ANSA NEWS

Summer Edition 2017

Dear all

Welcome to the Spring/summer edition of your ANSA newsletter. ANSA had another successful annual conference in Birmingham in May 2017. A big THANK YOU to all of you who attended and contributed to its success. A special mention to Gemma from EBS, ANSA secretariat, who did a very good job in the organisation of the conference. The conference would not have been possible without our corporate sponsors and exhibitors so a big acknowledgement and gratitude to them . The committee will be meeting very soon to start working on the 2018 conference, taking into consideration your feedback.

ANSA said goodbye to Past President Vicki Hipkiss who will be dearly missed. On behalf of ANSA executive committee, members and secretariat, I would like to take this opportunity to thank Vicki for all her hard work and tremendous commitment in taking ANSA steps further on its exciting journey. I am personally grateful for all her excellent advice and support.

From April 2016, ANSA has been through a transitioning period: New President, Treasurer and Secretariat, there have been few challenges but the committee pulled together to overcome them. I must say that I feel very honoured and privileged, as President, to be surrounded and supported by very dynamic professionals. Thank you all.

This year, ANSA is committed to developing the website further, making it more user friendly and interactive. Remember, this is your website, please let us know how we can make it better for you.

There was a discussion at the AGM relating to ANSA registration and membership. The committee took this very seriously and is in the process of working on a resolution.

As it was pointed out at the AGM, ANSA's sponsorship has been affected due to the financial climate, ANSA secretariat, along with your committee are looking at new avenues to overcome this, so that as members you can still benefit from ANSA's valuable resources, to include its conference, at no extra costs. Being an association run by nurses for nurses, ANSA would welcome your thoughts and suggestions. If you are involved with any interesting innovative projects, have any experiences you

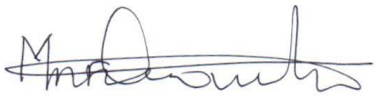
would like to share, or indeed if you have any questions or need advice, do not hesitate to contact ANSA via its secretariat at ansa@anaemianurse.org

ANSA still has vacancies on the executive committee, if you feel you are that dynamic person to contribute to ANSA fascinating journey, why not take the plunge and contact our secretariat. Gemma will be happy to send you relevant information and application form

All the very best to you all and hope to hear from you soon. In the meantime, enjoy the glorious summer we are having

With very best wishes

Marie Chowrimootoo



ANSA President

The 2017 ANSA conference "21st Century Person Centred Anaemia Management was held on May 12th at Austin Court in Birmingham

Our President, Marie, welcomed over 100 delegates to the conference and presented an overview of the programme.

Professor Iain Macdougall gave an interesting presentation on "What lies on the horizon" in anaemia management. He examined the role of hypoxia inducing factor (HIF) stabilisers which are currently starting patient trials. Although it was slightly heavy on the science, Professor Macdougall explained this with his usual expertise.

Elizabeth Clarke, a renal research nurse gave an update on the PIVOTAL study, the largest clinical trial in the UK, covering 50 different hospital sites, started in 2013 and is looking at the best amount of iron to give to haemodialysis. She also very enthusiastically gave the delegates an insight into her role which she described as "a link from researchers to patients". A role that allows her to contribute "to the body of knowledge and ultimately improving patients' care". At the end of her talk, Prof. Iain Macdougall thanked her for being an amazing ambassador for the study and conveyed his sincere thanks to the 50 research nurses involved in that study.

Iain Wittwer and Genalyn Sodusta from Oxford gave an extended presentation about Diabetes, CKD. And anaemia. Iain pointed out that the incidence of diabetes is on the increase and describes it as a tsunamic effect, with the first wave being unsuspecting and the second developing cardiovascular disease, retinopathies, neuropathies and anaemia. He stressed that in 2010, 285 million people were diagnosed with anaemia with a projected figure of 486 million in 2030. Genalyn concentrated on the "old school disease of diabetes", specifying the clinical syndrome of diabetic kidney disease, characterised by

persistent albuminaemia, hypertension, progressive reduction in eGFR and increased risk of cardiovascular morbidity and mortality. She also elaborated on the relationship between diabetes, CKD and anaemia and went through the stages of progression. It was a very well received session.

Dr Richard Borrows give an enjoyable and interesting presentation on post - transplant anaemia management. He looked at all the myths regarding this area and explained them away. One point of discussion was an apparent increase in prescribing ESA within a short time after renal transplant. Dr Borrows did say that he knew of no new evidence to show that this may be beneficial. Dr Borrows also discussed Parvo virus infection post- transplant. Information was given regarding the problem of ITP related to post transplant immunosuppression

The afternoon session was filled by 2 different workshops. The first was led by Emma Prescott, a Thalassaemia Nurse. This was very informative, interesting and thought –provoking. She gave a different perspective to Thalassaemia treatment than is usually the case for renal anaemia nurses.

The other workshop was a lively Question and Answer session dealing with anaemia questions you wanted to ask but had not done so before. Dianne McDaid and Elaine Locke had a variety of very good questions to answer with delegates giving their own experiences to the answers for the benefit of their colleagues.

Overall, it was a good conference with some different learning opportunities presented to the delegates. 96 % of delegates agreed that they found the conference useful and 94% said that the conference has provided them with valuable information which is a fantastic response.

Iain Wittwer

ANSA 'BRS Pop up Session' All Your Questions Answered

For the first time, the BRS conference held 'pop up sessions' throughout this year's annual conference. ANSA were invited to hold a 45 minute session open to all and this was facilitated by our executive members Dianne McDaid and Elaine Locke.

The session was well attended with standing room only five minutes after opening. A brief introduction detailing ANSA's vision, membership and available educational resources (e-learning modules) was followed by the opportunity for questions and answers relating to renal anaemia in clinical practice .

We received many questions and these mainly focused on the following topics:

What effect does renal anaemia have on HbA1c results?

Should newly transplanted patients have ESA?

Should patients with a history of cancer or /and those who develop cancer whilst on ESA therapy be made aware of the associated risks and by whom?

What are the boundaries of informed consent in this situation?

Which guidelines & algorithms exist for renal anaemia?

What is new in renal anaemia? PIVOTAL Study & Hypoxia Inducible Factor Stabilisers (HIF'S) were outlined

Is it common practice in haemodialysis to discard circuit if patients Hb >140?

The ensuing interaction amongst the audience resulted in engaging discussions and sharing of clinical practice.

Dianne McDaid

Hepatitis E Virus- Update

Hepatitis E (HEV) infection usually presents as an acute but mild transient illness. Most people who become infected with HEV have no symptoms and it clears completely within a couple of months. However, in some immunocompromised patients infection can become persistent and may lead to chronic disease.

HEV may be acquired in the UK both through diet and through receiving blood components, tissues and organs from viraemic donors. The Scientific Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) reviewed and updated their recommendations in November 2016, these can be found in full at; https://app.box.com/s/m6or0zdspah90u6kg3r9/1/14460576146

In relation to blood component transfusion SaBTO has extended its July 2015 recommendation (that HEV screened components be provided for solid organ and allogeneic stem cell transplant patients). It is now recommended that all immunocompromised patients (those patients categorised by the need to avoid live vaccines) should receive HEV screened blood components, together with foetuses and neonates. SaBTO guidelines also indicate that patients who are within three months of a planned elective organ transplant and patients who may otherwise receive a solid organ transplant, due to being on the UK national transplant waiting list, should also receive blood components screened for HEV.

It was therefore recommended that universal screening of donated blood, for HEV, should be introduced. NHS Blood and Transplant (NHSBT) have confirmed that from 1st May 2017 all red cell and platelet components routinely issued to hospitals in England, are HEV negative. However, there are still unscreened frozen components (i.e. FFP, Cryoprecipitate) in stock both within NHSBT and hospital transfusion laboratories. Therefore, it is important that you continue to inform your hospital transfusion laboratory if patients require HEV screened components. All UK screened components will continue to be labelled as HEV negative until NHSBT are certain there are no unscreened components remaining in hospital stock. The exception to this are all methylene blue treated, imported plasma components as they are currently HEV screened at source and therefore will not be labelled HEV negative. Also, Octaplas, solvent detergent treated FFP (a commercial blood product), is now screened during manufacture; for further information see:
http://www.octapharma.co.uk/fileadmin/user_upload/2016.009.C_Emerging_virus_flyer.pdf

Remember, immunocompromised patients are at greater risk of contracting HEV infection from their diet than from transmission by blood, tissues, cells or organs. Further advice is available from the Food Standards Agency, at: https://www.food.gov.uk/science/microbiology/hepatitis-e

SaBTO considers the following patient groups at risk of harm from persistent HEV infection.

1. Patients with evidence of severe primary immunodeficiency
2. Patients currently being treated for malignant disease with immunosuppressive chemotherapy or radiotherapy, or who have terminated such treatment within at least the last six months.
3. Patients who have received a solid organ transplant and are currently on immunosuppressive treatment.
4. Patients who have received a haematopoietic stem and progenitor cell transplant for at least 12 months after finishing all immunosuppressive treatment or longer where the patient has developed graft versus host disease.
5. Patients receiving systemic high dose steroids until at least three months after treatment has stopped.
6. Patients receiving other types of immunosuppressive drugs, either alone or in combination with lower doses of steroids, until at least six months after terminating such treatment.
7. Patients who are immunocompromised due to Human Immunodeficiency Virus (HIV) infection with a CD4 count of <200/mm3.
8. Foetuses and neonates.
9. Patients who are within three months of a planned elective organ transplant and patients who may otherwise receive a solid organ transplant within three months due to being on the UK national transplant waiting list or are within three months of being placed on the waiting list.

NHS Blood and Transplant Non-Medical Authorisation of Blood Components (NMABC) course

The NHS Blood and Transplant (NHSBT) Non-Medical Authorisation of Blood Components (NMABC) course was launched in March 2012 in Manchester. Since then over 200 delegates have attended a course held in various locations across England.

The course provides senior nurses and midwives with the theoretical knowledge so they can work towards making the clinical decision and providing the written instruction for blood component transfusion.

Delegates work in an area of clinical practice where making the clinical decision to transfuse and authorise blood components is relevant. It is important that Trusts have a policy for NMABC which states those practitioners who can authorise a blood component, the patient criteria that needs to be met, the blood components covered e.g. red cells, platelets, Fresh Frozen Plasma and the training / level of experience required by the practitioner. All delegates must have the Trust's written permission to undertake the course as part of service development and an identified clinical mentor to support learning in practice.

The course is run over 3 days and includes:

- Haemopoiesis, coagulation and anaemia
- Blood components, specific requirements
- ABO and Rh blood group systems
- Pre-transfusion testing
- Gaining informed consent for blood transfusion
- Hazards of transfusion and reporting adverse reactions and events

- Indications for the use of red cells, platelets and plasma
- Transfusion alternatives and the clinical management of patients who refuse a blood transfusion

Once the delegates have secured a place, they will be asked to complete the ‘Safe Transfusion Practice’ and ‘Blood Components and Indications for Use’ modules on the e-learning package

LearnBloodTransfusion to ensure that all delegates start the course with the same baseline level of knowledge. The e-learning package is available on:

- LearnPro NHS Learning Management System at www.learnbloodtransfusion.org.uk
- E-learning for Health at www.e-lfh.org.uk/programmes/blood-transfusion
- National Learning Management System at http://www.esrsupport.co.uk/catalogue.php5

The course is facilitated by the NHSBT Patient Blood Management (PBM) Practitioner team, with support from teams within NHSBT e.g. PBM Clinical team, Organisation and Workforce Development team, Practice Development and Innovation team, as well as the Serious Hazards of Transfusion haemovigilance team.

Each course is evaluated by the delegates and their comments / feedback is reviewed by a multi-disciplinary working group who will decide if any amendments to the course are required.

Following the course, the delegates will work with their identified mentor to complete the Trust competency assessment. Once deemed competent by their mentor, they will then be able to independently authorise a blood component. It is the responsibility of the authorising practitioner to ensure that their skills and competence are maintained.

Delegates are encouraged to complete a 6 month post course survey and many of those who attended in early 2016 stated that the introduction of non-medical authorisation in their clinical area resulted in a positive impact on patient care/ experience. They noted the greatest impact was the reduced time from decision to transfuse to administration, and how this has improved the holistic approach to the patient pathway.

Dates and venues for future courses can be found on the Hospitals and Science Training page at http://hospital.blood.co.uk/training/programme-diary/

Denise Watson

NHSBT

British Renal Society to Develop First UK Renal Nurse Association

The British Renal Society (BRS) embraces affiliates from all disciplines, and representation from these groups make up the BRS council. For many years nurse groups such as ANSA and EDTNA have been part of the BRS council and BRS has actively recruited senior nurses as Vice Presidents and as a Past President of the society. However, the UK has no formal renal nurse association meaning that there is no single voice representing either registered or non-registered nurses working in the field of kidney care. Therefore renal nurses have a limited and quiet voice with respect to influencing key aspects of the renal workforce, policy, clinical practice and professional education1.
The BRS surveyed 300 nurses with an 83% response. Highest responders were band 7 nurses followed by bands 6, 5, 8a, and 8b. In response to the questions asked 98% felt a renal nurse association would be useful; 67% did not belong to any existing nurse groups/associations; of the 33% who did the most popular were EDTNA/ERCA, ANSA and the dialysis access forum.

Participants were asked to identify what they felt the five key activities of an association would be, consensus was:

- Have a strong nursing voice leading and influencing renal care in the UK (85%)
- Provide a national network of nurses to disseminate, share and discuss best practice (82%)
- Develop evidence based nursing guidelines to inform high quality care/clinical practice (75%)
- Provide access to best practice standards for renal care (52%)
- Set standards for MDT workforce competency and skill mix to ensure high quality patient care (39%)

An interest for sub-groups within the Association was explored, to develop different groups of nurses (other than just treatment specific), and responses indicated that two groups would be important, Health care workers and Clinical Research Nurses.

Nurses were asked if they would consider paying a membership fee to help fund the administration of a Renal Nurse Association. 18% would consider paying £20-£30; 42% £10-£20; 28% £5-£10, 12% no more than £5.

A focus group was held at 2017 BRS conference with 30 nurses attending to discuss the survey results and consensus was to move this initiative forward. Representatives from other nursing groups ANSA, EDTNA, vascular access and research were not opposed to the concept and felt it was a great opportunity for collaborative working.

The BRS needs you as nurses to take this forward and will be networking with renal units. If you are interested in being kept informed, connected and involved in the development of a renal nurse association please email info@britishrenal.org

References: Jenkins K, Ormandy P (2017) British Renal Society to Develop First UK Renal Nurse Association; Journal of Kidney Care Vol 2 No3

Karen Jenkins, BRS Vice President Clinical Practice

Useful Articles

Published in Dove Medical Press and online 2017 Mar 10. oi: 10.2147/HP.S130526
PMCID: PMC5354531Hypoxia (Auckl). 2017; 5: 1–9.
'Induction of erythropoiesis by hypoxia-inducible factor prolyl hydroxylase inhibitors without promotion of tumor initiation, progression, or metastasis in a VEGF-sensitive model of spontaneous breast cancer'
Authors: Todd W Seeley, Mark D Sternlicht, Stephen J Klaus, Thomas B Neff, and David Y Liu

An in depth article that includes information and explains the mechanics behind hypoxia-inducible factor (HIF). Well worth reading in order to gain knowledge and insight into HIF.

Published by PLOS ONE: January 3, 2017
https://doi.org/10.1371/journal.pone.0169117
RESEARCH ARTICLE
'Relationship between Hemoglobin Levels Corrected by Interdialytic Weight Gain and Mortality in Japanese Hemodialysis Patients: Miyazaki Dialysis Cohort Study'
Authors: Tatsunori Toida et al

An interesting trial that takes into account haemoglobin analysis in relation to low and high interdialytic weight gains. The findings aren't necessarily what you'd expect to see.

Published in American Journal of Haemotology. First published: 7 December 2016
DOI: 10.1002/ajh.24595
Critical Review
'Management of anemia in patients with congestive heart failure'
Authors: Lawrence Tim Goodnough et al

It is often difficult to determine how best to treat anaemia in patients with congestive heart failure (CHF) given associated co-morbidities and risk factors. This article includes a helpful algorithm that offers guidance on which direction to take.