Te Hononga Whētuki ā-Motu
National Trauma Network

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

# Meeting Minutes

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| **Meeting:** | **Critical haemorrhage project expert reference group meeting** |
| **Location:** | Via Zoom. |
| **Date:** | Monday 15 June 2020 |
| **Time:** | 11.00 – 13.00 |
| **Attendees:** | Kerry Gunn, James Moore, Richard Charlewood, Susan Mercer, Ian Civil, David Drower, Gabrielle Nicholson, Paul McBride, David Lang, Caroline Gunn, Christopher Jephcott, Orla Fowden, Richard Aickin, Dominic Fleischer, David O'Bryne, Andy Swain, Sandy Ngov |
| **Apologies:** | Jack Hill, Renate Donovan, Siobhan Isles |
| **No response:** | Tony Smith |

| Discussion | Actions/ Follow up |
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| **Introductions**<br><br>New members welcomed:<br>Caroline Gunn (Consumer rep), Jack Hill (Māori rep), Renate Donovan (Clinical nurse specialist), Christopher Jephcott (Anaesthetist), Orla Fowden (St John), Richard Aickin (NZ Resuscitation Council rep).<br><br>Minutes from the last meeting approved. | |
| **Project plan and TOR**<br>*The project plan and terms of reference were shared with the group*<br><br>Due to COVID-19, the original project timeline has been deferred by three months, this is reflected in the updated project plan.<br><br>Feedback from group on project plan:<br>- Update bullet points under Project Objectives to emphasise the importance of an initial focus on controlling bleeding (i.e. something like 'rapid identification of and early intervention to control critical haemorrhage' should be explicitly stated).<br>- Further to above, Project Objectives needs to include the importance of effective pre-hospital warning that an exsanguinating patient is incoming<br>- Critical haemorrhage deaths are often associated with: process, education and system issues/ problems – need to ensure that the Project Objectives and implementation of the guidance/ bundle addresses these.<br>- Another potential bullet under the Project Objectives heading is to get pre-hospital whole blood available throughout NZ (where resources/ skills make this feasible).<br>- Also, further to above, simplifying and improving access to whole blood in hospital should be stated under the Project Objectives heading. | 1. Gabrielle to update the project plan and share.<br>2. Sandy to update the TOR (i.e.: remove 'draft' heading) and send out as final version. |

| Discussion | Actions/ Follow up |
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| - Discussion re how we capture patients that receive blood without an MTP being activated and/ or they don't make the threshold for entry into the ANZMTR (massive transfusion registry) because the entry criteria is set very high (5 units). Further discussion re this is needed.<br>- This led to a discussion re the entry/activation criteria for the bundle (notwithstanding we should also avoid unnecessary activation). Further discussion re this is needed<br><br>Endorse TOR:<br>- Attention to Point D under key tasks: The ERG members are required to assist with sector engagement/to champion the outputs of the project during implementation and sector uptake.<br>- **Group agreed the TOR**. | |
| **ERG membership and wider reference group**<br>*Revised group list shared with the group*<br><br>Suggested for James McKay (trauma surgeon at Canterbury DHB) to be added to the core group.<br><br>Decisions re the bundle made by this group will be brought to the wider group for consultation periodically. | 3. Gabrielle to follow up with Dominic to get James McKay's contact info.<br>4. Gabrielle to work with Kerry to initiate communications with the wider group. |
| **Case for change infographic**<br>*Draft infographic was shared with the group*<br><br>The infographic is targeted at the consumer. Its purpose is to help people understand why we're doing the project (the case for change) and what we are trying to achieve.<br><br>Feedback from group on infographic:<br>- Add a statement to say the project aim is to create a national, best practice guidance and bundle of care for critical haemorrhage that hospitals can adjust for local context.<br>- Revise statement on reduced blood product waste to remove the $ figure and instead emphasis the benefits being reduced pressure for blood donors and reduced wastage of blood products.<br><br>Further down track our communications will specify what is the make-up of the bundle (output of this project), and how it achieved what we set out to in this infographic. | 5. Team to update the infographic and send to the group (outside of ERG meetings). |
| **Draft evidence to date/ short review paper**<br>*Paper was shared with the group in advance of the meeting.*<br><br>Time constraints meant this item was not discussed. It will be added to the agenda for the next meeting. Comments and feedback welcome at any time. | 6. Everyone to review and provide any feedback for discussion at the next meeting. |
| **Draft critical bleeding bundle/ guidance components**<br>*Kerry presented to the group, including a high-level proposed bundle components/flowchart.*<br><br>Feedback from group on bundle components: | 7. Share presentation slides with the group. Everyone to review and provide feedback. |

| Discussion | Actions/ Follow up |
|---|---|
| - Discussion on pre-hospital destination policy. Currently this requires uncontrolled bleeding patients to be taken to a facility that can manage the bleeding; irrespective of size of hospital/ whether or not it's a trauma centre, so this could mean being taken to a small hospital.<br>- Remove reference to commercial brand names (i.e., TEG)<br>- Recommend shifting the technology interventions closer to the emergency department (or earlier in the patient pathway).<br>- Clinical gestalt (ie, clinical impression/intuition) should be included as part of the activation criteria. This is important for e.g., older trauma patients that have different physiology that is not supported by ABC.<br>- Process needed for transient responders (patients with ongoing bleeding) for instance, to include radiology as part of the diagnostics (CTA- Computed tomography angiography) that inform intervention options (therapeutics).<br>- Pre-hospital identification of critical bleeding: ABC score would be difficult to use as FAST Scan is 5-6 years away.<br>- Do not include burns under 'Defined specific patient groups' as the initial response for burn patients is crystalloid resuscitation, not prescribing blood products.<br>- Specify the application of tourniquet, binders, local haemorrhage control activities, and include background documents with more detail.<br><br>Discussion about availability of whole blood products on air ambulances:<br>- Important emphasis that administered blood must be part of a wider bundle of care/process.<br>- National policies will require a doctor to be on-scene (a registrar in emergency medicine, intensive care or anaesthesia). This is in- line with other pre-hospital transfusion services around the world and is required as blood is considered a prescribed medicine.<br>- Group raised concerns this will exacerbate equity issues for regions outside of Auckland. It is not possible for a doctor to be deployed on air ambulances 24/7.<br>- Acknowledge this project/bundle must be developed with this policy/parameter in mind.<br><br>The next step is for the team to continue developing the bundle and coming back to this group with guiding questions to inform this over the next months (**aim to complete by end September 2020**). | |
| **Close –** Next meeting for this group scheduled for 24 June 2020. | |