Transfusion Professionals Network

SUMMER NEWSLETTER January 2017

## HAA: November 13-16

HAA, as usual, was well attended and it was good to see so many members of our Transfusion Professional network in attendance and enjoying the opportunity to learn and network with colleagues.

We attended some really interesting sessions, though it was sometimes difficult to decide which session to attend when there were so many interesting talks on at the same time!

On day one there session on disaster preparedness and recovery which highlighted that often the effects on the blood supply are not felt at the time of the disaster but afterwards, when donors, personnel and equipment are all negatively affected. It was particularly poignant to have Peter Flanagan from the NZ Blood Service discuss the Christchurch earthquake, only to wake up the next morning to find NZ had suffered another major quake. Our thoughts were with all our NZ colleagues.

There were a number of sessions focusing on obstetrics and paediatrics. One session discussed the option of single dose RhD Immunoglobulin prophylaxis, but did not appear to support this as a better option than current two-dose regime. In another session, the use of Ferric carboxymaltose in children was discussed, a practise that is not currently supported as the product is not licensed for patients under 14 years of age at this time,

The nurses symposium explored a case study where a Jehovah's Witness patient with MDS was allografted. This gave the audience a number of ethical issues and dilemmas to ponder. The nurses 'how-to' sessions were also well attended and helped delegates to understand topics such as clinical audit, cytogenetics and MPNs more clearly.

The Gala dinner was a great opportunity to catch up with friends and colleagues in a less formal setting.

The final day saw fewer numbers attending (perhaps some sore heads from the night before?) but the speakers were still exceptional. The final talk on the day was given by Sunny Dzik, from Boston. Attendees left feeling they were a very small part of a big world.

The ANZTPN AGM was held on Tuesday 15th and was well attended. The group discussed what the network could be doing to support the membership into the future. There were some really useful suggestions and the committee will look at following up on these over the next year. Adrienne Wynne (nee Harper) and Chris Akers will continue on as the secretariat for this year, with Angie Monk and Sue Darby from WA taking over in 2018.

The Clinical Practice Improvement Committee (ANZSBT) arranged a lunchtime meeting to discuss the 30 minute rule in transfusion. There is some evidence available that up to 60 minutes out of controlled storage does not increase the risk to the patient, however there are some limitations to this as discussed in an article by Foley et. al. in Transfusion Medicine , Vol 26, Iss 3 p 166-169. The Canadian Blood Service has undertaken some research and in conjunction with the Canadian Standards Association have extended the 30 minute rule to 60 minutes. This is something to think about as a way to reduce wastage.

For those who attended HAA this year we hope you had a great time and found it useful. For those who didn't get there this year, hopefully we will see you in Sydney in 2017!

## ISBT: Report from April Haberfield, Transfusion Safety Officer, Alfred Health

The International Blood Transfusion Society (ISBT) was founded in 1935 and has members in over 100 countries. All professionals involved in transfusion medicine are eligible to become members; the aims of the society being to connect other transfusion professionals, provide opportunities for exchanging information related to blood transfusion medicine and support safe and sufficient transfusion therapy globally. PTO

## ISBT: Report (cont.)

In 2016 the 34th international congress was held from September 3-8 at the Dubai World Trade Centre. This was the first time the meeting had been held in the Middle East, and I was fortunate to be able to attend. Having also attended the previous year in London, I was part of the inaugural Transfusion Practitioner (TP) subgroup meeting during the Academy Day, this consisted of a whole session dedicated to TP's where presenters spoke of their experience working in the TP role in their own countries, their effectiveness within the role and national influences that guide their practice. An inaugural TP networking breakfast helped facilitate and solidify international working relationships.

The subgroup evolved further in 2016, initiating the TP forum during the congress, to help TP's further connect and share knowledge by providing a platform for international TP collaboration. The forum helps promote the TP role and its value within international PBM initiatives, while providing tools and evidence to implement these initiatives. It also empowers TP's by providing resources and information to support us in our workplace.

The forum sessions were both informative and interactive, with presentations on massive transfusion by Haematologists, the role of the Transfusion Practitioner in patient safety, and a data workshop which focused on using clinical audit data to set up and monitor an anaemia clinic to optimise patients for elective surgery. The sessions finished with a networking afternoon tea which was a great opportunity to discuss common interests within the field of transfusion and network. It was great to see some familiar faces from the previous congress too!

In 2017 ISBT will be held in Copenhagen, Denmark. I feel these meetings are a wonderful opportunity for TN's, TSO's, TT's to gain international support for their own role, network with like-minded colleagues, develop personally and professionally and be part of the international TP transfusion community the TP role is alive and well and I hope to see you in Copenhagen!

## Pre-operative anaemia management:

In 2015 Blood Matters undertook an audit of pre-operative anaemia assessment and management for elective surgery. The audit found that although a large proportion of patients were reportedly assessed for anaemia, the quality of this assessment varied and did not always meet current recommendations. Frequently the assessment took place with a limited time in which to identify and manage anaemia prior to surgery. This lack of quality assessment impacts the patient and the health service, as patients who were anaemic at surgery were more likely to be transfused and in general had a longer length of stay.

The Australian Commission on Safety and Quality in Health Care is leading a National Patient Blood Management Collaborative to support improvements in the management of anaemia for patients having selected elective surgery procedures. Following a national expression of interest, the Collaborative commenced in April 2015 with 12 participating Health Services from across Australia. The Collaborative encompasses the scope of the patient journey, from the time that the need for surgery is identified, through inpatient care, and then subsequent care in the community. The Collaborative will run to April 2017 and resources developed by Collaborative teams will be shared more broadly after this, in consultation with the National Blood Authority, as part of the Collaborative process.

## What's happening around Australia and New Zealand?:

**New South Wales:** The NSW Blood Watch program partners have undertaken a second round of Patient Blood Management audits in the Perioperative and Medical populations. Blood Watch is continuing to work in collaboration with the Agency for Clinical Innovation on a surgical pathway and engaging in work on clinical variation.

**Queensland: The launch of** BloodStar went smoothly, although there have been some issues with SCIg. Two Transfusion Education forums for QLD nurses are planned for March 2017 in Brisbane and the Gold Coast. The annual face to face meeting of TNs will also occur in March.

**Tasmania:** Work has been focused on aligning IVIg protocols and documentation across the state.

**Victoria: the** 2015 audit of identification and management of pre-operative anaemia has been released and is available on Blood Matters website, as is the 2014-15 STIR report. 2017 audit planning is ongoing—the first will be a snapshot audit covering iatrogenic blood loss. A number of education sessions and TN forums have been

A CPI project on Emergency O neg stock holdings across regional/rural Victoria is ongoing.

**Western Australia:** BloodSTAR is due to go live in December. Angie and Dawn are interested to hear about the experience in other states.

**Upcoming Conferences:**

**Inaugural perioperative PBM symposium – journey of a trauma patient**

Saturday 18th February

**Register at** [www.health.qld.gov.au/metronorth/events/ppbms/default.asp](www.health.qld.gov.au/metronorth/events/ppbms/default.asp)

**Transfusion Update:** Sydney, April 27th, Time—TBA


## Your Transfusion Professional Representatives

| Area | Name |
|---|---|
| ACT | Maria Burgess |
| New South Wales | Sally Francis, Angie Dalli |
| New Zealand | Liz Thrift |
| New Zealand Blood Service | Fiona King |
| Northern Territory | Julie Domanski |
| Queensland | Susan Kay, Fiona Clarke |
| South Australia | Barbara Parker |
| Tasmania | Dawn Richardson |
| Victoria | Chris Akers & Adrienne Wynne |
| Western Australia | Angie Monk & Sue Darby |
| Australian Blood Service | Bev Quested |
| ANZSBT Council | Debbie Pinchon |