalidated every 2 years. The frequency of re-training varies between hospitals and it was agreed to check any available evidence on the frequency of re-training of emergency services. **Action: KC** • There is a need for a mechanism to register failure to achieve the require standard at re-training with an email alert to the administrator notifying failure. The transfusion practitioner to advise the ward manager or other appropriate manager that a member of staff has failed. • There is a requirement for a definition of 'new starter'. Staff who are new starters but not newly qualified will need to provide

	evidence of having undertaken re-training of the knowledge-based competency in the last 2 years. • Devolve training from transfusion practitioners by cascading to transfusion assessors on wards. • For medical staff – only anaesthetists, emergency department staff and medical admission staff will require to be assessed. • Foundation Year 1 and 2 doctors – require training in obtaining a blood sample. • Consultant haematologists should be assessed in sampling. • There is a requirement for medical staff, particularly those with responsibility for junior doctors, to undertake e-learning transfusion training including safe practice but not competency assessment.
3.0	**Assessment criteria**
	The accepted pass rate for mandatory training in hospitals is 80%. Some essential questions on specific standards which cover increased depth of knowledge will require a 100% pass rate. This is necessary to achieve best practice. Guidance is required from the transfusion practitioner with regard to staff who are deferred or failed at re-assessment. It was suggested this should include a review with the ward manager (or other line manager) and the staff member will be suspended from practicing blood transfusion pending re-training and re-assessment. Suspended staff will be seen by the transfusion practitioner within 7/14 (?) working days. There is a need to quantify the severity of the fail, to develop a robust system and provide guidance on the steps to be followed. The onus is on the individual to accept professional responsibility.
4.0	**Pre-transfusion Sampling - template**
	The pre-transfusion sampling document was reviewed and revised as per Appendix B.
5.0	**Scenarios for e-learning**
	It was agreed to develop some scenarios to cover each process of the e-learning module. Suggestions included: 1. Dealing with a non-English speaking patient. 2. Nurse being handed a sample to label. 3. A member of staff asked to bleed a patient and handed pre-labelled tubes 4. You find a dish at the nurses' station with pre-labelled sample tubes what do you do? 5. A patient with haematemesis needed an urgent transfusion. The patient's wristband is contaminated with blood what do you do?

6.0	**Community Hospitals**
	The group have been requested to consider the issue of competencies in community hospitals and to provide guidance on the number of transfusions which should be administered by staff to maintain skill levels.
7.0	**Next steps**
	Agreed actions: • The group will review/revise the draft pre-transfusion sampling assessment document and algorithm. • Once agreed, the two documents will be circulated in pdf format to transfusion practitioners via the RTC administrators for comment. • AJ to develop a template feedback form (in word format) to be circulated with the above two documents. • CJT to provide an update report to the NBTC meeting on 22 April. • As the full guidance will take some time to develop there is a need to provide an interim update for transfusion practitioners.